



## ESSENT HEALTHCARE, INC.

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<b>Section:</b> Corporate Compliance	<b>Effective Date:</b> 08/01/05
<b>Subject:</b> Extending Benefits to Federal Healthcare Program Beneficiaries	<b>Revision Date:</b> 08/01/05
<b>Policy #:</b> CC-8-A	<b>Review Date:</b> 11/18/09
<b>Responsible Party:</b> Corporate Compliance Officer	<b>Revision #:</b> 1

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**Scope:**

This policy applies to all employees of Essent Healthcare, Inc. and all employees of affiliates of Essent Healthcare, Inc. (collectively, “Essent” or “the Company”).

**Purpose:**

The purpose of this policy is to establish guidelines for extending benefits to federal healthcare program beneficiaries in a manner that complies with all legal standards and Company ethics.

**Policy:**

Essent does not extend benefits to federal healthcare program beneficiaries with the intent of inducing them to choose an Essent facility or Essent-affiliated physician as their health care provider. Essent extends benefits to federal healthcare program beneficiaries only in limited circumstances and only in accordance with all applicable laws, regulations and rules. Employees are to contact the Corporate Compliance Officer (“CCO”) if there are questions regarding benefits provided to federal healthcare program beneficiaries not addressed in this policy.

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**Definitions:**

**Federal healthcare program beneficiary** means an individual who is eligible to receive items or services for which payment may be made under a Federal health care program, including Medicare, Medicaid, Tricare or any other benefit program paid entirely or in part by the Federal government, but does not include a provider or supplier of healthcare items or services.

**Benefits** include any item of value provided to a federal healthcare program beneficiary such as, without limitation, gifts, free or discounted services, and waivers of copayment or coinsurance obligations.

**Nominal Value** is defined as *insignificantly small*. For purposes of this policy, nominal means a retail value of no more than \$10 for any one benefit, and no more than \$50 in the aggregate annually per individual.



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**Preventive Care** is defined as items or services that (i) are covered by Medicare or Medicaid and (ii) are either a) pre-natal or post-natal well-baby services or b) services described in the Guide to Clinical Preventive Services published by the U.S. Preventive Services Task Force (available online at <http://www.ahrq.gov>).

### Procedure:

Essent facilities may extend benefits to federal healthcare program beneficiaries without CCO approval only under the conditions set forth below.

1. Benefits of Nominal Value may be extended to federal healthcare program beneficiaries so long as the benefits are not cash or cash equivalents (*e.g.*, gift certificates). Each facility shall maintain documentation sufficient to calculate the annual \$50 limit per individual.
2. A facility may provide benefits that are intended to incentivize individuals to seek Preventive Care, so long as the benefits are not cash or cash equivalents and so long as the benefits are not disproportionate to the value of the Preventive Care provided. The Preventive Care itself may not be provided free or at a discount unless it meets another provision of this Policy. For example, a facility may sponsor health fairs organized for the purpose of promoting Preventive Care, and may offer federal healthcare program beneficiaries free admission, free local transportation and/or free non-covered screenings.
3. A facility may provide discounts on items or services to federal healthcare program beneficiaries, so long as the discounts are in accordance with the applicable discount policy.
4. A facility may waive or reduce a copayment or coinsurance obligation under the following circumstances:
  - a. A Medicare copayment or deductible amount may be waived or reduced if:
    - i. The amounts are owed to the facility for inpatient hospital services which are paid for under the Prospective Payment System;
    - ii. The facility doesn't later claim the amount reduced or waived as a bad debt for payment purposes under Medicare or otherwise shift the burden of the reduction or waiver onto Medicare, Medicaid, other payers, or individuals;
    - iii. The reduction or waiver is offered without regard to the reason for admission,



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the length of stay of the beneficiary, or the DRG for which the claim for Medicare reimbursement is filed;

- iv. The reduction or waiver is not made as part of a price reduction agreement between the hospital and a third-party payer, unless the agreement is with the furnisher of a Medicare SELECT policy.
- b. Non-routine, unadvertised waivers or reductions of copayments or deductible amounts are permitted if based on an individualized determination of financial need, as defined by the Essent facility, or after exhaustion of reasonable collection efforts.

If a facility wishes to extend benefits to any group that may include federal healthcare program beneficiaries, including financially needy federal healthcare program beneficiaries that do not fit squarely within the above guidelines, the facility must receive prior approval from the CCO.

### **References:**

HCCA Compliance Manual  
OIG Hospital Compliance Program Guidance  
OIG Special Advisory Bulletin (Gifts and other inducements)