CORPORATE POLICY

Manual/Library Name: Law	**No**: L-06
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Title: Hospital-Provided Post-Discharge Assistance to Federal Healthcare Program Beneficiaries	**Effective Date:** 12-3-2021
	Previous Versions: 10-05-20**;** 05-06-15
	Approved By: Executive Leadership Team
	Approval Date: 12-2-2021

I. Scope:

This policy applies to Tenet Healthcare Corporation and its subsidiaries and affiliates other than Conifer Holdings Inc. and its direct and indirect subsidiaries (each, an "Affiliate"), any other entity or organization in which Tenet or an Affiliate owns a direct or indirect equity interest of greater than 50%, and any 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:

To ensure that facilities operated by Tenet Entities (each a "Facility") furnish Patient Assistance in a manner that complies with applicable laws and regulations, including the Anti-Kickback Law and the Beneficiary Inducement Law applicable to Federal Healthcare Program beneficiaries.

III. Definitions:

Care Coordinator: A healthcare professional employed by a Facility to manage and coordinate the care (and assist with arrangements for the post-discharge care) of Facility patients.

Eligible Patient: A hospital inpatient or patient in observation status for at least 24 hours who is a Federal Healthcare Program beneficiary and eligible to receive Patient Assistance pursuant to the terms of this policy**.**

Federal Health Care Programs: "Federal Healthcare Programs," as defined in 42 U.S.C. § 1320a-7b(f). It includes, but is 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.

Patient Assistance: To furnish certain items and/or services to Eligible Patients upon their discharge from a hospital pursuant to the terms of this policy.

Physician: 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 and his or her immediate family members. Immediate family member means husband or wife; birth 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.

Preventive Care Services: As defined in 42 C.F.R. § 1003.10, it is 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 healthcare program.

Qualified Preventive Care (QPC) Services: The services listed in the current edition of the Guide to Clinical Preventative Services published by the U.S. Preventative Services Task Force online at http://www.uspreventiveservicestaskforce.org/ or through the Agency for Healthcare Research and Quality at http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/uspstf/index.html.

IV. Policy:

Facilities may furnish Patient Assistance to Federal Healthcare Program beneficiaries upon discharge from inpatient care or at least 24 hours in observation status, 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 $15.00 or less and $75.00 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).

V. Procedure:

All Patient Assistance to Eligible Patients must meet the following general requirements:

A. Eligible Patients must demonstrate financial need by of the following factors:

1. Eligibility under the Medicaid program;
2. Qualification for charity care in accordance with Tenet Charity Care policies;
3. Both items (a) and (b); or
4. Lack of sufficient financial resources.

A patient will be considered to lack sufficient financial resources review of the patient's total assets, liabilities, income, and expenses demonstrates that their financial resources are insufficient to fund the needed post-discharge items or services after payment of reasonable expenses of everyday living.

Review of the patient's assets, liabilities, income, and expenses may be conducted by a Care Coordinator, Facility financial counselor, the Director of Case Management, or any other person determined qualified by the Facility CFO to perform the review.

B. Facilities may not furnish Patient Assistance if there are alternative 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. Facilities may not furnish Patient Assistance to a Physician.

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

E. Facilities may offer Patient Assistance to Eligible Patients only during their stay at the hospital. Although a Facility may furnish Patient Assistance to be used upon or after discharge, it may not offer Patient Assistance before admission or after discharge.

F. Facilities may furnish Patient Assistance only once to each Eligible Patient.

1. The Eligible Patient must be notified in writing of this one-time limitation.

2. Facilities must maintain a copy of the written notice in the Eligible Patient's financial records, as retained by Tenet Patient Financial Services or Conifer.

3. 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 and any other diagnosis included the Hospital Inpatient Prospective Payment System Readmission Reduction Program, which is intended to prevent hospital readmission, shall not be subject to the one-time per beneficiary limitation described above.

G. If a Facility provides Patient Assistance under this policy, it 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 Healthcare Program cost report or claim or otherwise shifted to any Federal Healthcare 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 pursuant to Exhibit A.

J. Available Patient Assistance is limited to the items or services set forth in Exhibit B, provided that all charges or fees for such Patient Assistance are paid directly to the appropriate provider or vendor and not to the patient. Types of Patient Assistance not available are also listed in Exhibit B.

L. Any Patient Assistance provided by a referral source vendor must be documented in writing, approved in accordance with Law Policy L-15 prior to delivery.

M. The Facility must document 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 the date of payment to the vendor.

VI. 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.

VII. 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)

COMP-RCC 4.50 Offering Free or Discounted Goods and Services to Individuals

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

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

VIII. Exhibits:

Exhibit A - Eligibility for Patient Assistance

Exhibit B - Items or Services for Patient Assistance

Exhibit C - Post-Discharge Assistance Form

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Exhibit A – Eligibility for Patient Assistance

A Director of Case Management for the Facility may determine Eligibility for Patient Assistance pursuant to the steps below:

A. Each Federal Healthcare Program inpatient's discharge plan must reflect the patients reasonably anticipated post-discharge needs.

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

C. 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:

   1. community resources, such as public and private charities (including those that are affiliated with the hospital);
   2. utility assistance programs;
   3. pharmaceutical company patient assistance drug programs; and
   4. the Medicare drug discount card program and Transition Assistance eligibility.

D. If the patient and those individuals legally responsible for providing for their healthcare 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.

E. 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.

F. The Director of Case Management may approve requests for post-discharge assistance in accordance with this policy; provided, however, that the Facility may require Chief Financial Officer (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.

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Exhibit B – Items or Services for Patient Assistance

A. 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:

1. Payments for non-covered but medically appropriate outpatient services at hospital or another provider of the patient's choice, not to exceed 30 days. Payments must be made after the services are rendered;
2. Payment of up to 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);
3. Payment of up to 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 ordered by the treating Physician or LIP;
4. Payments for nursing home care at a provider of the patient's choice, not to exceed 30 days for nursing home care;

   See Law Department Policy L-25 "Referral Source Fair Market Value" for additional requirements on determining Fair Market Value and Law Policy L-23 for other contracting requirements.
5. Payments for up to 30 consecutive days of visits by a home health agency to provide home health services or assistance with the activities of daily living;
6. Payment of the first and second due utility bill after the patient's discharge up to a total aggregate payment of $200.00 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 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 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;

B. The limitations on the number of Patient Assistance days or visits set forth above 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 90 days or 30 visits may be paid.

C. The types of patient assistance not available are:

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 their caregivers or for the convenience of the patient's physician or LIP.

Exhibit C – Post-Discharge Assistance Form

[Hospital Name]

I am a patient at _____ ("Hospital"). My doctor, or other health care provider, has recommended that when I leave the Hospital, I will need:

_____
_____ ("Service").

I am not able to pay for the Service and I have no other resources. The Hospital can pay for the Service for me so that I can safely be discharged from the Hospital. But this is the ***only time*** the Hospital can/will pay for the Service – ***the Hospital cannot pay for the Service another time***.

I acknowledge that the Hospital can only pay for the Service this one time.

Patient Signature: _____ Date: _____

Patient printed name: _____