I. SCOPE:

This policy applies to (1) Tenet Healthcare Corporation and its wholly-owned subsidiaries and affiliates (each, an “Affiliate”); (2) any other entity or organization in which Tenet Healthcare Corporation or an Affiliate owns a direct or indirect equity interest greater than 50%; and (3) any hospital and/or healthcare entity in which an Affiliate either manages or controls the day-to-day operations of the entity (each, a “Tenet Entity”) (collectively, “Tenet”).

II. PURPOSE:

This policy addresses the circumstances under which Tenet hospitals may furnish Patient Assistance to hospital inpatients who are Federal Health Care Program beneficiaries upon discharge, provided that the patients are eligible to receive such assistance. This policy does not address the provision of items or services with a retail value of ten dollars ($10.00) or less, and fifty dollars ($50.00) or less in the aggregate in any given calendar year (see Regulatory Compliance policy COMP-RCC 4.50 Offering Free or Discounted Goods and Services to Individuals).

The purposes of this policy are to ensure, through the implementation of prudent and reasonable controls, that:

A. Patient Assistance is furnished for the safety or benefit of certain financially needy Federal Health Care Program inpatients; and

B. Patient Assistance is furnished in a manner that complies with applicable laws and regulations, including the Federal Health Care Program anti-kickback law and the Beneficiary Inducement Law applicable to Federal Health Care Program beneficiaries.

III. DEFINITIONS:

A. “Patient Assistance” means the furnishing of certain items and/or services to Eligible Patients upon their discharge from a hospital pursuant to the terms of this policy.

B. “Federal Health Care Programs” means “Federal health care programs,” as defined in 42 U.S.C. § 1320a-7b(f) and include, but are not limited to, Medicare, Medicaid/Medi-Cal, managed Medicare/Medicaid/Medi-Cal, TriCare/VA/CHAMPUS, SCHIP, Federal Employees Health Benefit Plan, Indian Health Services, Health Services for Peace Corp Volunteers, Services Provided to Federal Prisoners, Black Lung Program, Railroad Retirement Benefits and Section 1011 Requests.
C. “Eligible Patient” means a hospital inpatient who is a Federal Health Care Program beneficiary, and eligible to receive Patient Assistance pursuant to the terms of this policy.

D. “Physician” means a duly licensed and authorized doctor of medicine or osteopathy, doctor or dental surgery or dental medicine, doctor or podiatric medicine, doctor of optometry, or chiropractor who has medical staff privileges at a hospital.

E. “Immediate Family Member” means a husband or wife; natural or adoptive parent, child or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild.

F. “Preventive Care Services,” as defined in 42 C.F.R. § 1003.10, means prenatal services, post-natal well-baby visits, or QPC Services (as defined below) reimbursable, in whole or in part, by Medicare or an applicable state health care program.


H. “Care Coordinator” means a health care professional, who is employed by a Tenet Entity to manage and coordinate the care (and assist with arrangements for the post-discharge care) of hospital patients.

IV. POLICY:

All Patient Assistance must meet the following General Requirements:

A. Patient Assistance may be furnished to Eligible Patients. In order to be considered an Eligible Patient, a patient must demonstrate his or her financial need. A patient may establish financial need by virtue of his or her (1) eligibility under the Medicaid program, (2) qualification for charity care in accordance with Tenet Charity Care policies, (3) both items (1) and (2), or (4) lack of sufficient financial resources. A patient will be considered to lack sufficient financial resources if after a review of the patient’s total assets (only those convertible to cash and unnecessary for daily living), liabilities, and income and expenses, his or her financial resources are insufficient to fund the needed post-discharge items or services after payment of mortgage or rent, vehicle and insurance payments, a reasonable allowance for food and utilities and other reasonably essential items.
Review of the patient’s assets, liabilities, and income and expenses may be conducted by a Care Coordinator, a hospital financial counselor, the Director of Case Management, or any other person determined qualified by the hospital CFO to perform such a review.

