CORPORATE COMPLIANCE MANUAL

(as amended and restated as of April 1, 2011)
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**TOPICS COVERED IN OUR COMPANION “CODE OF BUSINESS CONDUCT AND ETHICS”**

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6. Public Company Reporting
7. Insider Trading
8. Corporate Opportunities
9. Antitrust and Fair Dealing
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11. Health and Safety
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1. **INTRODUCTION AND OUR COMPLIANCE PROGRAM**

Vanguard Health Systems was founded in July 1997 by several long-term healthcare executives who shared a vision of a great new healthcare company having employees who conduct themselves in their professional and personal lives with the highest standards of business and personal ethics. These standards are not new to any of us; they are the foundation of every life (personal or corporate) built upon *a quest to do the right thing*.

In the 1990’s adoption of a formal corporate compliance program became a virtual necessity for healthcare companies. Infractions of Federal statutes that might have been considered technical and maybe even over-looked a few years before began being viewed by the regulators as healthcare fraud, with serious sanctions such as large civil and criminal fines, and even jail and exclusion from the Medicare program became remedies applied by the regulators. Such an exclusion on any widespread basis surely means bankruptcy for a hospital management company.

Since 1998 Vanguard has voluntarily maintained a company-wide compliance program designed to ensure that we maintain high standards of ethics and conduct in the operation of our business and implement policies and procedures so that all our employees act in compliance with all applicable laws, regulations and company policies. The organizational structure of our compliance program includes oversight by our Board of Directors (or the Audit Committee of our Board of Directors once we establish such Audit Committee) and a high-level corporate management compliance committee made up of our Chief Executive Officer and Chairman of our Board of Directors, our Vice Chairman, our President and Chief Operating Officer, our Chief Financial Officer, our General Counsel (who is our Chief Legal Officer), our Chief Compliance Officer and our Chief Medical Officer. The Board of Directors and compliance committee are responsible for ensuring that the compliance program meets its stated goals and remains up-to-date to address the current regulatory environment and other issues affecting the health care industry. Our Senior Vice President of Compliance and Ethics, Bruce Chaﬁn, reports jointly to our Chairman and Chief Executive Officer and to our Board of Directors, serves as Chief Compliance Officer and is charged with direct responsibility for the day-to-day management of our compliance program. Other features of our compliance program include initial and periodic ethics and compliance training and effectiveness reviews, a toll-free hotline for employees to report, without fear of retaliation, any suspected legal or ethical violations, annual “fraud and abuse” audits to look at all of our payments to physicians and other referral sources and annual “coding audits” to make sure our hospitals bill the proper service codes in respect of obtaining payment from the Medicare and Medicaid programs.

A recent focus of our compliance program is the interpretation and implementation of the new standards set forth by the Health Insurance Portability and Accountability Act (“HIPAA”) for privacy and security. To facilitate reporting of potential HIPAA compliance concerns by patients, family or employees, we have established a second toll-free hotline dedicated to HIPAA and other privacy matters and placed it in service in April 2003. Corporate HIPAA compliance staff monitors all reports to the privacy hotline and each phone call is responded to appropriately. Ongoing HIPAA compliance also includes self-monitoring of HIPAA policy and procedure implementation by each of our health care facilities and corporate compliance oversight.

In connection with establishing our compliance program, the Vanguard Board of Directors approved the original version of this Manual in 1998. In 2004 the Vanguard Board of Directors adopted a Code of Business Conduct and Ethics (the “Code”) which conforms to the requirements of
(1) Section 406 of the Sarbanes-Oxley Act of 2002 and the rules of the Securities and Exchange Commission related thereto and (2) the listing standards of the two principal stock exchanges. Since the requirements for the subject matters to be set forth in the Code duplicated provisions in the 1998 version of the Manual, Vanguard amended and restated this Manual in 2004 to remove provisions governed by the Code and since 2004 has updated this Manual periodically for recent legal developments.

This Manual (along with the Code) is intended as a guide for each employee's conduct so that Vanguard and its affiliates may fulfill their obligations to observe the laws and public policies affecting their businesses and to deal fairly with the Company's patients, physicians, communities in which they operate, shareholders and employees. The standards of conduct described in this Manual are intended generally to define the scope of conduct that the Manual covers. In many cases these standards exceed the standards required by law. But no set of standards or written rules can substitute for the personal integrity, good judgment, and common sense required to meet the challenges of the daily work of Vanguard’s employees. As is often said, "Be prepared to have every single thing you say or do appear on the first page of The New York Times and be sure it won't embarrass you, your employer or your fellow employees."

The standards of conduct described in this Manual (along with those described in the Code) cannot, nor were they intended to, cover every situation which a Vanguard employee encounters. When the best course of action is unclear or if a Vanguard employee observes a violation of these standards, Vanguard employees are urged to seek the guidance of or report the violations to their supervisors, an officer at Vanguard’s Corporate Office in Nashville or to Vanguard’s Senior Vice President - Compliance & Ethics who is responsible for the Corporate Compliance Hotline (1-888-895-9945). Calls to the Hotline will be treated confidentially, and may, at the caller's request, be anonymous, as discussed in the Section of this Manual entitled “Hotlines”.

Failure to observe the provisions of the Manual or of the Code can result in serious consequences to the employee, such as termination and criminal charges, and to the Company, such as criminal prosecution, substantial monetary fines and, of primary importance, the loss of the Company's reputation for integrity.

This Manual is a "living" document which will be updated or otherwise changed periodically to keep Vanguard employees abreast of the most current information available on these topics. If an Vanguard employee has suggestions for improvements in this Manual, please call the Vanguard General Counsel or its Senior Vice President - Compliance & Ethics at the phone numbers set forth below.

In addition to the Code and this Manual, please be aware that the Company periodically distributes policies of various departments or facilities, memoranda and policy statements describing matters of interest to the Company, or prohibiting specified activities by all or some of the Company's employees. To the extent that they prohibit or require certain conduct, these policies, memoranda and policy statements should be considered a part of this Manual.

Each Vanguard employee has the responsibility to report any actions that he/she believes, in good faith, may violate any provision contained in the Code or contained in this Manual or which damage the public trust. Vanguard has a firm no retaliation policy against those who report violations and Vanguard assures its employees that senior management will protect those who report
potential incidents of malfeasance. Employees having knowledge of retribution or retaliation due to the report of malfeasance should promptly report the information via the Vanguard Hotline at (1-888-895-9945).

If a Vanguard employee has concerns about improper actions of other Vanguard employees, the employee should contact either his or her supervisor, his or her facility CEO, Vanguard’s General Counsel, or Vanguard’s Senior Vice President - Compliance & Ethics who is responsible for the Corporate Compliance Hotline (1-888-895-9945). Calls to the Hotline will be treated confidentially and may, at the caller’s request, be anonymous as discussed in the Hotline Section of this Manual. See the Section of this Manual entitled “Hotlines”.

Other phone numbers of Vanguard executives you may wish to call in respect of these matters (other than the Hotline number) are as follows:

<table>
<thead>
<tr>
<th>Name &amp; Title</th>
<th>Phone No.</th>
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</thead>
<tbody>
<tr>
<td>Bruce Chafin, Senior Vice President-Compliance &amp; Ethics</td>
<td>(202) 393-3920</td>
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<tr>
<td>(Our Chief Compliance Officer)</td>
<td></td>
</tr>
<tr>
<td>Kent H. Wallace, President and Chief Operating Officer</td>
<td>(615) 665-6003</td>
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<td>Larry Fultz, Senior Vice President-Human Resources</td>
<td>(615) 665-6371</td>
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<tr>
<td>Charles N. Martin, Chairman and Chief Executive Officer</td>
<td>(615) 665-6001</td>
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<tr>
<td>Phillip W. Roe, Executive Vice President, Treasurer &amp;</td>
<td>(615) 665-6005</td>
</tr>
<tr>
<td>Chief Financial Officer</td>
<td></td>
</tr>
<tr>
<td>Keith P. Pitts, Vice Chairman</td>
<td>(615) 665-6025</td>
</tr>
<tr>
<td>Ronald P. Soltman, Executive Vice President, General</td>
<td>(615) 665-6006</td>
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<tr>
<td>Counsel &amp; Secretary (Our Chief Legal Officer)</td>
<td></td>
</tr>
<tr>
<td>Gary D. Willis, Senior Vice President, Controller &amp;</td>
<td>(615) 665-6098</td>
</tr>
<tr>
<td>Chief Accounting Officer</td>
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2. OUR ETHICAL PRINCIPLES

Vanguard’s Ethical Principles:

In June 1998 the Company first published and distributed to its employees the following ethical principles which we reaffirmed in 2004 in the Code. Although these principles are set forth in Section 1 of the Code, Vanguard feels that these principles bear repeating in this Manual since they reflect our basic values which promote honest and ethical conduct.

- **Full compliance with both the letter and spirit of the law.**

- **Delivery of high quality health care services at fair prices which are reasonable and competitive.**

- **Conduct all our relationships with integrity, being honest, truthful, trustworthy and responsible in our professional and personal dealings.**

- **Pursue financial responsibility, stability and growth, delivering a quality of earnings that meet the highest standards of legal and fiscal principles.**

- **Be a positive influence and good corporate citizen in the communities where Vanguard has offices, health care facilities or provides services.**

- **Develop mutually beneficial partnerships with competitors, payers, and other providers of health care services, placing the good health of the community above personal or corporate gain.**

- **Treat employees, customers and even competitors fairly and with respect.**

- **Report to Vanguard officials illegal or unethical practices of Vanguard employees, physicians or agents.**

These Ethical Principles are not a moral judgment or a license to dictate the religious, political, or personal preferences of our fellow employees. Rather, these Principles are a bedrock of professional and personal standards on which to anchor our business decisions and relationships. These Ethical Principles are simply founded in the time-honored tenets of being honest, loyal, industrious, fair, responsible, reliable and of service to others.

Vanguard’s Ethical Principles are a blueprint for living and decision-making in the business environment, but are not a substitute for following Vanguard’s other policies, procedures and practices either set forth elsewhere in this Manual, in the Code or elsewhere in Vanguard’s other policies. If you have any questions about Vanguard’s Ethical Principles or other ethical concerns, discuss these with your supervisor if appropriate. If you are uncomfortable discussing certain issues at the local level, feel free to telephone the Vanguard Senior Vice President - Compliance & Ethics who is our Chief Compliance Officer at (202) 393-3920 or the Vanguard Hotline at **(1-888-895-9945)**.
Compliance with Laws, Rules and Regulations. As stated in the very first of our ethical principles above, Vanguard has a long-standing commitment to conduct our business in compliance with applicable laws, rules and regulations and in accordance with the highest ethical principles. This commitment of course includes Vanguard’s and each of its facility’s commitment to full compliance with all Federal health care program requirements, including the commitment to prepare and submit accurate claims consistent with such requirements and the requirement that all of Vanguard’s and each facility’s personnel are expected to comply with all Federal health care program requirements and with the Vanguard policies and procedures regarding the operation of our corporate compliance program and Vanguard’s and each of its facility’s compliance with Federal health care program requirements. The possible consequences to Vanguard, its facilities and its personnel of the failure to comply with Federal health care program requirements and with Vanguard’s own compliance policies and procedures are very serious. The consequences to Vanguard, to its facilities as well as to its personnel can be criminal liability as well as substantial civil damages. Additionally, Vanguard’s facilities can be excluded from the Medicare and Medicaid programs, as well as other Federal programs. See the Section of this Manual entitled “Federal Anti-Kickback Statute”, the Section of this Manual entitled “Fraud and Abuse” and the Section of this Manual entitled “Stark Self-Referral Statutes” for the specific consequences of any such failure.

Ethical Practices. The public and Vanguard’s shareholders have a right to expect that the business of Vanguard will be conducted ethically and competently by our officers and employees. Each employee should adhere to the spirit and language of the Code and this Manual and strive for excellence in performing his or her duties. Each employee must maintain a high level of integrity in business conduct and avoid any conduct that could reasonably be expected to reflect adversely upon the integrity of Vanguard, its officers, directors or other employees. Furthermore, each employee should encourage other Vanguard employees to do likewise.

Employee Conduct. Vanguard relies on the ability and professionalism of its employees and representatives to communicate effectively the merits of their services to the patient, physician and consumer, and expects them to use only legitimate competitive practices. Each employee should perform his or her Vanguard duties in good faith, in a manner that he or she reasonably believes to be in the best interests of Vanguard, and with the due care that a reasonably prudent person in the same position would use under similar circumstances.

Company employees must scrupulously make sure they do not perform any illegal conduct, both in business and personal matters, including efforts to circumvent the law by devious means or questionable interpretations. No employee shall take any action that he or she believes is in violation of any statute, rule or regulation.

Each employee should be open and honest in his or her business relationships with other officers and employees of Vanguard, Vanguard’s Board of Directors, and the lawyers, accountants and other professionals retained by Vanguard. The failure to deliver information that is known or thought to be necessary, or the provision of information that is known or thought to be inaccurate, misleading or incomplete, is unacceptable.

Improper Payments. No employee shall engage, either directly or indirectly, in any corrupt business practice, including bribery, kickbacks or payoffs, intended to induce, influence, or reward favorable decisions of any government personnel or representative, any customer, contractor or vendor in a commercial transaction, or any person in a position to benefit Vanguard or the employee in any
way. No employee shall make or offer to make any payment or provide any other thing of value to another person with the understanding or intention that such payment is to be used for an unlawful or improper purpose.

**Business Entertainment and Gifts.** Vanguard personnel may provide ordinary and reasonable business entertainment and gifts of nominal value, (e.g., tickets to sporting events or concerts, meals and similar gift items) provided that such entertainment and gifts (1) do not violate the laws of the locale in which the business is transacted, (2) are not given for the purpose of influencing the business behavior of the recipient and (3) if the recipient is a physician or other referral source, such entertainment is subject to certain special rules of CMS under the Stark Self-Referral Statute set forth below. In any event, such ordinary and reasonable entertainment and gifts may be given only with the prior approval of the officer, department head, or hospital CEO for whom the employee works. Vanguard’s officers and administrators must exercise discretion and control in authorizing such entertainment or gifts. As special rules for entertainment and gifts to physicians and other referral sources: (1) cash or cash equivalent gifts are prohibited and (2) such gifts and entertainment are limited in value to an aggregate of $300 per person in each calendar year (such $300 limit linked to inflation so in calendar 2011, the maximum amount was $359). The $300 maximum does not apply, generally, to customary medical staff benefits which are valued at less than (in calendar year 2011) $30 per occurrence, which are provided within the facility and which are given to all members of the medical staff and are not determined in any manner by the referrals of the recipient (e.g., free parking, meals in the physician’s lounge). For more specific rules on gifts and entertainment to physicians, see Legal Department Policy LEGL.025, “Business Courtesies to Potential Referral Sources”.

**Transactions Involving Government Employees.** The public trust associated with transactions between the private sector and government entities imposes special responsibilities on Vanguard employees and representatives to adhere to the same high standard of conduct expected of the government employee.

