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## 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 or healthcare entities in which an Affiliate either manages or controls the day-to-day operations of the entities (each, a “Tenet Entity”) (collectively, “Tenet”).

## II. PURPOSE:

The purpose of this policy is to describe the situations in which Tenet Entities may waive or reduce that portion of the patient bill which is the direct responsibility of the patient.

## III. DEFINITIONS:

- A. **“Determination of financial need”** means a good faith determination depending on an individual patient’s circumstances. The factors that may be considered include: the local costs of living; a patient’s income, assets, and expenses; a patient’s family size; and the scope and extent of a patient’s medical bills. A provider should take reasonable measures to document a determination of financial need. Further, because a patient’s financial status may change over time; the provider should recheck a patient’s eligibility at least yearly to ensure that the patient remains in financial need.
- B. **“Federal health care program”** means any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government, including but not limited to: Medicare, Medicaid/Medi-Cal, managed Medicare/Medicaid/Medi-Cal, Tricare/VA/CHAMPUS, SCHIP, Indian Health Services, Health Services for Peace Corp Volunteers, Federal Employees Health Benefit Plan, Railroad Retirement Benefits, Black Lung Program, Services Provided to Federal Prisoners, Pre-Existing Condition Insurance Plans (PCIPs) and Section 1011 Requests.
- C. **“Reasonable collection efforts”** requires that the effort to collect Federal health care program deductible and coinsurance amounts be similar to the effort the provider puts forth to collect comparable amounts from non-Federal health care program patients. Specifically, the collection effort must involve the issuance of a bill on or shortly after discharge or death of the beneficiary to the party

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responsible for the patient's personal financial obligations. Additionally, the collection effort should include other actions such as subsequent billings, collection letters and telephone calls or personal contacts with this party which constitute a genuine, rather than a token, collection effort.

#### **IV. POLICY:**

The portion of the patient bill that is the direct responsibility of the patient can be reduced or waived only under certain limited circumstances.

##### **A. Federal Health Care Program Patients**


Tenet Entities may not routinely waive or reduce copayments, coinsurance, or deductibles for Federal health care program patients. However, Tenet Entities may waive or reduce copayments, coinsurance, or deductibles for Federal health care program patients in accordance with the provisions set forth this Section IV.A. upon approval of the Tenet Entity's Chief Financial Officer (or equivalent title).

##### **1. Hospital Inpatients**

##### **a. Safe Harbor Waiver**

Waivers or reductions of deductibles and co-payments for Federal health care program patients for inpatient hospital services are permitted, when such waivers meet each of the following criteria:

- (1) The hospital must not later claim the amount reduced or waived as a bad debt for payment purposes under any Federal health care program or otherwise shift the burden of the reduction or waiver onto any Federal health care program, State health care program, other payers, or individuals.
- (2) The hospital must offer to reduce or waive the coinsurance or deductible amounts without regard to the reason for admission, the length of stay of the beneficiary, or the diagnostic related group for which the claim for reimbursement is filed.

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- (3) The hospital's offer to reduce or waive the coinsurance or deductible amounts must not be made as part of a price reduction agreement between a hospital and a third-party payer (including a health plan).

b. Financial Need


Hospitals, providers, practitioners or suppliers may waive or reduce a patient's Federal health care program coinsurance or deductible amounts for inpatient hospital services after consideration of a particular patient's financial need so long as:

- (1) The waiver is not offered as part of any advertisement or solicitation;
- (2) The entity offering the waiver does not routinely waive coinsurance or deductible amounts; and
- (3) The entity reduces or waives the coinsurance amounts after determining in good faith that the individual is in financial need or after reasonable collection efforts have failed.

c. Prompt Payment

Hospitals, providers, practitioners or suppliers may waive or reduce a patient's Federal health care program coinsurance or deductible amounts for inpatient hospital services in order to provide a legitimate prompt payment incentive, and in order to avoid collection costs. To qualify for a prompt payment discount, the following requirements must be met:

- (1) The waiver or discount is not offered as part of any advertisement or solicitation;
- (2) Patients and their representatives must only be informed of the prompt pay discount's availability during the course of the actual billing process;

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- (3) The amount of fees discounted to patients under the prompt pay discount must bear a reasonable relationship to the avoided collection costs; and
- (4) The hospital must not later claim the amount reduced or waived as a bad debt for payment purposes under any Federal health care program or otherwise shift the burden of the reduction or waiver onto any Federal health care program, a State health care program, other payers, or individuals.

2. Patients Other than Hospital Inpatients


d. Financial Need

Hospitals, ambulatory surgery centers, independent diagnostic testing facilities, outpatient centers, other health care providers, practitioners or suppliers may waive or reduce a patient's Federal health care program coinsurance or deductible amounts after consideration of a particular patient's financial need so long as:

- (1) The waiver is not offered as part of any advertisement or solicitation;
- (2) The entity offering the waiver does not routinely waive coinsurance or deductible amounts; and
- (3) The entity reduces or waives the coinsurance amounts after determining in good faith that the individual is in financial need or after reasonable collection efforts have failed.

e. Prompt Payment

Hospitals, ambulatory surgery centers, independent diagnostic testing facilities, outpatient centers, other health care providers, practitioners or suppliers may waive or reduce a patient's Federal health care program coinsurance or deductible amounts in order to provide a legitimate prompt payment incentive, and in order to avoid collection costs. To qualify for a prompt payment discount, the following requirements must be met:

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- (1) The waiver or discount is not offered as part of any advertisement or solicitation;
- (2) Patients and their representatives may only be informed of the prompt pay discount's availability during the course of the actual billing process;
- (3) The amount of fees discounted to patients under the prompt pay discount must bear a reasonable relationship to the avoided collection costs; and
- (4) The entity must not later claim the amount reduced or waived as a bad debt for payment purposes under any Federal health care program or otherwise shift the burden of the reduction or waiver onto any Federal health care program, a State health care program, other payers, or individuals.