B. Patient Assistance may not be furnished in the event that there are alternative resources (including the resources of family members residing in the same household, individuals eligible to claim the patient as a dependent for federal income tax purposes and community or charitable resources) to fund the healthcare items or services at issue, or a third party payor is obligated to provide such items or services pursuant to a law or contract.

C. Patient Assistance may not be furnished to a Physician or the Immediate Family Member of a Physician.

D. Patient Assistance in the form of cash (or its equivalent) may not be furnished to an Eligible Patient.

E. Patient Assistance may be offered to hospital Federal Health Care Program inpatients only during their stay at the hospital. Although Patient Assistance may be furnished upon or after discharge, it may not be offered or furnished before admission or offered after discharge.

F. Except as set forth below, Patient Assistance may be furnished only once to each Eligible Patient. The Eligible Patient must be notified and acknowledge in writing of this one-time limitation. A copy of the written notice must be maintained in the Eligible Patient’s financial records, as retained by Tenet Patient Financial Services or Conifer. Patient Assistance provided to patients discharged with a diagnosis of Heart Failure, Pneumonia, Acute Myocardial Infarction, Congestive Obstructive Pulmonary Disease, Total Hip Arthroplasty, or Total Knee Arthroplasty (or any other diagnosis included the Hospital Inpatient Prospective Payment System Readmission Reduction Program) in order to prevent hospital readmission shall not be subject to the one-time per beneficiary limitation described above.

G. Patient Assistance provided under this policy may not be advertised, publicized or otherwise marketed, unless it involves Preventive Care or QPC Services.

H. The costs of Patient Assistance may not be included, directly or indirectly, in any Federal Health Care Program cost report or claim or otherwise shifted to any Federal Health Care Program. These costs must be allocated to a non-allowable cost center.

I. Eligibility for Patient Assistance will be determined, with input from a Care Coordinator or a financial counselor, by the Director of Case Management.
Upon admission as an inpatient to the hospital, a Care Coordinator will evaluate each Federal Health Care Program inpatient for potential discharge planning issues, including the potential need for post-discharge assistance.

Each Federal Health Care Program inpatient’s discharge plan must reflect the patient’s reasonably anticipated post-discharge needs.

If the Care Coordinator identifies a Federal Health Care Program inpatient who is reasonably likely to require post-discharge assistance permitted by this policy, the Care Coordinator will request that a financial counselor conduct a thorough review of the patient’s financial resources to determine if the patient is an Eligible Patient.

The hospital’s Case Management Department will maintain a list of community resources that may help to fund or subsidize the provision of items or services to Eligible Patients. This list will include community resources, such as public and private charities (including those that are affiliated with the hospital), utility assistance programs, pharmaceutical company patient assistance drug programs and the Medicare drug discount card program and Transition Assistance eligibility. If the patient and those individuals legally responsible for providing for his or her health care are unable to pay for the necessary post-discharge items or services, the Care Coordinator will contact the available community resource organizations to inquire if they would furnish the needed items and/or services.

If the Care Coordinator is unable to secure community funding to pay for the necessary items or services, the Care Coordinator will submit a written request for Patient Assistance to the Director of Case Management.

The Director of Case Management may approve requests for post-discharge assistance in accordance with this policy; provided, however, that the Tenet Entity may require CFO approval for assistance in excess of a predetermined dollar amount for an individual patient’s assistance or for assistance exceeding a quarterly or annual aggregate amount.