Vanguard employees or representatives must take no actions that would cause the government employee to violate, to appear to violate, or that would be otherwise inconsistent with, that standard of conduct. Specifically, except as described in the next sentence, no Vanguard employee or representative may offer or give anything of monetary value, including gifts, gratuities, favors, entertainment or loans, to an employee or representative of a government agency with which Vanguard has or is seeking to obtain contractual or other business or financial relations or that regulates any Vanguard activities or operations. A Vanguard employee may pay for the reasonable costs of meals of government employees and members of legislative bodies in connection with lawful lobbying efforts on behalf of Vanguard, if such activities are permitted by law and undertaken with the knowledge and prior approval of a Vanguard officer.
3. EMPLOYEE OBLIGATION TO REPORT ILLEGAL OR UNETHICAL PRACTICES

Vanguard employees not only have the obligation not to violate the law and to conduct themselves in an ethical manner, they also need to report to their supervisors, the Vanguard General Counsel, or the Vanguard Senior Vice President - Compliance & Ethics, any violations of law, the Code, this Manual or any unethical practices of other Vanguard employees, physicians or other agents. This includes the requirement that all of Vanguard’s and each of its facility’s personnel are expected to report to the Vanguard Senior Vice President - Compliance & Ethics or to the Vanguard General Counsel suspected violations of any Federal health care program requirements or of Vanguard’s own policies and procedures. Example: A Vanguard hospital nurse observes a primary care physician on Monday of each week filling in notations on his patient’s medical records indicating that such physician saw the patient on the previous Saturday and/or Sunday in space left in the medical record by specialist physicians who wish to “reward” the primary care physician for the referral of the patient to the specialist physicians even though such primary care physician did not come into the hospital to see the patient during the week-end. It is not proper for the Vanguard nurse not to report this illegal practice for the reason of "not wanting to get involved" or any other reason. Under this Vanguard policy, the Vanguard hospital nurse has the obligation to report the illegal practice to his/her supervisor, the facility CEO, the Vanguard General Counsel (our Chief Legal Officer) or the Vanguard Senior Vice President - Compliance & Ethics (our Chief Compliance Officer).

The possible consequences to Vanguard’s and its facilities’ personnel of the failure of any of them to report noncompliance with Federal health care program requirements and with Vanguard’s own compliance policies and procedures will be some type of serious disciplinary action, all the way up to termination from employment.

*If an Vanguard employee has concerns about the improper actions of other Vanguard employees, the employee should contact either his or her supervisor, his or her facility CEO, Vanguard’s General Counsel, or Vanguard’s Senior Vice President - Compliance & Ethics who is responsible for the Corporate Compliance Hotline*(1-888-895-9945). Calls to the Hotline will be treated confidentially and may, at the caller’s request, be anonymous as discussed in the Section of this Manual entitled “Hotlines”.

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<tr>
<td>Phillip W. Roe</td>
<td>(615) 665-6005</td>
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<tr>
<td>Executive VP, Treasurer &amp; Chief Financial Officer</td>
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<tr>
<td>Ronald P. Soltman</td>
<td>(615) 665-6006</td>
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<tr>
<td>Executive Vice President &amp; General Counsel</td>
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4. HOTLINES

Vanguard has established a Corporate Compliance Hotline (1-888-895-9945) located in Washington, D.C. in order to provide Vanguard employees with every avenue possible in which to raise their concerns and report possible wrongdoing. Every call will be treated confidentially. Calls will not be recorded or traced; and the caller will not be required to furnish his or her name. Vanguard’s Senior Vice President - Compliance & Ethics (our Chief Compliance Officer) will investigate all calls and insure that proper follow-up actions are taken. Vanguard policy prohibits any employee from taking retaliation against a Hotline caller, and as stated above, the caller may retain anonymous if he or she desires to do so.

Vanguard has also established a Corporate Privacy (HIPAA) Hotline (1-800-854-6413) located in Nashville, Tennessee, in order to provide Vanguard employees and facility patients with another avenue to address patient information confidentiality concerns. In addition, each Vanguard facility has a Privacy Officer who is available to address privacy concerns for Facility staff and patients.

Other phone numbers you may wish to call in respect of these compliance matters (other than the Vanguard Hotline) are as follows:

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<tr>
<td>HHS-OIG Hotline</td>
<td>(800) HHS-TIPS</td>
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<tr>
<td>Ronald P. Soltman</td>
<td>(615) 665-6006</td>
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<tr>
<td>Executive VP, General Counsel &amp; Secretary (Our Chief Legal Officer)</td>
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5. NON-EMPLOYMENT OF CONVICTED OR EXCLUDED INDIVIDUALS

Vanguard policy prohibits the employment of individuals who have been recently convicted of a criminal offense related to health care or who are listed as debarred, excluded or otherwise ineligible for participation in federal or state health care programs.

Background Investigation. In respect of all new Vanguard or facility employees who have discretionary authority to make decisions that may involve compliance with the law or compliance oversight, it is Vanguard policy that the corporate or the facility Human Resources Department should conduct a reasonable and prudent background investigation, including a reference check, as part of every such employment application.

Data Banks. Also, prior to employment (or medical staff membership) of any new person, the Vanguard corporate or facility Human Resources Department must check the following Data Banks and exclude from employment (or medical staff membership) all such persons found with problems in such listings:

- **OIG Cumulative Sanction Report** - a list maintained by the HHS Office of Inspector General showing persons excluded from participation in the Medicare and Medicaid programs. This list is available on the Internet at [http://exclusions.oig.hhs.gov](http://exclusions.oig.hhs.gov) and at [http://oig.hhs.gov](http://oig.hhs.gov).

- **GSA List of Parties Excluded from Federal Procurement and Nonprocurement Programs** - a list maintained by the U.S. General Services Administration and available on the Internet at [http://epls.arnet.gov](http://epls.arnet.gov).

- **National Practitioners Data Bank** - a data bank to be used in the hiring of (or medical staff membership of) physicians, nurses, or other healthcare professionals.

Charges Against Current Employees. In addition, pending the resolution of any criminal charges or proposed debarment or exclusion, it is Vanguard policy that such individuals be removed from direct responsibility for or involvement in any federal or state health care program. If resolution of the matter results in conviction or exclusion, Vanguard or its facility should immediately terminate the employment of such individual.

Contractual Arrangements with New Independent Contractors. Likewise, it is Vanguard policy to prohibit the execution of contracts with persons or entities that have been recently convicted of a criminal offense related to health care or that are listed by a federal agency as debarred, excluded, or otherwise ineligible for participation in federal or state health care programs. The same Data Banks listed above should be searched in respect of new independent contractors.

Charges Against Current Independent Contractors. In addition, pending the resolution of any criminal charges or proposed exclusion, it is Vanguard policy that such independent contractors be removed from involvement in any federal or state health care program. If resolution of the matter results in conviction or exclusion, Vanguard or its facility should terminate its contract with such independent contractor.
6. ADMISSIONS

Vanguard believes that it attracts physicians who admit patients to its hospitals because of the quality of services, facilities and equipment provided by the hospitals, their location and technological sophistication, and the competence of our hospital medical staffs and employees.

**Vanguard only admits patients who need and will benefit from the treatment Vanguard and its physicians provide.** Vanguard's medical admission criteria are based strictly upon medical necessity. Only a physician makes the determination whether to admit an individual to a Vanguard facility. The medical treatment of patients in Vanguard facilities must be based solely on clinical needs. Vanguard does not pay bonuses of any type to employees or other individuals working with Vanguard in the admission process based on the number of patients admitted or the length of patients' stays. Vanguard expects its facility CEOs, COOs, CNOs and CFOs to ensure that facility personnel and medical staff members never feel pressure to admit patients and that patients are admitted only on the basis of medical need. **If physicians are detected admitting patients without reasonable medical necessity, Vanguard employees are encouraged to report their concerns to the facility CEO, to Vanguard’s General Counsel or to Vanguard’s Senior Vice President - Compliance & Ethics who is our Chief Compliance Officer and responsible for the Corporate Compliance Hotline (1-888-895-9945).**

**Vanguard treats patients -- not insurance policies.** At the time of admission, information is provided on the anticipated treatment plan as well as financial and insurance information. Discharge planning begins at the time of admission and continues throughout the treatment process. The patient, the patient's family, loved ones, and the clinical team are all involved in the discharge planning process. **Vanguard does not admit or discharge patients on the basis of their insurance policies.**
7. BILLING

Billing. Vanguard bills patients and/or third-party payors accurately and in compliance with Federal and state laws and regulations. Vanguard is committed to accurate and truthful billing to patients and/or third-party payors, and will not misrepresent charges to, or on behalf of, a patient and/or third-party payor. Vanguard must comply with special billing requirements for government-sponsored programs and other payors. All Vanguard employees must exercise care in any written or oral statement made to any government agency or other payor. Vanguard will not tolerate false statements by Vanguard employees to a government agency or other payor. Deliberate misstatements to government agencies or other payors will expose the employee involved to criminal penalties and termination.

General Risk Areas. The following are general risk areas in respect of billing:

- Billing Transfers as Discharges. Transferring of patients between acute care hospitals should not be billed as discharges. To avoid allegations of false billing, records should indicate where the patient is to be discharged, i.e. to home or some other facility which is not an acute care hospital. If the patient nevertheless ends up in an acute care hospital without knowledge of the discharging hospital, the records should help insulate the hospital billing the discharge.

- Credit Balances. The failure to return overpayments within a reasonable period of time is an area of concern to the regulators.

- Diagnosis and Procedure Coding. Targets of investigations include improper coding of some DRGs and improper coding in certain departments, including laboratories, radiology departments, and emergency departments.

- Duplicate Bills. Permitted when Medicare contractors lose bills, duplicate bills should always be marked as duplicates to avoid allegations of double billing.

- DRG “Creep”. Similar to upcoding, this fraudulent activity involves using a DRG code providing higher payment than the one intended for the service or item.

- Secondary Payer Questionnaire. Such questionnaires help identify primary payers. Use of the questionnaire protects against allegations of reckless disregard or intent to remain ignorant of relevant facts.

- Upcoding. This involves the practice of using a billing code that provides a higher payment, rather than the code intended for use with the item or service, i.e., billing for allergy shots as if a physician was present during administration when the shots were actually administered by a nurse or the patient.

- Cost Reporting. In recent years CMS has been taking action to encourage and facilitate reporting of cost report fraud by intermediaries and carriers.

Examples of cost report fraud included in the Medicare Intermediary Manual include:
a. Incorrectly apportioned costs on cost reports;
b. Including costs of noncovered services, supplies or equipment in allowable costs;
c. Improper arrangements by providers with employees, independent contractors or suppliers designed primarily to overcharge Medicare;
d. Claims for costs not incurred or costs attributable to nonprogram activities, other enterprises, or personal expenses;
e. Repeated inclusion of nonallowable cost items in the cost report except for establishing a basis for appeal;
f. Manipulating statistics to obtain additional payments, e.g. increasing the square footage in the outpatient areas to maximize payment;
g. Claims for bad debts without genuine attempts to collect payment;
h. Amounts paid to owners or administrators that have been determined to be excessive in prior cost report settlements;
i. Days that have been improperly reported and would result in an overpayment if not adjusted;
j. Depreciation for assets that have been fully depreciated or sold;
k. Depreciation methods not approved by Medicare;
l. Interest expense for loans that have been repaid or an offset of interest income against the interest expense; and
m. Program data where provider program amounts cannot be supported;
n. Improper allocation of costs to related organizations that have been determined to be improper.

**Durable Medical Equipment (DME).** Billing for DME is a common source of fraud allegations with an emphasis on proper coding. Auditors have often focused on “popular” items with large increases in billing. Examples include: TENS devices, seat lift chairs, lymphedema pumps and orthotic body jackets.

**Home Health.** Sources of fraud allegations in home health include: shifting of hospital organization expense onto home health books; billing for visits not furnished; billing for services before obtaining physician approval and signature on the plan of treatment; billing for services without recertification by the physician for care after 60 days; and forging physician signatures.

**Laboratory, Radiology, and Emergency Department Billing.** These billing areas have been the focus of investigations for several years. One area of particular concern is laboratory order forms which force a physician to order higher-priced groups of test, rather than only those tests medically necessary.

**Contingency Fee Arrangements with Rebilling Contractors.** It is against Vanguard policy for a hospital to contract with a rebilling service for incorrect hospital bills with fees paid to the contractor on a contingency basis only out of collected additional amounts of billings. Some of these contractors have been known to incorrectly bill additional amounts, ignore prior overpayments in their work and otherwise incorrectly calculate the rebillings. No exception to this policy shall be made without the approval of the Vanguard Chief Operating Officer and General Counsel.
**Reporting Billing Overpayments.** The Fraud Enforcement and Recovery Act, which became law on May 20, 2009, changes the scienter requirements for liability under the False Claims Act. An entity may now violate the False Claims Act if it “knowingly and improperly avoids or decreases an obligation” to pay money to the United States. This includes obligations based on an “established duty . . . arising from . . . the retention of any overpayment.” Thus, if a provider is aware that it has retained an overpayment that it has an obligation to refund, this may form the basis of a False Claims Act violation even if the provider did not know the claim was “false” when it was submitted. The 2010 Health Reform Law expressly requires healthcare providers and others to report and return overpayments. The term overpayment is defined as “any funds that a person receives or retains under title XVIII or XIX to which the person, after applicable reconciliation, is not entitled under such title.” The Health Reform Law also defines the period of time in which an overpayment must be reported and returned to the government. The Health Reform Law provides that “[a]n overpayment must be reported and returned” within “60 days after the date on which the overpayment was identified,” or “the date any corresponding cost report is due,” whichever is later. The provision explicitly states that if the overpayment is retained beyond the 60-day period, it becomes an “obligation” sufficient for reverse false claim liability under the False Claims Act, and is therefore subject to treble damages and penalties if there is a “knowing and improper” failure to return the overpayment.

**Duties Of An Employee Once a Billing or Overpayment Issue is Detected Or Suspected.** If a Vanguard employee thinks he has detected or suspects that he or she has detected a billing or overpayment issue, the employee should immediately report the findings or suspicions to the Vanguard General Counsel, the Vanguard Senior Vice President - Compliance & Ethics, or the Hotline at **(1-888-895-9945)**.
8. CONFIDENTIALITY OF PATIENT INFORMATION

Vanguard and its affiliated entities are committed to protecting the confidentiality of patient information (personal, medical, financial and insurance) in compliance with all aspects of the Health Insurance Portability and Accountability Act, 42 U.S.C. 1320d et seq. and its associated regulations (“HIPAA”).

Each Vanguard affiliated facility has adopted policies, forms and procedures compliant with HIPAA and has educated its workforce on protection of confidential patient information. Vanguard has a corporate Privacy Official, and each Vanguard facility has a Privacy Official responsible for implementation and on-going compliance with HIPAA privacy requirements. Every Vanguard employee has a responsibility to protect the confidentiality of patient information; this responsibility includes appropriate use, dissemination, release, storage (security) and destruction of confidential patient information.

The duty to protect confidential patient information does not stop when the patient leaves the facility or finishes treatment – it continues after discharge (and even after a patient’s death). The duty to protect confidential patient information applies to all forms of storage and transmission – electronic (facsimile, electronic mail, etc.) as well as paper, microfilm and microfiche.

Vanguard facility policies and procedures must be followed for the use, dissemination, release, storage and destruction of confidential patient information. Only individuals with a legitimate “need to know” may access, use or disclose patient information. This includes all activities related to treatment, payment and health care operations on behalf of Vanguard and its affiliated entities. Each individual may only access, use or disclose the minimum information necessary to perform his or her designated job responsibilities regardless of the existence of access provided or available.

Each Vanguard facility has established procedures to:
- Educate its workforce on protection of patient information;
- Designate a Privacy Official to oversee each facility’s Privacy Program and HIPAA compliance;
- Provide a Notice of Privacy Practice to each patient as required by HIPAA;
- Respond to intentional or unintentional breaches of patient privacy in a manner consistent with Vanguard’s Code of Ethics and human resources policies and procedures; and
- Establish appropriate computer system access for systems containing individually identifiable health information.