3. Quality of Care Issues


Where charges are eliminated or reduced as the result of quality of care issues, the adjustment must be made to the total charge, not just the patient's co-payment or deductible part of the charge, so as to also benefit the applicable payer, and not just the patient. (See CO-2.010.04 Bill Hold Process for Possible Preventable Events Resulting in Harm)

4. Other Waivers or Discounts

Waiver or reduction of copayments, coinsurance, or deductibles for Federal healthcare program patients other than those described in this Section require the prior written approval of the Tenet Facility's assigned Regulatory Counsel. Regulatory Counsel may provide approval for categories of waivers or reductions, and is not restricted to case by case approvals.

B. Commercial Payers

Tenet Entities may not routinely waive or reduce copayments, coinsurance, or deductibles for patients with commercial insurance. However, Tenet Entities may waive or reduce copayments, coinsurance, or deductibles for patients with

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commercial insurance in accordance with the provisions set forth in this Section B upon approval of the Tenet Entity’s CFO (or equivalent title), unless prohibited by applicable law (as described on Attachment A to this policy). Prior to relying on Attachment A, the Tenet Entity’s CFO (or equivalent title) is to confer with its assigned Managed Care Counsel to confirm that Attachment A continues to be correct. Other than waivers or reductions for financial need, described in Section IV.B.4. below, waivers or reductions granted under this Section IV.B. must be disclosed to the patient and commercial payer, as advised by Managed Care Counsel, including whether the disclosure is required, and if so, the form of the disclosure.

1. High Deductible Health Plans (“HDHPs”)

Tenet Entities may not waive or reduce copayments, coinsurance, or deductibles obligations for patients enrolled in an HDHP who have not satisfied their deductible. However, a patient may request that a Tenet Facility not file a claim with their HDHP for Elective Services rendered, and instead access the hospital’s cash pay rate in accordance with the requirements of COMP-RCC 4.57 Cash Pay Rates.


2. Courtesy Discounts

Waivers or reductions of deductibles and co-payment amounts may be given for patients with commercial insurance who qualify for a courtesy discount in accordance with Law Department policy L-13 Courtesy Discounts for Physicians and Governing Board Members.

3. Out of Network Patients

Waivers or reductions of deductibles and co-payment amounts may be given to patients who have commercial insurance through a company that a Tenet Entity does not have a contract with, in order to bring the deductible and co-payment amounts due down to the amount that the patient would incur if the Tenet Entity was “in-Network” with the insurance company.

4. Prompt Pay Discount

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Waivers or reductions of deductibles and co-payment amounts may be given to patients in order to provide a legitimate prompt payment incentive, and in order to avoid collection costs. Commercial payers must be informed of the Tenet Entity’s prompt payment program, and the amount of fees discounted to patients under the prompt pay discount must bear a reasonable relationship to the avoided collection costs.

5. Financial Need

Hospitals, ambulatory surgery centers, independent diagnostic testing facilities, outpatient centers, other health care providers, practitioners or suppliers may waive or reduce a patient’s coinsurance or deductible amounts after consideration of a particular patient’s financial need so long as:


- a. The waiver is not offered as part of any advertisement or solicitation;
- b. The entity offering the waiver does not routinely waive coinsurance or deductible amounts; and
- c. The entity reduces or waives the coinsurance amounts after determining in good faith that the individual is in financial need or after reasonable collection efforts have failed.

6. Quality of Care Issues

Where charges are eliminated or reduced as the result of quality of care issues, the adjustment must be made to the total charge, not just the patient’s co-payment or deductible part of the charge, so as to also benefit the applicable payer, and not just the patient. (See CO-2.010.04 Bill Hold Process for Possible Preventable Events Resulting in Harm)

7. Other Waivers or Discounts

Waivers or reduction of copayments, coinsurance, or deductibles for patients with commercial insurance other than those described in this Section IV.B. require the prior written approval of the Tenet Entity’s assigned Managed Care Counsel. Managed Care Counsel may approve

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categories of waivers or reductions, and is not restricted to case by case approvals.

**V. PROCEDURE:**

A. Document Retention

Tenet Entities must retain the documentation required by this policy according to the requirements of Administrative Policy AD 1.11 Records Management and its Record Retention Schedule. The documentation must be retained in the Tenet Entity’s patient accounts system.

B. Responsible Person

The Tenet Entity’s CFO (or equivalent title) is responsible for ensuring that all individuals adhere to the requirements of this policy. If the CFO (or equivalent title) is unable to create adherence to this policy, the CFO (or equivalent title) will immediately report the non-adherence to the Tenet Entity’s Compliance Officer.

C. Auditing and Monitoring

Audit Services Department will audit and monitor adherence to this policy in its routine audits.


D. Enforcement

All employees whose 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:**

- 42 USC § 1320a-7a(i)(6)(A)
- 42 CFR § 1001.952(k)



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- Office of the Inspector General, “*Hospital Discounts to Patients Who Cannot Afford to Pay Their Hospital Bills,*” February 2, 2004
- [Office of the Inspector General, “Addendum to “Hospital Discounts to Patients Who Cannot Afford to Pay their Hospital Bills \(02/02/2004\)”” July 18, 2007](#)
- OIG Advisory Opinion 08-03 (Jan. 30, 2008)

**VII. ATTACHMENTS:**

- Attachment A: Summary of State Laws on Patient Responsibility Waivers and the Patient Protection and Affordable Care Act