Types of Patient Assistance Available

Available Patient Assistance is limited to the items or services set forth below, provided that all charges or fees for such Patient Assistance are paid directly to the appropriate provider or vendor and not to the patient. The limitations on the number of Patient Assistance days or visits set forth below does not apply to patients for whom a Medicaid application is pending, and which the hospital believes in good faith will be approved, in which case up to ninety (90) days or thirty (30) visits may be paid.
Title: HOSPITAL-PROVIDED POST-DISCHARGE ASSISTANCE TO FEDERAL HEALTH CARE PROGRAM BENEFICIARIES

<table>
<thead>
<tr>
<th>No.</th>
<th>L-6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Page:</td>
<td>5 of 7</td>
</tr>
<tr>
<td>Effective Date:</td>
<td>05-06-15</td>
</tr>
<tr>
<td>Retires Policy Dated:</td>
<td>06-14-04</td>
</tr>
<tr>
<td>Previous Versions Dated:</td>
<td></td>
</tr>
</tbody>
</table>

1. Payments for non-covered but medically appropriate outpatient services at hospital or another provider of the patient’s choice, not to exceed thirty (30) days or ten (10) visits. Payments must be made after the services are rendered.

2. Payment of up to thirty (30) days of rental of non-covered durable medical equipment required for the patient’s continued recovery from the condition that necessitated inpatient care as ordered by the treating physician or licensed independent provider (LIP) and as evidenced by a prescription.

3. Payment of up to thirty (30) days’ supply of medication, including IV medication, and nutritional supplements required for the patient’s continued recovery from the condition that necessitated inpatient care as determined by the treating physician or LIP and as evidenced by a prescription.

4. Payments for nursing home care at a provider of the patient’s choice, not to exceed thirty (30) days for nursing home care provided that the payment for such services is determined to be fair market value and the arrangement is set forth in a written agreement between the nursing home and the hospital.

5. Payments for up to thirty (30) consecutive days of visits by a home health agency to provide home health services or assistance with the activities of daily living, provided that the payment for such services is determined to be fair market value and the arrangement is set forth in a written agreement between the home health agency and the hospital.

6. Payment of the first and second due utility bill after the patient’s discharge up to a total aggregate payment of one hundred dollars ($100.00) when the patient requires the use of electric-powered medical equipment.

7. Payment for outpatient dialysis for a newly-diagnosed End Stage Renal Disease patient who is within the three (3) month waiting period for Medicare coverage to begin, continuing until the first to occur of the effective date of Medicare ESRD program coverage or three (3) months of payment.

8. Complimentary Local Transportation if furnished in compliance with the terms of Law Department policy L-7 Complimentary Local Transportation.
9. Patient Assistance of a type other than described in sections 1 - 8 above require prior written approval by the hospital’s assigned Operations Counsel.

K. Types of Patient Assistance Not Available

1. Assistance for medical conditions unrelated to the patient’s primary condition requiring inpatient hospital services; and

2. Assistance primarily for the convenience of the patient or his or her caregivers or for the convenience of the patient’s physician or LIP.

V. PROCEDURE:

A. Documentation

The hospital is responsible for documenting all items of Patient Assistance provided pursuant to this policy. The documentation must include a description of the Patient Assistance offered, the date the Assistance was offered, the date(s) during which the Assistance will be provided, the patient’s name, the patient’s account number, the date(s) of service on the patient’s account, the vendor through which Patient Assistance will be provided and the amount and date of payment to the vendor.

B. Auditing and Monitoring

Audit Services will audit compliance with this policy.

C. Responsible Person

Each hospital’s Director of Case Management is responsible for ensuring that all individuals adhere to the requirements of this policy, that these procedures are implemented and followed at the hospital, and that instances of policy noncompliance are reported immediately to the Compliance Officer.

D. Enforcement

All employees whose job responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.
VI. REFERENCES:

- Anti-Kickback Law, 42 U.S.C. § 1320a-7b(b), and implementing regulations

- Beneficiary Inducement Law, 42 U.S.C. § 1320a-7a(a)(5)

- OIG Special Advisory Bulletin, Offering Gifts and Other Inducements to Beneficiaries, August 2002

- OIG Advisory Opinions 97-4, 98-6, 99-6, 99-7, 00-5, 01-12, 01-14, 01-18, 02-7, 02-16, and 13-10