A. Confidential Patient Information. Confidential Patient Information means all information (written, verbal, recorded in a computer or by other means) about an identifiable individual that relates to:
- The individual’s health or health history, including genetic information about the individual or the individual’s family;
- Conduct or behavior that may be the result of illness or the effect of treatment;
- The provision of health care to the individual;
- Payment for health care provided to the individual, including:
o Personal health identification number and/or any other identifying number, symbol, or particular assigned to an individual, and
o Any identifying information about an individual that is collected in the course of, and is incidental to, the provision of healthcare or payment for healthcare;
 o The person’s personal information, including financial position, home conditions, domestic difficulties, or any other private matters relating to the patient that have been disclosed to staff or persons associated with any Vanguard facility in the course of healthcare activities.

B. **Examples of Confidential Patient Information.** Confidential patient information includes: treatment records or plans, registration and admission records, billing records (including diagnosis), incident reports, patient complaints, marketing information, clinical research documentation, medical devices and supply records, case records, reimbursement detail and employee benefit detail. Use, access or disclosure of confidential health information is permitted only in the discharge of an employee’s responsibilities and duties, including reporting required by law. An employee’s inappropriate use, access or disclosure of confidential patient information could be embarrassing, an invasion of privacy, have negative effects on Vanguard’s position and operations, and may have adverse legal/financial consequences for the organization.

An inherent part of providing healthcare is employee access to patient information and data in many formats (including paper, electronic, facsimile and verbal). All formats and all types of patient information and data may contain or permit access to confidential patient information.

C. **Information Shared Within the Vanguard Organization or With Business Associates.** All confidential patient information shared within the Vanguard organization or with Business Associates must be the minimum necessary to accomplish the task or project, and meet a documented need for the confidential patient information. Each Vanguard facility has policies and procedures in place to identify Business Associates and enter into appropriate Business Associate agreements for the sharing of confidential patient information.

D. **Compliance Responsibilities.** Every Vanguard employee is responsible for protection of confidential patient information entrusted to Vanguard and its affiliated entities. Every Vanguard employee should be familiar with Privacy polices, forms and procedures applicable to his/her job functions.

Vanguard Privacy Officials are responsible for assisting and monitoring compliance with Privacy policies. Any Vanguard employee should contact his/her facility Privacy Official regarding any questions or concerns about handling confidential patient information.

E. **Penalties for HIPAA Violations.** Violations of the HIPAA privacy regulations may result in civil and criminal penalties, and the more recent Health Information Technology for Economic and Clinical Health Act (the “HITECH Act”) has strengthened the enforcement provisions of HIPAA, which may result in increased enforcement activity. For violations occurring on or after February 18, 2009, entities are subject to tiered ranges for civil money penalty amounts based upon the increasing levels of culpability associated with violations. Under the October 30, 2009, Interim Final Rule, the range of minimum penalty amounts for each offense increases from up to $100 to $100 to $50,000 (for violations due to willful neglect and not corrected during the 30-day
period beginning on the first date the entity knew, or, by exercising reasonable diligence, would have known that the violation occurred). Similarly, the penalty amount available in a calendar year for identical violations is substantially increased from $25,000 to $1,500,000. In one recent enforcement action, HHS imposed a $4,300,000 civil monetary penalty against a covered entity for violations of the privacy rule related to patient access to health records. In another action, the covered entities that were the subject of an investigation by HHS paid a settlement of $1,000,000 and agreed to be bound by a corporate integrity agreement. In addition, the The American Recovery and Reinvestment Act of 2009 (“ARRA”) authorizes state attorney generals to bring civil actions seeking either injunction or damages in response to violations of HIPAA privacy and security regulations that threaten the privacy of state residents. Additionally, ARRA broadens the applicability of the criminal penalty provisions to employees of covered entities and requires HHS to impose penalties for violations resulting from willful neglect. Further, under ARRA, HHS is now required to conduct periodic compliance audits of covered entities and their business associates.

F. Privacy Breach Notification Requirements. The HITECH Act and the HHS Rules described above provide a framework for privacy breach notification requirements to individuals affected by a breach and, in some cases, to HHS or to prominent media outlets. Specifically, the statute and Rules require covered entities to report breaches of unsecured protected health information to affected individuals without unreasonable delay but not to exceed 60 days of discovery of the breach by a covered entity or its agents. Notification must also be made to HHS and, in certain situations involving large breaches, to the media. HHS is required to publish on its website a list of all covered entities that report a breach involving more than 500 individuals. This reporting obligation applies broadly to breaches involving unsecured protected health information and became effective September 23, 2009. In addition, the HITECH Act extends the application of certain provisions of the security and privacy regulations to business associates (entities that handle identifiable health information on behalf of covered entities) and subjects business associates to civil and criminal penalties for violation of the regulations beginning February 17, 2010. In addition, HHS is currently in the process of finalizing regulations addressing security breach notification requirements. HHS initially released an Interim Final Rule for breach notification requirements on August 24, 2009. HHS then drafted a Final Rule which was submitted to OMB but subsequently withdrawn by HHS on July 29, 2010. Currently, the Interim Final Rule remains in effect but the withdrawal suggests that when HHS issues the Final Rule, which it has indicated it intends to do in the near future, the requirements for how covered entities should respond in the event of a potential security breach involving protected health information are likely to be more onerous than those contained in the Interim Final Rule.

G. State Privacy Laws. Vanguard is also subject to any state laws that relate to privacy or the reporting of security breaches that are more restrictive than the regulations issued under HIPAA and the requirements of the ARRA. For example, various state laws and regulations may require us to notify affected individuals in the event of a data breach involving certain individually identifiable health or financial information.

H. The Red Flag Rules. In 2010 the Federal Trade Commission issued regulations that initially required health providers and health plans to implement by December 31, 2010 written identity theft prevention programs to detect, prevent, and mitigate identity theft in connection with certain accounts. However, on December 18, 2010, President Obama signed the Red Flag Program Clarification Act of 2010 (“Clarification Act”) which clarified the categories of individuals and entities that are “creditors” subject to the Federal Trade Commission’s Red Flags Rule. Pursuant to
the Clarification Act creditors subject to the Red Flag Rule include entities or individuals that regularly and in the ordinary course of business: (1) obtain or use consumer reports, directly or indirectly, in connection with a credit transaction; (2) furnish information to consumer reporting agencies in connection with a credit transaction; or (3) advance funds to or on behalf of a person based on an obligation of the person to repay the funds. Vanguard is subject to these Red Flag Rules as they now apply to our hospitals and health plans.

I. **Privacy (HIPAA) Hotline.** Vanguard also has a corporate Hotline access number dedicated solely to patient privacy issues. This number is 1-800-854-6413. Calls to the Privacy Hotline may also be made anonymously.
9. CONFLICTS OF INTEREST

Conflicts of interest are addressed in the Code in Sections 3, 4 and 5. Because this subject is so important, Vanguard is also addressing the subject in an expanded manner in this Manual.

If a deal or relationship feels and looks like a conflict of interest, it probably is and should be disclosed and resolved. Vanguard requires its employees to act honestly and ethically and not to have conflicts of interest with the Company. Conflicts of interest are often not black and white decisions, but a fine rule of conduct to follow is: Avoid any business relationship in which you, a family member, a close friend or a business associate materially benefits from a personal viewpoint.

What Is a Conflict of Interest? A “conflict of interest” exists when a person’s private interest interferes in any way, or even just appears to interfere, with Vanguard’s interests. Conflicts of interest also exist where an individual’s actions or activities involve the obtaining of an improper personal gain or advantage, or an adverse effect upon Vanguard’s interest. In other words, employees must avoid engaging in any activity or act which conflicts with the interests of Vanguard, its hospitals or patients. Vanguard employees must avoid situations that would create an actual or even an appearance of a conflict of interest, unless approved in advance in writing by Vanguard’s General Counsel or Senior Vice President - Compliance & Ethics. Appearances do count when it comes to conflicts of interest, because those on whom the success of Vanguard may depend may judge the conduct of a Vanguard employee by the appearance of the conduct. Each Vanguard employee also has a duty of loyalty to Vanguard. While it is not possible to describe all of the situations which involve a conflict of interest or violate the duty of loyalty, the following paragraphs indicate areas where conflicts of interest or violations of the duty of loyalty may arise.

Acceptance of Gifts and Entertainment. No employee, nor any member of any employee's family, may accept any personal gift or favor (including complimentary business or personal trips) from any of Vanguard’s competitors, contractors, customers or suppliers, or anyone with whom that employee does business on behalf of Vanguard. Perishable gifts, other gifts of a nominal value or reasonable personal entertainment may be ethically accepted if the gift would not influence, or reasonably appear to others to be capable of not influencing, the employee's business judgment in making objective and fair business decisions in conducting Vanguard's affairs with the donor. If the value of the gift is over $100 or there is any serious question regarding whether the gift meets this standard of objectivity and reasonableness, the employee must either disclose the details of the gift, seek prior approval to accept the gift, refuse the gift or promptly return the gift to the donor. Such disclosure (or approval) should be to Vanguard’s General Counsel or Senior Vice President - Compliance & Ethics, Vanguard’s Chief Compliance Officer.

Disclosure of Possible Conflicts of Interest. Employees must disclose possible conflicts of interest involving themselves or their immediate families (spouse, parents, brothers, sisters, and children) to their supervisor, one of their managers, Vanguard’s General Counsel or its Senior Vice President - Compliance & Ethics who is the Company’s Chief Compliance Officer. In turn, all supervisors, managers, and Vanguard’s General Counsel will report substantiated conflicts of interest which have been reported to them by employees to the Company’s Chief Compliance Officer. The Chief Compliance Officer will investigate and report all substantiated conflicts to the Management Compliance Committee. Vanguard’s Management Compliance Committee will evaluate these reported conflicts of interest and determine whether significant conflicts of interest have occurred or might occur and take the necessary steps to protect Vanguard. If a Vanguard
employee believes a conflict of interest exists, the employee must treat the situation as if a conflict definitely exists until the employee and other appropriate Vanguard officials have resolved the potential conflict.

**Personal Benefit.** Each Vanguard employee is expected to conduct Vanguard business to the best of his/her ability for the benefit of and in Vanguard’s best interests. No employee may become involved in any manner with competitors, contractors, customers or suppliers of Vanguard if such involvement would result in improper personal gain or the appearance of improper personal gain. Such involvement may include the purchase, sale or lease of any goods or services from or to any customer or supplier of Vanguard, or serving as an officer, director or in any other management or consulting capacity with a competitor, contractor, customer or supplier of Vanguard. An employee is not prohibited from purchasing goods or services from a customer or supplier to Vanguard if those goods or services are purchased on terms generally available to non-employees of Vanguard.

Placing business with any entity in which there is a family or close personal relationship or hiring or having a reporting relationship to relatives could constitute a conflict of interest, or create the appearance of a conflict of interest.

The foregoing shall not preclude holding less than five percent (5%) of any class of securities in a publicly-held corporation listed on a nationally recognized stock exchange or regularly traded on an over-the-counter market. However, even if the holdings are less than 5%, where an employee is in a position to control or influence Vanguard’s decisions or actions with respect to a transaction with such a corporation, a conflict of interest might still exist and such holdings must be disclosed.

**Outside Business Activities.** Although activities outside of Vanguard are not necessarily a conflict of interest, a conflict could arise depending upon your position within Vanguard and Vanguard’s relationship with your new employer or other activity. Outside activities may also be a conflict of interest if they cause you, or are perceived to cause you, to choose between that interest and the interests of Vanguard. Vanguard employees who have been hired on a full-time, regular basis are expected to devote their entire working time to the performance of their duties for Vanguard. Outside business or consulting activities that would divert time, interest or talents from Vanguard business should be avoided. Vanguard employees are encouraged to engage in charitable activities; however, if such activities require that an employee spend a substantial amount of Company time, he or she should seek the consent of the person to whom he or she reports at Vanguard.

**Business Information.** Vanguard employees may not use for their personal benefit any information about Vanguard or proprietary or non-public information acquired as a result of the employee’s relationship with Vanguard. Employees should disclose such business information only as required in the performance of their job or as expressly authorized by Vanguard. Employees should not under any circumstances use or share “inside information” about Vanguard or those with whom Vanguard does business which is not otherwise available to the general public for any manner of direct or indirect personal gain or other improper use. Furthermore, employees possessing patient or provider information must ensure that such information, in whatever form it exists, is handled in a manner so as to protect against improper access or use by individuals not entitled to it. Violation of this policy may result in personal liability to the employee for any benefit gained from improper use
of such information or any damages sustained by Vanguard as a result of improper disclosure of such information in addition to termination of such employee's employment with Vanguard.
10. ENVIRONMENTAL LAWS

Vanguard is committed to promoting sound corporate environmental practices that will prevent and eliminate damage to the environment, enhance human and community resources, and reduce or avoid exposure to environmental liabilities.

**Medical Waste.** Vanguard employees are expected to exercise good judgment with regard to environmental aspects of the use of Vanguard buildings, equipment, property, lab processes and medical products. Employees must comply with all applicable laws and apply due diligence and care to minimize the generation, discharge and disposal of medical waste or other hazardous materials. Employees who are uncertain of the correct procedures for disposing of any such material should consult their supervisors for assistance.

**Report of Hazardous Condition.** Any Vanguard employee who detects an existing or potential condition hazardous to human health or the environment or in violation of the Company's environmental practices should report the condition immediately to the officer, department head or facility CEO to whom he or she has functional responsibility. Prompt disclosure of such events is critical to effective remedial action and to Vanguard’s efforts to ensure that such events do not recur. Vanguard employees with responsibility for the proper handling and disposal of hazardous substances and infectious waste must ensure that contractors hired to dispose of such materials do so in a proper manner.

**Safety of Patients and Employees.** Also, Vanguard will maintain the safety and well-being of its patients and employees. Vanguard’s managers are charged with the responsibility to develop programs to eliminate, or minimize to the extent reasonably feasible, any hazards to the health and safety of employees and patients, in accordance with applicable laws and regulations.
11. FEDERAL ANTI-KICKBACK STATUTE

This very important statute applicable only to the healthcare industry states as follows: “Whoever knowingly and willingly offers or pays any remuneration (including any kick-back, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person … to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under [the Medicare program or any other Federal Health Care Program e.g., Medicaid] shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five (5) years or both.” (42 U.S.C. §1320a-7b(B)). Also, violation of this Statute provides for civil money penalties of up to $50,000 per violation, damages up to three times the total amount of the improper payment to the referral source and exclusion from participation in Medicare, Medicaid or other federal healthcare programs.

History. Although adopted in 1977, it was not until the mid 1980s that courts were called upon to interpret the statute. The courts, however, were forced to make judgments based solely upon the language of the very broad statute because no regulations had been promulgated which offered clues as to its interpretation. In July of 1991, the Office of the Inspector General (“OIG”) of the Department of Health and Human Services (“HHS”) first promulgated very narrow Safe Harbors which provided some (if little) guidance on how the statute should be interpreted and enforced.

What the Fraud and Abuse Statute Prohibits. The Anti-Kickback Statute prohibits:

- Soliciting or receiving remuneration for referrals of Medicare or Medicaid patients, or for referrals for services or items which are paid for, in whole or in part, by Medicare or Medicaid;

- Soliciting or receiving remuneration in return for purchasing, leasing, ordering, or arranging for, or recommending purchasing, leasing, or ordering, any good, facility, service or item for which payment may be made, in whole or in part, by Medicare or Medicaid;

- Offering or paying remuneration for referrals of Medicare or Medicaid patients or for referrals for services or items which are paid for, in whole or in part, by Medicare or Medicaid; and

- Offering or paying remuneration in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering, any good, facility, service or item for which payment may be made, in whole or in part, by Medicare or Medicaid.

Intent. The Anti-Kickback Statute imposes an intent standard. The person engaging in the prohibited conduct must do so knowingly and willfully. However, the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, the “Health Reform Law”), amended the Anti-Kickback Statute to expressly state specific intent is not an element of a violation of the statute. The Health Reform Law thus repeals the judicially recognized specific intent element recognized by some courts, including the Ninth Circuit Court of Appeals in Hanlester Network v. Shalala, 51 F.3d 1390 (9th Cir. 1995). This new standard thus increases criminal and civil fraud exposure for transactions and arrangements where there is no intent to violate the statute.
Violation is also a False Claim. The Health Reform Law provides that submission of a claim for services or items generated in violation of the Anti-Kickback Statute constitutes a false or fraudulent claim and may be subject to additional penalties under the federal False Claims Act.

Statutory Exceptions. The Anti-Kickback Statute specifically provides that it does not apply to:

- Remuneration paid to a bona fide employee
- Discounts, if the discount is properly disclosed to the Government
- Amounts paid pursuant to a written contract by vendors of goods or services to a person authorized to act as a purchasing agent for a group
- Any other exceptions which the HHS Secretary promulgates. The Secretary of HHS delegated its authority to promulgate these exceptions to the OIG, which in fact has promulgated several exceptions which are described below.

Safe Harbors. The OIG has promulgated from time to time certain very narrow regulations called “Safe Harbors” which have the effect of shielding limited types of transactions from prosecution by the government. In other words, if each element of the Safe Harbor is met, payments made by that entity will be deemed not to constitute illegal remuneration. It should be noted that the safe harbor regulations do not purport to represent the only types of arrangements that are permissible under the Anti-Kickback Statute. In other words, the failure of an arrangement to meet all of the criteria of an applicable safe harbor does not necessarily mean that the arrangement violates the Statute. The conduct or business arrangement not meeting the safe harbor, however, does increase the risk of scrutiny by government enforcement authorities. Vanguard is usually less willing than some of its competitors to take actions or enter into business arrangements that do not clearly satisfy the safe harbors, so when the arrangement does not satisfy a safe harbor, employees are directed to work closely with the Vanguard Legal Department.

The Safe Harbors most relevant to hospital management companies are discussed below.

- Small Entity Safe Harbor. Payments made to investors in the following type of entity will be deemed not to constitute payments for referrals if the entity meets all of the following requirements:
  1. No more than 40 percent of the value of the investment interests are held by investors who are in a position to make or influence referrals;
  2. Terms on which investment interests are offered are the same regardless of whether the investor is in a position to make or influence referrals;
  3. Terms on which an investment is offered are not affected by previous or expected volume of referrals;
  4. Investors are not required to refer business to the entity as a condition of remaining an investor;
  5. The entity does not market or furnish services to investors differently than to noninvestors;
  6. No more than 40 percent of the gross healthcare revenues of the entity in the previous fiscal year comes from referrals;
  7. The entity, another investor or other individual acting on behalf of the entity or any investor does not loan funds to or guarantee a loan for an investor who is in a position to make referrals if the investor uses any part of such loan to
purchase the investment interest; and
8. Payments to an investor must be directly proportional to the amount of capital investment of that investor.

**Space and Equipment Rentals.** Payments made by a lessee to a lessor will be deemed not to constitute payments for referrals if the following criteria are met:

1. The lease agreement is in writing and for a term of at least one year;
2. The lease specifies the equipment or space covered by the lease and covers all the equipment or space leased;
3. If the lease is intended to provide the lessee with use of the space or equipment for periodic intervals of time, the lease specifies the schedule of such intervals, their precise length and the exact rent for such intervals;
4. The aggregate equipment or space leased may not exceed that which is reasonably necessary to accomplish the commercially reasonable business purpose of the rental; and
5. The aggregate rental charge is set in advance and is not determined in a manner that takes into consideration the volume or value of any referrals or business generated between the parties.

**Personal Service and Management Contracts.** Payments made by a principal to an agent will be deemed not to constitute payments for referrals so long as all of the following requirements are met:

1. The agreement is in writing and its term is at least one year;
2. The agreement specifies the services to be rendered by the contractor and covers all of the services provided;
3. If the agreement is intended to provide for the services of the agent on anything other than a full time basis, the agreement specifies the schedule of intervals, their precise length and the exact charge for such intervals;
4. The aggregate services contracted for may not exceed those which are reasonably necessary to accomplish the commercially reasonable business purpose of the services; and
5. The aggregate compensation is set in advance, is consistent with fair market value and is not determined in a manner that takes into account the value or volume of referrals.

**Referral Services.** Payments exchanged between an individual and a referral service (other than payments based upon the volume or value of referrals to the individual) will be deemed not to constitute payments for referrals if the following requirements are met:

1. The referral service does not exclude as a participant in the referral service any individual who meets the qualifications for participation;
2. Payments the participant makes to the referral service are assessed equally against and collected equally from all participants;
3. The referral service imposes no requirements on the manner in which the participant provides services to a referred person; and
4. The referral service make the following disclosures to persons seeking referrals:
   (A) The manner in which it selects participants in the referral services;
and

(B) Whether the participant has paid a fee to the referral services.

**Ambulatory Surgical Centers.** The ambulatory surgical center (ASC) safe harbor protects investment payments from ASCs to their physician-investors who perform procedures at the ASC because the OIG believes that the risk of impermissible referrals is low when an ASC functions as an extension of the physician’s office. Since the facility fee generated by the referral to the ASC is substantially lower than the professional fee, the OIG explains in the preamble that the ASC profits distributed to the physician-investors (which profits are derived from the facility fee) are not great enough to induce physician-investors to refer to ASCs. The ASC safe harbor is divided into four categories described below. In addition, each category must fulfill certain common requirements, including the following: the ASC must be Medicare certified; the ASC and its investors may not loan money to potential investors for the purpose of investing in the ASC; and neither the ASC nor the physicians practicing at the ASC may discriminate against beneficiaries of the federal health care programs. The ASC safe harbor also requires that patients referred to an ASC by an investor be fully informed of such investment interest.

- **Surgeon-Owned ASC.** This category protects ASC investments in which all the investors are either: (i) general surgeons or engaged in the same surgical specialty and who are in a position to refer patients to the ASC and perform procedures on referred patients; (ii) group practices composed of such surgeons; or (iii) investors who do not provide items or services to the ASC or its investors, are not employed by such entities, and are not in a position to influence referrals to such entities. Surgeon investors are in a position to refer patients to ASCs and perform procedures there if they derive at least one-third of their medical practice income from their performance of procedures that require an ASC or hospital surgical setting in accordance with Medicare reimbursement rules (the “one-third practice income test”).

- **Single-Specialty ASC.** This category is similar to the first category but the physician investors must be in the same medical specialty, although they need not be traditional surgeons. In addition, the one-third practice income test applies to such investors.

- **Multi-Specialty ASC.** This category is similar to the first two categories but permits the physician investors to be a mix of specialists. The one-third practice income test applies to such investors. In addition, at least one-third of the physician’s procedures that require an ASC or hospital surgical setting must be performed at the ASC in which the physician is investing.

- **Hospital/Physician ASC.** In this category, at least one investor must be a hospital and the remaining investors must be a non-referral source investor or a physician or group practice that qualifies under one of the other categories of this safe harbor. The hospital must not be in a position to refer patients to the ASC or to the other investors. The OIG also states in the preamble that any space that is leased by the
hospital to the ASC and any services that are provided by the hospital to the ASC must meet separate safe harbors.

**Important Case Law Interpreting the Anti-Kickback Statute.** Federal case law has broadly interpreted the Anti-Kickback Statute and applied it to a wide variety of relationships much broader than the simple kickback for a patient referral. Federal courts and administrative bodies considering the statute in the context of actual enforcement proceedings have established several important interpretive principles:

1. The statute may be violated if even one purpose, as opposed to a primary or sole purpose, of a payment arrangement is in exchange for, or to induce, the referral of patients or the ordering, purchasing, leasing or recommending of items or services (US v. Greber, 760 F.2d 68, 72 (3d Cir. 1985));
2. Giving a referral source the opportunity to earn a fee, particularly a fee that exceeds the reasonable value of any services provided or return on investment made, is evidence that the payment is unlawful. US v. Bay City Ambulance, 874 F.2d 20,29 (1st Cir. 1989).
3. The fact that a particular arrangement is common in the health care industry is not a defense (Polk County v. Peters, 800 F. Supp. 1451 (ED Tex. 1992)); and
4. An illegal intent may be inferred from the circumstances of the case, absent an explicit agreement to refer business. Hanlester Network v. Shalala, 51 F. 3d 1390 (9th Cir. 1995).

**Where the Statute Applies and No Safe Harbor is Met.** Where a particular practice falls within the ambit of the Statute and does not qualify for a safe harbor, the OIG and Department of Justice will consider a variety of factors in determining whether the arrangement is abusive and a candidate for investigation and prosecution. Specifically, consideration is usually given to: (1) the potential for increased charges or reported costs to a Federal Health Care Program; (2) the possible encouragement of over-utilization; (3) the potential for adversely affecting competition by freezing competing suppliers out of the marketplace; and (4) the intent of the parties.

**Fraud Alerts.** In addition to the “Safe Harbors”, the OIG regularly advises the public regarding situations of which it should be aware through Special Fraud Alerts. These are circulars issued by the OIG which are now published in the Federal Register, which give guidance to the public regarding which issues and facts the OIG believes are problematic from a fraud and abuse standpoint. See the Section of this Manual entitled “OIG Special Fraud Alerts”.

**Advisory Opinions.** Since June 1997 the OIG has been required to issue advisory legal opinions on the Anti-Kickback Statute. By the end of 2005 over 130 advisory legal opinions have been issued by the OIG. While such opinions are legally binding only upon the party requesting the opinion, they have been very useful in counseling providers as to what specific acts in healthcare constitute illegal inducements. All of such opinions can be accessed on line on the OIG’s website at [http://oig.hhs.gov/fraud/advisoryopinions.html](http://oig.hhs.gov/fraud/advisoryopinions.html)

**Criminal Penalties for Violation of Anti-Kickback Statute.** Any person who violates the Anti-Kickback Statute is guilty of a felony punishable by up to 5 years imprisonment and/or fines of up to $25,000. If a person is convicted of violating the Statute, the person is subject also to exclusion from the Medicare and Medicaid programs.
Civil Penalties for Violation of Anti-Kickback Statute. The Balanced Budget Act (P.L. 105-33), signed by President Clinton on August 5, 1997, created a civil monetary penalty (42 U.S.C. §1320a-7a(a)(7)) for Anti-Kickback Statute violations in addition to the criminal penalties and the sanction of exclusion. The civil penalty is treble damages (three times the illegal remuneration) plus $50,000 per violation. The Government can impose these large fines for Anti-Kickback Statute violations that it proves with a simple preponderance of the evidence, a standard much easier to satisfy than the criminal standard of beyond a reasonable doubt. The Government thus has a much lower civil standard to enforce the Statute’s considerable civil monetary penalties.

State Anti-Kickback Statutes. Many states also have statutes that are similar to the Anti-Kickback Statute. Before consummating transactions with referral sources in a particular state, the Vanguard employee should consult with a member of the Vanguard Legal Department as to whether any additional requirements are mandated by the relevant state anti-kickback statute.
12. FRAUD AND ABUSE

The rash of huge investigations and huge monetary settlements in recent years involving the healthcare fraud of healthcare providers has spawned the emergence of the era in healthcare of major corporate compliance programs for all healthcare companies. These investigations (Tenet Healthcare) and settlements (e.g. $631 million from HCA in 2003, $731 million from HCA in 2000, $324 million from National Medical Enterprises (now Tenet) in 1994, $900 million from Tenet in 2006, $265 million for the St. Barnabas Hospitals in 2006) make aggressive compliance efforts critical for healthcare entities operating today.

The primary areas of concern for healthcare providers are the Medicare and Medicaid Anti-Kickback Statute, state anti-kickback provisions (including, in some cases, state fee-splitting prohibitions), the Stark Self-Referral Statutes and state and Federal civil and criminal false claims provisions. Additional civil monetary penalty and exclusion provisions also exist. These matters are summarized below.

**Anti-Kickback Statute.** The Medicare and Medicaid anti-kickback statute, 42 U.S.C. § 1320a-7(b)(B), prohibits the knowing and willful solicitation or receipt of any remuneration “in return for” referring an individual, or for recommending or arranging for the purchase, lease, or ordering of any item or service for which payment may be made under Medicare or a state healthcare program. In addition, the statute prohibits the offer or payment of remuneration “to induce” a person to refer an individual, or to recommend or arrange for the purchase, lease, or ordering of any item or service for which payment may be made under the Medicare or state healthcare programs. For a more thorough discussion of this statute, see the Section of this Manual entitled “Federal Anti-Kickback Statute”.

**The Federal False Claims Act and Similar Laws.** Another trend affecting the healthcare industry today is the increased use of the federal False Claims Act, and, in particular, actions being brought by individuals on the government’s behalf under the False Claims Act’s “qui tam” or whistleblower provisions. Whistleblower provisions allow private individuals to bring actions on behalf of the government alleging that the defendant has defrauded the federal government. If the government intervenes in the action and prevails, the party filing the initial complaint may share in any settlement or judgment. If the government does not intervene in the action, the whistleblower plaintiff may pursue the action independently, and may receive a larger share of any settlement or judgment. When a private party brings a qui tam action under the False Claims Act, the defendant generally will not be made aware of the lawsuit until the government makes a determination whether it will intervene.

The Fraud Enforcement and Recovery Act, which became law on May 20, 2009, changes the scienter requirements for liability under the False Claims Act. An entity may now violate the False Claims Act if it “knowingly and improperly avoids or decreases an obligation” to pay money to the United States. This includes obligations based on an “established duty . . . arising from . . . the retention of any overpayment.” Thus, if a provider is aware that it has retained an overpayment that it has an obligation to refund, this may form the basis of a False Claims Act violation even if the provider did not know the claim was “false” when it was submitted. The Health Reform Law expressly requires healthcare providers and others to report and return overpayments. The term overpayment is defined as “any funds that a person receives or retains under title XVIII or XIX to which the person, after applicable reconciliation, is not entitled under such title.” The Health Reform Law also defines the period of time in which an overpayment must be reported and returned to the
government. The Health Reform Law provides that “[a]n overpayment must be reported and returned” within “60 days after the date on which the overpayment was identified,” or “the date any corresponding cost report is due,” whichever is later. The provision explicitly states that if the overpayment is retained beyond the 60-day period, it becomes an “obligation” sufficient for reverse false claim liability under the False Claims Act, and is therefore subject to treble damages and penalties if there is a “knowing and improper” failure to return the overpayment.

The Health Reform Law also significantly increased the rights of whistleblowers to bring False Claims Act actions by materially narrowing the so-called “public disclosure” bar to their False Claims Act actions. Until the Health Reform Law was enacted, a whistleblower was not entitled to pursue publicly disclosed claims unless he or she was a direct and independent source of the information on which his or her allegations of misconduct were based. Under new Health Reform Law provisions:

- It will now be enough that the whistleblower has independent knowledge that materially adds to publicly disclosed allegations.
- Furthermore, the Health Reform Law limits the type of activity that counts as a “public disclosure” to disclosures made in a federal setting; disclosure in state reports or state proceedings will no longer qualify.
- Even if all requirements are met to bar a whistleblower’s suit, the Health Reform Law permits the Department of Justice to oppose a defendant’s motion to dismiss on public disclosure bar grounds, at its discretion so that the whistleblower can proceed with his or her complaint.

When a defendant is determined by a court of law to be liable under the False Claims Act, the defendant must pay three times the actual damages sustained by the government, plus mandatory civil penalties of between $5,500 to $11,000 for each separate false claim. Settlements entered into prior to litigation usually involve a less severe calculation of damages. There are many potential bases for liability under the False Claims Act. Typically, each fraudulent bill submitted by a provider is considered a separate false claim, and thus the penalties under the False Claims Act may be substantial. Liability arises when an entity knowingly submits a false claim for reimbursement to the federal government or, since May 2009, when an entity knowingly or improperly retains an overpayment that it has an obligation to refund. The False Claims Act defines the term “knowingly” broadly. Thus, simple negligence will not give rise to liability under the False Claim Act, but submitting a claim with reckless disregard to its truth or falsity can constitute “knowingly” submitting a false claim and result in liability. The Fraud Enforcement and Recovery Act of 2009 expanded the scope of the False Claims Act by, among other things, creating liability for knowingly and improperly avoiding repayment of an overpayment received from the government and broadening protections for whistleblowers. Under the Health Reform Law, the False Claims Act is implicated by the knowing failure to report and return an overpayment within 60 days of identifying the overpayment or by the date a corresponding cost report is due, whichever is later. Further, the Health Reform Law expands the scope of the False Claims Act to cover payments in connection with the new health insurance exchanges to be created by the Health Reform Law, if those payments include any federal funds.
In some cases, whistleblowers or the federal government have taken the position that providers who allegedly have violated other statutes and have submitted claims to a governmental payer during the time period they allegedly violated these other statutes, have thereby submitted false claims under the False Claims Act. Such other statutes include the Anti-Kickback Statute and the Stark Law. Courts have held that violations of these statutes can properly form the basis of a False Claims Act case. The Health Reform Law clarifies this issue with respect to the Anti-Kickback Statute by providing that submission of claims for services or items generated in violation of the Anti-Kickback Statute constitutes a false or fraudulent claim under the False Claims Act.

A number of states, including states in which Vanguard operates, have adopted their own false claims provisions as well as their own whistleblower provisions whereby a private party may file a civil lawsuit in state court. From time to time, companies in the healthcare industry, including Vanguard, may be subject to actions under the False Claims Act or similar state laws.

Provisions in the Deficit Reduction Act (the “DRA”) that went into effect on January 1, 2007 give states significant financial incentives to enact false claims laws modeled on the federal False Claims Act. Additionally, the DRA requires every entity that receives annual payments of at least $5 million from a state Medicaid plan to establish written policies for its employees that provide detailed information about federal and state false claims statutes and the whistleblower protections that exist under those laws. Both provisions of the DRA are expected to result in increased false claims litigation against healthcare providers. Vanguard has complied with the written policy requirements. See Legal Department Policy LEGL.055 (and Compliance Department Policy CD.006).

Stark Self-Referral Statutes. In 1989, Congress enacted the Ethics in Patient Referrals Act (the “Stark I” statute). Effective January 1,1992, the statute generally prohibited physicians from referring Medicare patients to clinical laboratories for testing, if the referring physician (or a member of the physician’s immediate family) had a “financial relationship” – either through ownership or compensation – with the lab. In 1993, Stark I was expanded by a statute commonly known as Stark II to prohibit physicians from referring Medicaid and Medicaid patients to an entity for the furnishing of a list of “designated health services”, including inpatient and outpatient hospital services, radiology services, durable medical equipment, physical therapy, home health services, and outpatient drugs. 42. U.S.C. §1395nn(h)(6). For a more thorough discussion of this subject see the Section of this Manual entitled “Stark Self-Referral Statutes”.

Other Provisions. Finally, the Social Security Act sets forth a variety of other provisions setting forth civil monetary and other penalties, including exclusion from participating in Medicare and Medicaid, for various billing-related offenses. For example, civil monetary penalties apply to violations of Medicare assignment regulations, violations of participating provider agreements, use of false physician credentials, the filing of claims by excluded entities, and providing false or misleading information regarding hospital discharge decisions. HHS can also initiate permissive exclusion actions for such improper billing practices as submitting claims “substantially in excess” of the provider’s usual costs or charges, failure to disclose ownership and officers, failure to disclose subcontractors and suppliers, and more.

New Federal Legislation-HIPA Act. On August 21, 1996, President Clinton signed into law sweeping health insurance reform legislation, the Health Insurance Portability and Accountability Act of 1996 (the "HIPA Act"). In addition to the provisions governing the offering of health
insurance products, the HIPA Act substantially amends the Federal fraud and abuse laws to add to the already enormous arsenal of weapons at the government's disposal to prosecute healthcare fraud. While much of the HIPA Act simply codifies the longstanding positions of the fraud enforcers as to what constitutes illegal conduct under existing law, this new Act does expand certain available sanctions for healthcare fraud. In addition, the reach of the Federal civil money penalty laws now was expanded to all Federal health care programs, with the exception of the Federal Employee Health Benefits Program.

1. Increased Sanctions. The HIPA Act increases criminal sanctions for health-care fraud against both private and government payors. The Act adds various Federal healthcare offenses to the criminal code, including a separate "health-care fraud" offense, theft or embezzlement in connection with healthcare, false statements relating to healthcare matters, and obstruction of criminal investigations of healthcare offenses. The existing money laundering, freezing of assets and forfeiture provisions, applicable to other Federal crimes and already in use in healthcare cases, are expressly applied to the new Federal healthcare offenses.

2. New Civil Money Penalty Provisions. The HIPA Act adds to the list of specific activities subject to civil monetary penalties. "Upcoding" -- that is, the submission of a claim for an item or service that is based on a code that the person knows or should know will result in greater payment than the person knows or should know is applicable to the item or service provided -- now is subject to a specific penalty. Similarly, civil money penalties are included for the provision of a pattern of medical items or services that a person knows or should know are not medically necessary. Also, a new civil money penalty also is specified for any offer or transfer of remuneration to individuals that a person knows or should know is likely to influence such individual to order from a particular provider, practitioner or supplier any item or service paid under Medicare or a state health program. Penalty amounts are increased from $2,000 to $10,000 for each service involved.

3. New OIG Advisory Opinions. The Act directs the OIG to issue advisory opinions concerning what constitutes prohibited remuneration within the meaning of the Federal Anti-Kickback Statute, whether an arrangement satisfies the statutory exceptions to the Anti-Kickback Statute, whether an arrangement meets a Safe Harbor, what constitutes an illegal inducement to reduce or limit services to individuals entitled to Medicare or Medicaid benefits under the Anti-Kickback Statute, and whether an activity constitutes grounds for the imposition of a civil or criminal penalties under the exclusion, civil money penalty and criminal provisions of the Social Security Act. The OIG issued the first of these advisory opinions in June 1997.

4. National Health Care Fraud and Abuse Control Program. Finally, the OIG and the Attorney General are directed in this Act to establish a program to coordinate Federal, state, and local law enforcement programs to control fraud and abuse with respect to health plans, conduct investigations, audits, evaluations, and inspections, and facilitate enforcement of the Anti-Kickback Statute, exclusion laws, and civil monetary penalties statute. To pay for this program, a Health Care Fraud and Abuse Control Account is established within the Federal hospital insurance trust fund. The trust fund will include criminal fines recovered for the new Federal healthcare fraud offense, civil money penalties and assessments imposed in healthcare cases, and amounts resulting from property forfeitures by reason of a Federal healthcare offense. Hundreds of millions of dollars have been appropriated to the Control Account from the Trust Fund each year to fund the activities of the OIG, the FBI, and HHS's contracts with entities for utilization and fraud review under the newly established "Medicare Integrity Program." In addition, it is likely that the government’s fraud and
abuse enforcement activities will be increased if proposed budget increases for fiscal year 2012 are enacted. In President Obama’s February 14, 2011 draft budget, discretionary funding for the Health Care Fraud and Abuse Control Account would double from roughly $311 million in fiscal year 2011 to $581 million for fiscal year 2012.

**Fraud and Abuse By Hospitals.** From a fraud and abuse standpoint, hospitals and hospital personnel can be both recipients of kickbacks (e.g., from medical equipment suppliers seeking referrals of discharged patients) and payors of kickbacks or other inducements (e.g., to physicians, whether in the form of payments for referrals or in the provision of sharply discounted rental space).

Other payments by hospitals to physicians can result in fraud and abuse (e.g., payments in order to recruit physicians). See the Section of this Manual entitled “Physicians Agreements and Perequisites” for a more thorough discussion of fraud and abuse in payments to physicians.

Hospital cost reporting issues have also given rise to false claims actions. Also, billing under the wrong DRG (i.e., one that pays a higher amount) has been a problem for some hospitals, as have “unbundling” practices (i.e., billing separately for items and services that should have been included within the base DRG rate). See the Section of this Manual entitled “Billing” for a more thorough discussion of fraud and abuse in hospital billing issues.

**Fraud and Abuse by Home Health Agencies.** The fraud and abuse in this area include: filing claims for home health visits never made and for visits to ineligible beneficiaries; fraud in annual cost reports, including claiming unallowable costs for entertainment, lobbying, gifts, and other expenses unrelated to patient care such as luxury cars and cruises; failure to report “related” parties; paying kickbacks (e.g., to physicians for each home health plan of care certified; to hospitals in the form of free discharge planning services; to beneficiaries agreeing to switch agencies; and to retirement homes in the form of free nursing coverage); and marketing non-covered or unneeded services to beneficiaries.

**Fraud and Abuse by Physicians.** Physicians, of course, are in the best position of any health care provider or supplier to refer patients and services, and accordingly to receive kickbacks. For example, in late 1995, a physician was found guilty in a Federal case in Minneapolis of receiving kickbacks in return for prescribing human growth hormone to children.

Physicians also have been charged in various cases with billing irregularities amounting to false claims, including such practices as “upcoding” or “miscoding” or other fraudulent practices (e.g., billing for an intermediate rather than a brief visit, and billing for a visit never made, especially weekend visits by primary care physicians filled in on a Monday in space left in the medical records by “friendly” specialists grateful to have received the referral from the primary care physician).

**Factors Influencing Risk of Investigation/Enforcement.** Numerous factors can play a part in assessing whether an arrangement that could potentially fall within the scope of the Medicare and Medicaid Anti-Kickback Statute is likely to be targeted for investigation and/or possible civil or criminal prosecution by the OIG or other Federal enforcement authorities. The same is true with healthcare false claims cases. While no single factor is determinative, most relevant appear to be:

1. **Financial Harm To Program.** Arrangements that the OIG or other enforcement authorities conclude have a detrimental financial impact on the Medicare or Medicaid programs are
more likely to be targeted than those arrangements that may be viewed as only “technical” violations that do not impact the public coffers. Proof of such financial harm, however, is not a required element of a violation of the Anti-Kickback Statute.

2. Informants. Risks of an investigation increase if the provider in question is brought to the attention of the OIG by a knowledgeable informant as involving illegal activity. Such complaints are typically made by employees (or disgruntled former employees), competitors, patients (or their families), other personal acquaintances, and cooperating witnesses in other investigations.

3. Significant Changes In Utilization Levels. Claims involving items or services whose utilization levels increase substantially, especially over a short period of time, have an increased risk of being flagged by a Medicare carrier or intermediary or by the OIG for investigation.

4. Substantial Compliance With Safe Harbors. As a practical matter, the OIG may be less inclined to undertake a major investigation of arrangements that comply with most (but not all) of the applicable Safe Harbor requirements when the parties have taken good faith steps to comply. A similar level of qualified comfort might also be achieved for arrangements that comply with proposed Safe Harbors. Additional comfort would be derived from being in an area that the OIG apparently considered to be essentially non-abusive.

5. Enforcement Activity Involving The Same Or Similar Industry Or Practice. There may be increased risk for activities that are similar to arrangements the OIG is known to be investigating. Recent examples include improper bundling of laboratory tests, improper unbundling of hospital services, improper faculty/resident billing, and others.

6. OIG Work Plans and Special Fraud Alerts. The OIG issues annual Work Plans, Semiannual Reports, and periodic Fraud Alerts describing, among other things, practices and geographic areas it is reviewing, or intends to review for potential violations.

7. Civil Litigation. When private litigants make allegations in the context of commercial litigation (e.g., breach of contract actions) about the impropriety/illegality of a contract term under the Medicare and Medicaid fraud and abuse laws, the pleadings and record of that case often serve as a basis upon which the OIG could begin an investigation.

8. Resources Of Enforcement Agency. Another practical consideration is the OIG’s need to allocate judiciously their limited financial and human resources. These agencies receive information on far more arrangements than they are able to pursue in depth, so their judgments on whether to investigate are often influenced by this factor, together with those mentioned above.

Program Integrity and Fraud and Abuse. The Health Reform Law makes several significant changes to healthcare fraud and abuse laws, provides additional enforcement tools to the government, increases cooperation between agencies by establishing mechanisms for the sharing of information and enhances criminal and administrative penalties for non-compliance. For example, the Health Reform Law: (1) provides $350 million in increased federal funding over the next 10 years to fight healthcare fraud, waste and abuse; (2) expands the scope of the RAC program to include Medicare advantage plans and Medicaid; (3) authorizes HHS, in consultation with the OIG, to suspend Medicare and Medicaid payments to a provider of services or a supplier “pending an
investigation of a credible allegation of fraud;” (4) provides Medicare contractors with additional flexibility to conduct random prepayment reviews; and (5) tightens up the requirements for returning overpayments made by governmental health programs and expands False Claims Act liability to include failure to report and return an overpayment within 60 days of identifying the overpayment or by the date a corresponding cost report is due, whichever is later.

**Healthcare Industry Investigations.** Significant media and public attention has focused in recent years on the hospital industry. In recent years, increased attention has been paid to hospitals with high Medicare outlier payments and to recruitment arrangements with physicians. Further, there are numerous ongoing federal and state investigations regarding multiple issues. These investigations have targeted hospital companies as well as their executives and managers. Like other hospital companies, Vanguard has substantial Medicare, Medicaid and other governmental billings and we engage in various arrangements with physicians, which could result in scrutiny of Vanguard’s operations. Vanguard continues to monitor these and all other aspects of its business and has developed a compliance program to assist Vanguard in gaining comfort that its business practices are consistent with both legal principles and current industry standards. In public statements surrounding current investigations, governmental authorities have taken positions on a number of issues, including some for which little official interpretation previously has been available, that appear to be inconsistent with practices that have been common within the hospital industry and that previously have not been challenged in this manner. In some instances, government investigations that have in the past been conducted under the civil provisions of federal law may now be conducted as criminal investigations.

Many current healthcare investigations are national initiatives in which federal agencies target an entire segment of the healthcare industry. One example is the federal government’s initiative regarding hospital providers’ improper requests for separate payments for services rendered to a patient on an outpatient basis within three days prior to the patient’s admission to the hospital, where reimbursement for such services is included as part of the reimbursement for services furnished during an inpatient stay. In particular, the government has targeted all hospital providers to ensure conformity with this reimbursement rule. The federal government also has undertaken a national investigative initiative targeting the billing of claims for inpatient services related to bacterial pneumonia, as the government has found that many hospital providers have attempted to bill for pneumonia cases under more complex and higher reimbursed diagnosis related groups codes. Further, the federal government continues to investigate Medicare overpayments to prospective payment hospitals that incorrectly report transfers of patients to other prospective payment system hospitals as discharges. The Health Reform Law includes additional federal funding of $350 million over the next 10 years ending 2020 to fight healthcare fraud, waste and abuse, including $95 million for federal fiscal year 2011, $55 million in federal fiscal year 2012 and additional increased funding through 2016. In addition, governmental agencies and their agents, such as the MACs, fiscal intermediaries and carriers, may conduct audits of our healthcare operations. Further, under the federal False Claims Act, private parties have the right to bring “qui tam” whistleblower lawsuits against companies that submit false claims for payments to the government. Some states have adopted similar state whistleblower and false claims provisions.

In addition to national enforcement initiatives, federal and state investigations commonly relate to a wide variety of routine healthcare operations such as: cost reporting and billing practices; financial arrangements with referral sources; physician recruitment activities; physician joint ventures; and hospital charges and collection practices for self-pay patients. Vanguard engages in
many of these routine healthcare operations and other activities that could be the subject of
governmental investigations or inquiries from time to time. For example, we have significant
Medicare and Medicaid billings, we have numerous financial arrangements with physicians who are
referral sources to our hospitals and we have joint venture arrangements involving physician
investors.

* Duties Of An Employee Once Fraud & Abuse is Detected Or Suspected. * If a Vanguard
employee thinks he has detected or suspects that he or she has detected healthcare fraud and abuse,
the employee should immediately report the findings or suspicions to the Vanguard General
Counsel, the Vanguard Senior Vice President - Compliance & Ethics, or the Hotline at *(1-888-895-9945).*
13. GOVERNMENTAL INVESTIGATIONS

_It is Vanguard’s policy to comply fully with the law and cooperate with any reasonable demand made in a government investigation._ In so doing, however, it is essential that the legal rights of Vanguard and of its personnel involved be protected. If any employee receives a governmental inquiry, a subpoena or other legal document regarding Vanguard business, whether at home or in the workplace, Vanguard requests that the employee notify his or her supervisor and the Legal Department immediately. If the government contacts an individual at home, the individual should ask the agent to come back later and immediately contact a member of the Vanguard Legal Department to discuss the matter. Usually, Vanguard will arrange for counsel representing Vanguard to accompany any Vanguard employee to any interview by a governmental person.

**What To Do in Case of a Fraud or State Investigator Requesting an Interview**

- Vanguard employees should understand that they are under no obligation to submit to an interview with any government investigator. _Whether or not the employee decides to submit to an interview is up to the employee._ If the employee is contacted, the employee should ask the identity of the agents and inspect their credentials. The employee should also ask the agents what their purpose is in requesting the interview and what is the employee's personal status in the investigation (for example, whether the employee is a witness, a suspect or a target of the investigation). However, it is rare that an agent will have the authority to promise that the employee has no civil or criminal exposure at the initial contact, and the agent will probably attempt to avoid answering this question. Moreover, if the employee does submit to an interview without consultation with counsel and the investigator is unhappy with the testimony, employees should note that their status can change.

- If an employee decides to submit to an interview, the employee has the right to demand that the interview take place during normal business hours at the Company's premises or at another location, and that either Company counsel or the employee's personal counsel be present during the interview. In appropriate circumstances, Vanguard may suggest that an attorney working in the Vanguard Legal Department or that outside counsel to Vanguard accompany the employee in any interview or even recommend that separate counsel be retained for the employee under an indemnification agreement whereby the Company can recommend an attorney and, under state law, an employee can be reimbursed for these costs.

- To facilitate any request for legal assistance, and to make available to you information that may assist you in deciding whether or not to submit to an interview, the Company requests that upon contact by an investigator, its employee immediately notify the Vanguard Legal Department. Our policy is to fully cooperate with federal investigations but only after the Company understands the legal implications of any cooperation on itself and its employees.

- Employees may not give or show to the investigators any Vanguard documents without the express permission of the Company.

**What To Do in Case of a Search Warrant**

- No law enforcement agent is allowed to conduct a search of any home or business without a valid search warrant signed by a Judge. Therefore, anyone claiming to be an agent with a warrant should be asked to SHOW PROPER IDENTIFICATION AND PROVIDE A COPY
OF THE WARRANT. Vanguard employees should ask for a business card from the agent. If he/she refuses, Vanguard employees should write down their names and agency. Vanguard has the legal right to review the warrant and keep a copy of it. If the affidavit in support of the warrant is not attached, the Vanguard employee should ask for a copy.

- Once the employee has been shown proper identification and has a copy of the warrant, then the employee should call a member of the Vanguard Legal Department to inform the attorney of the warrant. Employees should treat the agents' presence as AN EMERGENCY! Employees should not give up until they have reached Vanguard counsel.

- The warrant has an expiration date, must identify the place to be searched and often sets time limits for the search (eg. warrant for a daytime search only). Employees should read the warrant and make sure it gives the agents the authority to search the Vanguard premises.

- When the employee reaches the Vanguard Corporate Counsel, employees should relate to counsel the following information: (1) the fact of the warrant; (2) the law enforcement and regulatory agencies involved; (3) the areas to be searched under the provisions of the warrant; and (4) the types of evidence to be seized under the warrant.

- One employee should be designated to deal with the agents, to take notes during the search.

- It is a crime to obstruct an agent in the lawful exercise of his/her duties, including execution of a search warrant. However, asking questions and demanding a copy of the warrant are not obstruction. Remain calm, polite and OBSERVANT. In other words, observe the course of the search, but do not interfere with it.

- For various reasons agents often try to use copiers instead of seizing records. Do not give permission for the use of copiers without clearance from Vanguard Corporate Counsel.

- All federal and state agents are required to leave behind an "inventory" of items taken during the search. Employees should designate a Vanguard hospital employee to watch the agents and take notes as to the type of evidence seized, demand an inventory and make every effort to assure that the inventory is specific enough to be useful to Vanguard. Please note that descriptions such as "six boxes of files" are not detailed enough to comply with the law.

- In the confusion surrounding a search, agents often talk to employees in an informal fashion. However, we think there is no idle chatter. Employees should expect that anything they say to an agent will be written down and used later on. Other than directing an agent to the storage location for items SPECIFIED in the warrant, Vanguard employees do not have to submit to questioning. IT IS BEST IF AGENTS ARE ISOLATED AS BEST CAN BE.

No Destruction of Evidence
- Nothing is worse in a governmental investigation then destruction of evidence. Any hint of destruction of evidence leads the government to take quicker and more serious steps (e.g., use of search warrants rather than subpoenas). Also, sometimes the only criminal problems turn out later to be the destruction of evidence.
14. INTERNAL CONTROLS

Internal Controls. Internal controls provide Vanguard a system of “checks and balances” to help insure that administrative and accounting policies, including those described in this Manual, are complied with throughout the corporation. In addition to being necessary and good business practice, this policy’s requirements promote compliance with the Federal securities laws, including the Foreign Corrupt Practices Act of 1977.

Administrative controls promote organizational effectiveness, and help establish a uniform direction for employee efforts by ensuring adherence to company policies; and accounting controls safeguard Vanguard’s assets and ensure the reliability of company records. Vanguard managers are responsible for effective administrative and accounting controls in their areas of responsibility.

In administering internal controls, managers should communicate to their subordinates all company policies that apply to their job; the managers should also show leadership in adhering to the policies and enforcing them. Reasonable procedures for carrying out company policies and preventing deviations should be established. In keeping with the company’s management style, managers have considerable discretion in developing these procedures, which should be kept to a minimum within the spirit of the requirements of this policy. If deviations from policy do occur, appropriate (i.e., fair, but firm) disciplinary action may be necessary.

In carrying out their responsibility for administering accounting controls, managers must assure that:

- Business transactions of all kinds are executed by employees authorized to do so.
- Access to assets of all kinds (e.g., cash, inventory, securities, etc.) is permitted only with authorization by the appropriate management levels.
- Business transactions are reported as necessary to (a) permit preparation of accurate financial and other records and to (b) clearly reflect the responsibility for assets.
- Records identifying the responsibility for assets are compared with actual assets at reasonable intervals. Appropriate action must be taken if there are discrepancies.

Books and Records. Managers should ensure that company records accurately and fairly represent all business transactions. This means that:

- All assets and transactions must be recorded in normal books and records.
- No unrecorded funds shall be established or maintained for any purpose.
- Records shall not be falsified in any manner.
- Anyone with knowledge of inaccurate or false records must promptly report them to an appropriate senior manager, the Vanguard General Counsel or its Senior Vice President - Compliance & Ethics.
- Oral and written descriptions of transactions, whether completed or contemplated,
must be full and accurate. Special care must be exercised in describing transactions to those responsible for the preparation or verification of financial records to avoid any misleading inferences.

**Control of Funds.** Each officer, department head or administrator must monitor the commitment and expenditure of Vanguard funds by persons under his or her authority. Each must ensure that any expenditure or transfer of Vanguard funds is made for a valid business purpose, is appropriately documented, is made pursuant to authority in published guidelines and policy statements and is actually received by the recipient indicated in the Company records.

**Responsible Use of Vanguard’s Assets.** Employees shall preserve Vanguard’s property, facilities, equipment, and supplies. This includes all Vanguard property, whether owned or leased. Vanguard tangible and intangible property includes office and medical equipment, vehicles, supplies, reports and records, computer software and data, trademarks and service marks, intellectual property, facilities, and company-provided services.

Employees shall dispose of surplus, obsolete, or junked property according to Company policies. Incorrect disposal of property must be avoided.

**Responsible Use of the Assets of Others.** Employees shall protect patient property and information and handle all such property and information according to Vanguard policies. Patient information may be shared only with those who have a legitimate need and are authorized to receive such information.

Employees shall protect intellectual property developed as part of our employment by Vanguard. Employees shall not share this with another employer while working for Vanguard or after departing Vanguard and will return any tangible intellectual property in their possession to the Company upon termination of employment.
15. OIG SPECIAL FRAUD ALERTS

The Office of Inspector General ("OIG") was established at the U.S. Department of Health and Human Services ("HHS") by Congress in 1976 to identify and eliminate fraud, abuse and waste in HHS programs and to promote efficiency and economy in departmental operations. The OIG carries out this mission through a nationwide program of audits, investigations and inspections. To help reduce fraud in the Medicare and Medicaid programs, the OIG actively investigates violations of the Medicare and Medicaid Anti-Kickback Statute.

Since 1989 the OIG has issued many "Special Fraud Alerts" or “Special Advisory Bulletins” designed to provide guidance to healthcare providers and practitioners about business practices that may subject them to criminal prosecution or exclusion from the Medicare or Medicaid programs under the Anti-Kickback Statute. Although Special Fraud Alerts are not regulations having the force of law, they are significant since they offer insight into the OIG’s enforcement priorities and provide the OIG’s interpretation of the Anti-Kickback Statute as applied to various factual situations.

The OIG has identified several incentive arrangements as potential violations, including:

- payment of any incentive by the hospital when a physician refers a patient to the hospital;
- use of free or significantly discounted office space or equipment for physicians in facilities usually located close to the hospital;
- provision of free or significantly discounted billing, nursing or other staff services;
- free training for a physician’s office staff, including management and laboratory techniques;
- guarantees that provide that, if the physician’s income fails to reach a predetermined level, the hospital will pay any portion of the remainder;
- low-interest or interest-free loans, or loans which may be forgiven if a physician refers patients to the hospital;
- payment of the costs of a physician’s travel and expenses for conferences or a physician’s continuing education courses;
- coverage on the hospital’s group health insurance plans at an inappropriately low cost to the physician;
- rental of space in physician offices, at other than fair market value terms, by persons or entities to which physicians refer;
- payment of services which require few, if any, substantive duties by the physician, or payment for services in excess of the fair market value of the services rendered; or
“gain sharing,” the practice of giving physicians a share of any reduction in a hospital’s costs for patient care attributable in part to the physician’s efforts.

The OIG has encouraged persons having information about hospitals who offer the above types of incentives to physicians to report such information to the OIG.

In addition to issuing Special Fraud Alerts and Special Advisory Bulletins, the OIG from time to time issues compliance program guidance for certain types of healthcare providers. In January 2005, the OIG published a Supplemental Compliance Guidance for Hospitals, supplementing its 1998 guidance for the hospital industry. In the supplemental guidance, the OIG identifies a number of risk areas under federal fraud and abuse statutes and regulations. These areas of risk include compensation arrangements with physicians, recruitment arrangements with physicians and joint venture relationships with physicians. Vanguard encourages its employees to go onto the OIG website at www.oig.hhs.gov and download and read these guidance materials for hospitals. In addition, the Health Reform Law includes provisions that would revise the scienter requirements such that a person need not have actual knowledge of the Anti-Kickback Statute or intent to violate the Anti-Kickback Statute to be found guilty of a violation.

Here are more details about the most important OIG Special Fraud Alerts/Special Advisory Bulletins applicable to hospitals:

1. **Hospital Incentives to Physicians (May 1992).** In this Alert the OIG focuses on the possibility for abuse arising from practice incentives provided by hospitals as a means of recruiting and retaining physicians and increasing physician referrals. In this Alert the OIG further noted that, in return for practice incentives that result in reductions in a physician's professional expenses or increases in revenues, the physician may be expected to refer the majority (if not all) of his or her patients to the hospital providing the incentives. This Fraud Alert provides a non-exclusive list of hospital incentives to physicians that can be indicators of potentially unlawful activity. This Fraud Alert identifies the following incentives which are clearly illegal and which should not be provided by any Vanguard employee:

   (A) Payment of any type of incentive by the hospital each time a physician refers a patient to the hospital.
   (B) Providing the use of free or significantly discounted office space or equipment (usually in facilities located close to the hospital).
   (C) Providing free or significantly discounted billing, nursing, or other staff services.
   (D) Free training of a physician's office staff in areas where the primary motive therefor is not improving the operations of the hospital.
   (E) Low-interest or interest-free loans, or loans that may be "forgiven" if a physician refers patients (or some specific number of patients) to the hospital.
   (F) Payment of a physician's travel and other expenses to attend conferences where the subject matter of the conference does not primarily benefit the operations of the hospital.
   (G) Payment for a physician's continuing education courses.
   (H) Coverage under a hospital's group health insurance plans at an inappropriately low cost to the physician.

2. **Joint Venture Arrangements (August 1989).**
The OIG calls attention to joint ventures between those individuals or entities in a position to refer business, such as physicians, and those individuals or entities providing items or services for which Medicare or Medicaid pays. The OIG notes that it is specifically interested in those joint ventures formed to “lock up a stream of referrals” from the physicians and to compensate those physicians indirectly for the referrals, and focuses on three questionable features of the ventures:
(i) The manner in which the investors are selected and retained;
(ii) The nature of the business structure of the joint venture; and
(iii) The financing and profit distributions.

(A) The OIG calls attention to providers, practitioners, and suppliers who routinely waive collection of the deductible and copayment amounts from beneficiaries under Part B of Medicare for hospital outpatient services or physician services. According to the Special Fraud Alert, “[w]hen providers, practitioners or suppliers forgive [patients’] financial obligations for reasons other than genuine financial hardship of the particular patient, they may be unlawfully inducing that patient to purchase items or services from them” in violation of the Anti-Kickback Statute. Thus, a good faith effort should be made to collect deductibles and copayments in most cases; however, it is permissible to forgive a particular patient’s copayment and deductible obligations based upon a showing of financial hardship. The Special Fraud Alert identifies certain practices which indicate that providers, practitioners, or suppliers are routinely waiving Medicare deductibles and copayments:
(1) advertisements which state “Medicare accepted as payment in full,” “insurance accepted as payment in full,” or “no out of-pocket expense;”
(2) routine use of “financial hardship” forms which state that the beneficiary is unable to pay the coinsurance/deductible amounts (i.e., there is no good faith attempt to determine the beneficiary’s actual financial condition);
(3) collection of co-payments and deductibles only where the beneficiary has Medicare supplemental insurance coverage that pays the co-payments and deductibles;
(4) higher charges to Medicare beneficiaries than those made to other persons in order to offset the waiver of coinsurance;
(5) failure to collect co-payments or deductibles for a specific group of Medicare patients for reasons unrelated to indigency (e.g., a supplier waives coinsurance or deductible obligations for all patients from a particular hospital); and
(6) sham insurance programs which cover co-payments or deductibles only for items and services provided by the entity offering the insurance, where the premium is insignificant (e.g., $1/month, and not based on actuarial risks).

4. Home Health Fraud (June 1995)
(A) The OIG notes that home healthcare is particularly suspect to fraud because Medicare covers an unlimited number of visits per patient, beneficiaries pay no co-payments except on medical equipment, patients don’t receive explanations of benefits (EOBs) for bills submitted for home health services, and there is limited direct medical supervision of home health services provided by non-medical personnel. The OIG discussed several types of fraudulent concern, including:

(i) False or fraudulent claims relating to the provision of home health services;
(ii) Claims for home health visits that were never made and for visits to ineligible beneficiaries;
(iii) Fraud in annual cost report claims;
(iv) Paying or receiving kickbacks in exchange for Medicare or Medicaid referrals; and
(v) Marketing uncovered or unneeded home care services to beneficiaries.

5. Rental of Office Space in Physician Offices by Persons or Entities to Which A Physician Refers (February 2000).

(A) In this Fraud Alert, the OIG identifies three suppliers of health care items and services that often rent space in the offices of physicians:

1) Comprehensive outpatient rehabilitation facilities (“CORFs”) that provide physical and occupational therapy and speech-language pathology services in physicians’ and other practitioners’ offices;
2) Mobile diagnostic equipment suppliers that perform diagnostic-related tests in physicians’ offices; and
3) Suppliers of durable medical equipment, prosthetics, orthotics, and supplies (“DMEPOS”) that set up “consignment closets” for their supplies in the physicians’ offices.

(B) The OIG is concerned that the rental payments from these entities to the physicians may be disguised kickbacks to induce referrals. Specifically, the OIG claims that it has “received numerous credible reports” that suppliers offer and pay rents that are unnecessary or in excess of the fair market value for the space in order to obtain referrals for their items and services from the physicians. The OIG also sets forth three criteria in the Fraud Alert for determining whether an arrangement may be problematic under the Anti-Kickback Statute:

1) Appropriateness of Rent. The first criterion is whether the rent is appropriate at all. The OIG believes that the payment of rent for space that has “traditionally” been provided for free or for nominal charge may be a disguised kickback. Importantly, the OIG contends that payments of rent for consignment closets in physicians’ offices is “suspect.”
2) Fair Market Value of Rental Amounts. The second criterion is whether the rental amounts are at fair market value, fixed in advance, and do not take into account the volume or value of referrals or other business generated between the parties. The OIG states that rental amounts in excess of amounts paid for comparable property, that exceed the rental amounts per square foot in the physician’s primary lease, or that are
conditioned on physician referrals, may violate the Anti-Kickback Statute.

(3) Reasonable Time and Space Rental. The third criterion is whether the space rented is of a size and for a time that is reasonable and necessary for the commercially reasonable business purposes of the supplier. According to the OIG, the payment of rent for space that is unnecessary, not used, or in excess of the supplier’s needs creates a presumption that the payment is a pretext to induce referrals. Much of the Special Fraud Alert focuses on how rental amounts should be prorated based on the amount of space and duration of time that the premises are used. For exclusive office space, the rent should be calculated based on the ratio of the time and space in use by the supplier to the total amount of time the physician’s office is in use and the total amount of space in the physician’s office. For interior office common space shared by physicians and subtenants, such as waiting rooms, the rent should be apportioned among all users based on the amount of non-common space each occupies and the duration of their occupation. Finally, where a physician pays a separate charge for areas in the building shared by all tenants, such as building lobbies, the cost should be apportioned among all of his or her subtenants based on the amount of non-common space they occupy and the duration of the occupation.

   (A) This Special Advisory Bulletin describes "problematic" arrangements as those which arise when a healthcare provider (“Provider”) expands into a related healthcare business by contracting with an existing business (“Manager”) to service the Provider's existing patient population. The Manager manages the new business and may also supply it with inventory, employees, space, billing and other services. In the OIG’s view, the Provider is contracting out substantially the entire operation of the new business to the Manager, receiving in return profits of the business as remuneration for the Provider's referrals in violation of the Federal anti-kickback statute.

   (B) The OIG cites three examples of potentially problematic joint ventures:

   (1) A hospital forms a durable medical equipment (“DME”) subsidiary that contracts with an existing DME company to operate the subsidiary and provide inventory to the subsidiary.

   (2) A DME company expands into the mail order pharmacy business to provide nebulizer drugs by contracting with an existing mail order pharmacy to operate the new company and provide all the nebulizer drugs to the company.

   (3) A group of nephrologists establishes a home dialysis supply company to provide dialysis supplies to their patients by contracting with an existing home dialysis company to operate the new company and provide all the dialysis supplies to the new company.

   (C) The OIG outlined certain common factors of these "suspect" contractual joint ventures:
New Line of Business. The Provider expands into a healthcare service that can be provided to the Provider's existing patient base.

Captive Referral Base. The new business predominantly or exclusively serves the Provider's existing patients.

Little Business Risk. The Provider's primary contribution to the venture is referrals. The Provider makes little or no financial or other investment in the business and delegates the entire operation to the Manager.

Manager is a Competitor. The Manager is a would-be competitor of the Provider's new business.

Services Provided by the Manager. The Manager provides many or all of the key services of the new business: day-to-day management, billing, equipment, personnel, office space, training, marketing and healthcare items, supplies and services.

Remuneration. The practical effect of the arrangement is to give the Provider the opportunity to bill insurers and patients for business that would otherwise be provided by the Manager.

Exclusivity. The parties agree to a non-compete agreement which prohibits the Manager from providing items or services to any patients other than those coming from Provider and/or which bars the Manager from providing services in its own right to the Provider's patients.

(D) The OIG notes that this list of key elements is illustrative and not exhaustive. The presence or absence of any one factor is not determinative of whether a particular arrangement is suspect. The Advisory Bulletin points out further that some parties attempt to carve otherwise problematic contractual arrangements into several different contracts for discrete items or services (e.g., a management contract, a vendor contract and a staffing contract) and then qualify each separate contract for safe harbor protection under the anti-kickback statute. The OIG notes that such efforts may be "ineffectual" and leave the parties subject to prosecution for several reasons.

1) If the joint venture involves the sale of items or services by the Manager to the Provider at a discount, the discount safe harbor is not applicable because the discount safe harbor does not protect prices offered by a seller to a buyer in a common enterprise.

2) Contracts that fit into safe harbors only protect remuneration flowing from the Provider to the Manager for actual services rendered. In "suspect" joint ventures, the OIG views the illegal remuneration as the difference between the money paid by the Provider to the Manager and the reimbursement received from the federal healthcare programs. Since the Manager is providing services it could provide for less than the available government reimbursement, the Manager is giving the Provider the opportunity to generate a fee and a profit, which the OIG states could implicate the anti-kickback statute.
16. **PATIENT REFERRALS**

*Medicare/Medicaid Fraud and Abuse.* The Federal Anti-Kickback Statute prohibits, among other things, any person from offering or paying remuneration to a referral source of Medicare or Medicaid patients for making or recommending referrals of patients and from making false claims for Medicare or Medicaid reimbursement. In addition, many state laws contain similar limitations on such conduct regardless of source of payment. There are, however, a number of "Safe Harbors", or transactions that are expressly stated not to violate the fraud and abuse limitations if the intent or actual purpose of the transaction is appropriate. Lawyers in the Vanguard Legal Department are available to assist in the structuring of, and preparation of documentation reflecting, legal arrangements with physicians. No Vanguard employee should ever solicit or receive, or offer to pay or pay, any remuneration of any type (including kickbacks, bribes, or rebates) in return for referring, or recommending the referral of, an individual to another person, hospital or medical facility for services. See the Sections of this Manual entitled "Fraud and Abuse" and "Federal Anti-Kickback Statute" and “OIG Special Fraud Alerts” for further information on healthcare fraud and abuse.

*Vanguard Does Not Pay For Referrals.* Vanguard does not pay anyone -- employees, physicians, or health professionals -- for referrals of patients. Vanguard only pays people or entities for services provided to the hospital or other facility and its patients. Vanguard does not make payments or provide non-cash benefits (e.g., office space) to any physician or health professional providing services to the hospital without a written contract which has been approved through the corporate approval process. Vanguard requires physicians and health professionals to submit invoices outlining specific dates, hours, and types of services performed prior to any payment being made to them.

Physicians and health professionals who are not employees of Vanguard are free to refer patients to any person or entity they deem appropriate. Where Vanguard employees are in a position to make referrals to physicians, health professionals or other healthcare facilities, they must make such referrals solely based on what is best for the individual seeking treatment, and without regard to the value or volume of referrals any such physician, health professional or other healthcare facility has made to Vanguard.

*Vanguard Does Not Pay Patients.* Vanguard does not waive insurance co-payments or deductibles or otherwise provide financial benefits to patients in return for admissions. Under certain circumstances, a Vanguard hospital may provide appropriate financial accommodation (such as allowing monthly payments over time) to patients based purely on the financial need of the individual patient or may provide professional courtesy discounts or uncompensated care to patients who are members of the immediate family of physicians on its medical staff.
17. PERSONNEL AND WORK ENVIRONMENT

*Everyone Deserves to be Treated with Respect and Live and Work in a Safe Environment.* Vanguard is committed to reasonably protecting, supporting and developing its employees to the fullest extent of their potential in a fair and respectful manner. Vanguard realizes the importance of providing quality patient care through the use of qualified, competent employees. Therefore, Vanguard will provide reasonable training to its employees to assure that its employees who provide healthcare services at its facilities carry out their duties in a professional manner. Vanguard’s commitment to providing high-quality services to its patients requires that each Vanguard employee endeavors to improve his or her ability to perform his or her job responsibilities.

*Maintaining a Safe Hospital Environment.* Vanguard is committed to providing its employees with an environment wherein the health, safety, privacy and comfort of the patients and its employees comes first.

*Drug Free Workplace.* Vanguard maintains a drug free workplace and will not tolerate on its premises either the manufacture, dispensation, possession, distribution, use or an employee being under the influence of illicit drugs or alcohol. Vanguard also prohibits the consumption of alcoholic beverages on Vanguard premises other than in connection with celebrations or meals either (1) approved by the facility's CEO in connection with events held in healthcare facilities or (2) approved by a senior officer of the Company in connection with events held in non-healthcare facilities. Vanguard will in most cases discipline or discharge employees who violate this policy.

Any employee reporting to work or discovered at work in a condition that suggests that he or she is under the influence of narcotics, illegal drugs, prescription drugs used improperly or alcohol will not be permitted to report to or remain on his job. The employee's supervisor will escort the employee to the Human Resources Department for consultation and possible testing.

In order to ensure the safety of all Vanguard employees and patients, any employee who has been directed by a physician to take a prescription drug that may adversely affect or impair performance on the job must report that circumstance to his or her immediate supervisor, along with acceptable medical documentation. The Human Resources Department will then determine whether the effects of the medication pose significant risk of substantial harm to the health or safety of the employee or his or her co-workers or the patients for whom the employee is responsible. Reasonable accommodation will be made for employees suffering from any disability so long as accommodation does not create a significant risk of substantial harm to the employee, co-workers, patients, or others.

The Human Resources Department can arrange for confidential counseling for drug or alcohol dependence problems. The Human Resources Department may also make and coordinate referrals for medical/psychological treatment and arrangements for leaves of absence. Each facility has a drug/alcohol policy and employees should consult with their facility's Human Resources Department regarding the policy's specifics.

*Drug Testing Policy.* Vanguard has implemented a drug testing policy for applicants for employment and current employees. All job applicants at Vanguard healthcare facilities considered final candidates for employment will be tested for the presence of illegal drugs and alcohol as a part of the application process. Any job applicant who refuses to submit to drug or alcohol testing,
refuses to sign the consent form for such testing, fails to appear for testing, tampers with the test, or fails to pass the pre-employment drug and alcohol test will be ineligible to be hired by Vanguard.

Current employees must submit to a drug test if reasonable suspicion exists to indicate that their ability to perform work safely or effectively may be impaired. "Reasonable suspicion" means a belief that an employee is using or has used drugs in violation of Vanguard policy, drawn from facts in light of experience. As a condition of continued employment, participants in a rehabilitation program for drug and/or alcohol abuse must consent in writing to periodic, unannounced testing for a period of up to two years after returning to work. An employee who has a positive, confirmed test is subject to disciplinary action, up to and including termination of employment. Employees who refuse to submit to a drug or alcohol test are also subject to disciplinary action, up to and including termination of employment.

**Equal Employment Opportunities.** In determining suitability for employment, promotions, transfers, demotions, and wages, Vanguard looks only at the individual's ability to perform the job. Vanguard extends equal employment opportunities to all individuals, regardless of sex, sexual orientation, race, age, color, religious beliefs, marital status, citizenship status, national origin, physical/mental disabilities or any other characteristic protected by law. All supervisors and managers must be strongly supportive of equal employment and advancement opportunities and must insure that all employee relations decisions will be in accordance with this policy. All Vanguard employees have a fundamental responsibility to show appropriate respect and consideration of one another, regardless of position, station or relationship.

**Sexual Harassment.** For information on this topic see the Section of this Manual entitled “Sexual Harassment”.

**Disabled Workers.** Vanguard policy encourages the hiring of disabled workers and, thus, full compliance with both the letter and spirit of the federal Americans with Disabilities Act. The Americans with Disabilities Act prohibits discrimination against disabled individuals who are qualified-with or without reasonable accommodation-to perform the essential functions of the job. In general, an “accommodation” requires an employer to make “reasonable” changes in usual work rules, or terms or conditions of employment to enable a disabled person to work. Moreover, the regulations also refer to a “flexible”, interactive process that involves both the employer and the individual with the disability.

To conform with both the letter and spirit of the ADA, it is Vanguard policy to:
• Meet with an employee who requests an accommodation.
• Ask the employee what he or she specifically wants.
• Obtain as much information as possible about the medical condition.
• Engage in a dialogue with the particular line department personnel and a human resources representative to discuss the issue, not just as it affects the department, but also as it would affect the company as a whole.
• Discuss with the employee the reasons why an employee’s request for accommodation cannot be met, if that is the situation.
• Where an employee’s suggestion is not acceptable, provide an alternative, if possible.
• Try to come to a documented resolution.
18. PHYSICIAN AGREEMENTS AND PERQUISITES*

Physician/hospital agreements and physician perquisites are the primary focus of both the Federal Anti-Kickback Statute and the Stark Self-Referral Statutes. See the separate Sections on both of these statutory topics set forth in this Manual. In this Section Vanguard addresses how these physician agreements and perquisites can be established without violating these statutes. For more information on these topics see Legal Department Policies LEGL.001 through LEGL.021 and LEGL.025.

Every Vanguard Agreement With a Physician Must Be In Writing and Reviewed In Advance By a Vanguard Attorney. Every agreement with a physician who constitutes a referral source or a potential referral source for Vanguard must be in writing and reviewed in advance by (and is subject to the approval of) an attorney in the Vanguard Legal Department. The approval of outside attorneys not on the Vanguard payroll will not suffice except where hired by a Vanguard inside attorney specifically to make such review. No employee is allowed to offer or grant any benefit to a potential or actual referring physician on the condition that such physician agrees to refer any patients to the hospital. Physicians may be required to maintain membership on the medical staff of the hospital in order to receive certain permitted benefits. Also, it is proper for the medical staff bylaws of a hospital to require that, as a condition of membership, physicians admit a minimum number of patients to the hospital in order that the hospital may evaluate competence and quality of care.

Caution Should Be Exercised in Physician Agreements. Vanguard employees are urged to use caution when engaging in transactions that involve physicians or other potential or actual referral sources. Services or assets purchased from physicians must reasonably be needed at the Vanguard facility and amounts paid by Vanguard must not exceed fair market value. (*Fair Market Value* may be defined as what the Vanguard facility would pay for the service or asset from another physician who does not admit patients to the Vanguard facility or from a non-physician.) Large payments to physicians, high hourly payment rates, multiple agreements with the same physicians (including without limitation, multiple medical directorships at the same or more than one Vanguard hospital) are inherently suspect. Attorneys in the Vanguard Legal Department have prepared numerous memoranda and other materials which describe in greater detail transactions in which Vanguard may lawfully engage with referral sources. Employees are encouraged to carefully review these materials and solicit the advice of lawyers in the Vanguard Legal Department in respect of transactions with physicians or other potential or actual referral sources.

Legal Requirements as to Physician Agreements. Because of the Stark Self-Referral Statutes the legal requirements necessary for Vanguard employees to strictly follow for the relevant Stark exception in respect of non-employed physician personal services (including, without limitation, medical services for which the hospital bills, medical directorships, management arrangements) are as follows:

1. The agreement must be in writing, signed by the parties and specify the services covered by the arrangement.
2. The agreement must specify all of the services to be provided by the physician to the Vanguard entity. This requirement can be met if all separate arrangements between the entity and the physician incorporate each other by reference or if they cross-reference a master list of contracts that is maintained and updated centrally and is available for review by HHS.

* The use of the term “physician” in this Section means not only physicians, but also means other non-physician referral sources (like psychologists and social workers) and the members of a physician’s family.
3. The services contracted for do not exceed those which are reasonable and necessary for the legitimate business purposes of the arrangement.

4. The term of the contract must be at least one (1) year. If the arrangement is terminated during the term, the same arrangement cannot be entered into during the first year of the original term of the arrangement.

5. The aggregate compensation must be set in advance, not exceed fair market value and may not be determined in a manner that reflects the volume or value of referrals or business otherwise generated between the parties.

Joint Ventures with Physicians. No employee or agent, acting on behalf of Vanguard, is authorized to incur any obligation to any proposed joint venturer or partner or enter into or commit to enter into any joint venture, partnership or other risk-sharing arrangement with any entity that is a potential or actual referral source until such time as a lawyer in the Vanguard Legal Department has reviewed the terms and provisions of such joint venture or partnership to ensure compliance with applicable laws, regulations, agreements with lenders and Vanguard policies. As a result of the Stark Self-Referral statutes, it is illegal to have a hospital/physician joint venture in respect of any "Designated Health Service." See the Section of this Manual entitled "Stark Self-Referral Statutes".

Specific Advice as to Typical Physician Agreements.

- Medical Directorships/Related Miscellaneous Physician Services Agreements. All directorships must be for services reasonably needed by the hospital -- to fill a bona fide need (other than increased utilization) such as a real need for administrative services which would not ordinarily be provided by a physician without charge as part of medical staff duties or to increase efficiency in delivery of patient services or quality of care. Directorship agreements must define clearly the duties for which the physicians are under contract. The agreements should avoid the use of only the "boiler-plate" language in the "duties" section of the form directorship agreement. Numerous directorships at a hospital (or multiple directorships with the same physician) and/or those with unusual titles or non-specific duties will give the appearance of impropriety or may even be inherently suspect. Also, there should not be two medical directors with overlapping or similar functions unless (1) the administrative functions have been divided between two physicians, (2) the amounts paid in the aggregate are not significantly more than what would be paid to a single medical director and (3) the CEO of the facility corresponds with the Vanguard Legal Department to verify the division (and not duplication) of the administrative functions. Compensation under each agreement must be based upon a reasonable, fixed, fair market rate per hour of time spent in the performance of the duties without regard to the value or volume of any hospital admissions; and hours "bought" should be reasonable in number in light of the physician's private practice responsibilities and other duties as a member of the hospital's medical staff. Compensation may be actually paid only if (i) duties are actually performed and (ii) written documentation is provided to the hospital, completed by the physician, in the form of a time sheet detailing the number of hours spent and dates of service, and describing in reasonable detail the nature of the duties performed. Service agreements proposed with "in-town" recruits to the medical staff of a hospital are inherently suspect and will be scrupulously examined by a lawyer in the Vanguard Legal Department prior to execution for necessity of the services and for fair market value of the amounts paid by the hospital under the agreement.

- Recruitment Agreements. Recruitment incentives for non-employed physicians into the geographic area served by the hospital are regulated both by the Federal Anti-Kickback
Statute and the Stark Self-Referral Statutes. Final regulations under the Stark Self-Referral Statutes list many conditions to permissible recruitment incentives, the most important of which are that the incentives may be paid only to (i) residents and physicians who have been in practice 1 year or less as long as the practice is established in the geographic area served by the hospital; and (ii) established physicians relocating their practices from outside the geographic area serviced by the hospital into such area. An established physician will be considered to have relocated his practice if (i) the physician moves his practice at least 25 miles or (ii) at least 75% of practice revenues in the new practice come from patients whom the physician did not see in his prior medical practice during the previous three (3) years. Also, there must be a genuine community or medical staff need for the recruited physician's specialty. The recruitment collections guarantee must not exceed three (3) years (but normally does not exceed one (1) year) and the amount guaranteed must not exceed fair market value (amount must be supported by evidence of incomes for similar positions in the same area - the Vanguard Legal Department maintains information on average physician income). Normally, any amount paid in excess of the guaranteed amount must be repaid to Vanguard within 6 months if no interest is accessed by the hospital, but over a longer set term (usually, 2 years) if such amount bears interest. See Legal Department Policy LL. 003 for Vanguard’s additional conditions for recruitment agreements.

• MOB or Equipment Leases. Space or equipment rental agreements between a hospital and a physician must, among other conditions, (i) be for a term of not less than one year (and if terminated during the first year, not re-executed during the first year of the original term); (ii) provide for "fair market value" consideration not related to volume or value of business generated which is set in advance; (iii) specify the precise premises (or equipment) to be leased and (iv) be commercially reasonable even if no referrals were made between lessor and lessee. "Fair Market Value" may be defined as the value of the property for general commercial purposes (not taking into account its intended use), and also does not permit rental charges to reflect the value attributed by either party to the proximity or convenience of the property to physicians or other providers who are in a position to make referrals to the hospital. With minor exceptions approved in advance in each case by a member of the Vanguard Legal Department, no free rent or below market value rent of any kind or offset of rental payments with services performed for a hospital is allowable.

• Physician Employment Agreements. A physician employment agreement must define clearly the duties for which the physician is hired. Physician employment agreements should avoid the use of only the "boiler-plate" language in the "duties" section of the form agreement. Their salaries must be consistent with fair market value and be commercially reasonable even if no referrals were made to the hospital. Also, the compensation may not be determined in a manner that takes into account the volume or value of referrals (but this requirement does not prohibit a productivity bonus based on services personally performed by the physician). Employed physicians who are not in a group practice may not be paid a bonus based on incident-to services, if not personally performed by the physician. Similarly, bonuses based on supervision of services performed by others, such as nurse practitioners or other mid-level providers, may be not proper unless based on active supervision by the physician; but a flat fee based on actual time spent on supervision may be acceptable.

• Purchase of Physician Practices. The purchase price paid by Vanguard facilities for physician practices must be "fair market value" and supported by an independent appraisal. The determination of appropriate "fair market value" in connection with a hospital's practice purchase is a complex matter which must be evaluated in conjunction with a member of the
Vanguard Legal Department. The purchase of options on practices should be avoided unless for short periods where no significant amount of "option money" is paid by Vanguard. Employment of the physician whose "hard assets" are purchased is strongly advised.

**Agreements with Hospital-Based Physicians (e.g., radiologists).** Contracts between hospitals and hospital-based physicians should be:

1. Based on the fair market value of services;
2. Unrelated to physician income or billings; and
3. Limited to goods and services necessary for the provision of medical services by the hospital-based physicians.

Suspect agreements (which of course should be avoided) with hospital-based physicians include those which: (i) require hospital-based physicians to pay more than fair market value for services provided by the hospital; and (ii) compensate these physicians for less than the fair market value of goods and services that they provide to the hospital.

**Perquisites and Gifts to Physicians.** All perquisites or business courtesies provided to physicians are subject to special rules basically dictated by the provisions of the regulations promulgated under the Stark Self-Referral Statutes. Thus, as special rules for perquisites, entertainment and gifts to physician: (1) cash or cash equivalent gifts are prohibited and (2) such amounts are limited to an aggregate of $300 per person per calendar year. The $300 maximum does not apply to customary medical staff benefits which are valued at less than $25 per occurrence, are provided within the facility and are given or offered to all members of the medical staff practicing in the same specialty (e.g., free parking, meals in the physicians' lounge). The above $25 and $300 limits are increased periodically by CMS to reflect increases in the consumer price index; and in calendar 2011 the limits are $30 and $359, respectively. For more discussion on perquisites, gifts and entertainment to physicians, see the Section of this Manual entitled “Stark Self-Referral Statutes” and Legal Department Policy LEGL.025, “Business Courtesies to Potential Referral Sources”.

**Advertising and Marketing Expenses.** The payment or reimbursement of advertising or marketing expenses is permissible only to the extent monies are paid to advertise or market (i) a new physician recruit otherwise meeting recruitment criteria, or (ii) the hospital or its program. Any benefit to a physician must be only incidental -- the advertising must be primarily to benefit the hospital or its program. If the advertising or marketing fails to meet these criteria, the physician benefited must pay all or a reasonable portion, as applicable, of the cost to the hospital.

**Patient Transportation To or From Physician Offices.** If Vanguard hospital vans transport physician patients to or from physician offices, the physician (or the patients) must be charged a reasonable amount for the service.

**Everyone Is Doing It.** A common misconception is that a person or entity will not be prosecuted and punished if "everyone is doing it". That is simply not how the criminal and civil justice system works. It is no legal defense to allege or show that our competitors are also performing the illegal or unethical or abusive acts.
Although employees are encouraged to participate freely and actively in the political process, each employee should ensure that his or her political activities are lawful and separate from those of the Company.

**Applicable Laws.** In the United States, Federal law strictly controls corporate involvement in the Federal political process. Generally, no corporation may contribute anything of value to any political party or candidate in connection with any Federal election. While similar restrictions apply in many states and their political subdivisions, in some jurisdictions corporate contributions to state and local election campaigns may be permissible.

**Employee Political Activity.** Each employee is encouraged to participate actively in the political affairs of his or her community, state and country, and to stay informed on public issues and on the positions and qualifications of candidates for public office. This activity must not unreasonably interfere with the employee's ability to perform his or her duties for the Company and must not be inconsistent with applicable law, rule or regulation or the policies set forth in this Manual.

**No Company Political Contributions.** Vanguard will not contribute anything of value within the United States or in foreign countries to any political party or candidate for public office whether in conformity with or in violation of law, and no employee may make, or reimburse another person for making, any contribution, expenditure or payment directly or indirectly from Vanguard funds for the use or benefit of, or in support of or opposition to, any political party or candidate whether in conformity with or in violation of law. However, contributions may be made by Vanguard to Political Action Committees to the extent permitted by applicable law, and such contributions may be designated in favor of specific candidates or issues if such designation is not prohibited by Federal or state laws.

**Political Communications.** Communication of Vanguard’s views to legislators, governmental agencies or the general public concerning legislation and governmental policies or practices affecting business operations is not prohibited, so long as such communication is made in accordance with applicable laws, such as laws relating to lobbying. In many circumstances, Vanguard’s interest will require timely and effective communication of its views on public issues and policies affecting the Company, its business, employees and shareholders.
20. QUALITY CARE

Our guiding principle at Vanguard is that patient care decisions are based on clinical concerns and not business economics. Other related principles of Vanguard are as follows:

- Only qualified clinical professionals with proper licensure and credentials can make clinical assessment for admissions and plans of treatment.
- All medical records and documentation necessary to meet the requirements of medical staff by-laws, facility policies, accreditation standards and all laws/regulations will be maintained.
- Treatment at Vanguard facilities is provided in the least restrictive manner that meets clinical goals (i.e., home health versus outpatient or inpatient versus partial hospitalization).
- Patients have the right of informed consent. No medical procedure can be performed without the patient’s consent.
- Vanguard employees comply with Federal (COBRA) and State laws about treating patients with emergency medical conditions. Medical screening examinations are provided to all persons presenting themselves to the Emergency Room of a Vanguard facility for examination and/or treatment without inquiry as to financial or insured status.
- Only patients whose specific condition or disease cannot be safely treated at the hospital are diverted, refused admission, or transferred to another hospital.

Quality of Care and Treatment. The primary goal of Vanguard’s facilities is to provide high quality, cost effective healthcare services that respond to individual, family and community needs in a safe, healing environment. Vanguard is committed to providing a high quality of care to its patients and to the delivery of health care services in a responsible, reliable and appropriate manner. Vanguard is also committed to the goal of excellence in patient care and is sensitive to patient needs.

Since Vanguard facility employees are working for healthcare providers upon whom patients depend for their health and safety, it is the duty of all Vanguard employees never to ignore any deficiency or error in their healthcare services, no matter how small and insignificant. It is essential that all employees bring any such deficiencies or errors to the attention of those who can properly assess and redress the problem.

Patients deserve to be treated at all times with dignity and respect. Vanguard patients must be treated with dignity and respect. Vanguard facilities keep patient records strictly confidential as required by law.

Each patient deserves to be treated as an individual; informed consent. Treatment at Vanguard facilities is provided in the least restrictive environment appropriate to individual patient needs, such as inpatient care, partial hospitalization, outpatient care and home care. Vanguard is committed to creating a safe, compassionate treatment environment where patients and their families will be able to understand their individual illnesses and start the recovery process.

The law dictates that no medical procedure can be performed without the patient's consent. Attorneys in the Vanguard Legal Department are knowledgeable about "consent" issues. Please consult with them on all legal issues regarding patient consent. Vanguard facilities must strive to insure that their patients are always well informed about treatment alternatives and the various risk factors associated with each treatment or no treatment.

Vanguard complies with Federal (COBRA) and state laws about treating patients with emergency medical conditions. Vanguard facilities must comply with all Federal and state regulations and laws regarding evaluation and treatment of patients with emergency medical conditions (“EMCs”). Medical Screening Examinations are provided to all persons presenting themselves to the ER for examination/treatment of any Vanguard facility, without inquiry as to financial or insured status. Vanguard expects its Hospital management teams to implement Vanguard policy regarding examinations and treatment of patients with EMCs. See the Section of this Manual entitled “Treatment of Patients with Emergency Conditions”.

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21. SEXUAL HARASSMENT

Sexual harassment in the work place is now widely recognized as a form of discrimination which falls within the prohibitions of the Federal as well as many state civil rights statutes. The Federal Equal Employment Opportunity Commission (“EEOC”) has promulgated guidelines that shed some light on the elusive concept of sexual harassment and which discuss the parameters of permissible conduct within the work place.

Vanguard is committed to providing a work environment that is free of sexual harassment. Actions, words, jokes, or comments based on an individual’s sex or sexual orientation or any other legally protected characteristic will not be tolerated. Sexual harassment (both overt and subtle) is a form of illegal employee misconduct that is demeaning to another person, undermines the integrity of the employment relationship, and is strictly prohibited.

**Definitions of Sexual Harassment.** Sexual harassment may be defined as:

- Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature when:
  1. Submission to such conduct is made either explicitly or implicitly a term or condition of an individual’s employment, or
  2. Submission to or rejection of such conduct by an individual is used as a basis for employment decisions affecting such individual, or
  3. Such conduct has the purpose or effect of substantially interfering with an individual’s work performance or creating an intimidating, hostile, or offensive working environment.

- Usually, results from a "power" relationship between the employees.

- May be initiated by either male or female employees.

**Employer Liability – Quid Pro Quo Harassment.** Under the Guidelines, an employer is held strictly liable for the acts of its supervisory employees that require a subordinate employee to submit to unwelcome sexual demands as a condition to preferential job treatment regardless of whether the specific acts of harassment were authorized or even forbidden by the employer and regardless of whether the employer knew as long as the employer should have know of their occurrence. This is so-called quid pro quo sexual harassment when an employee accedes to sexual advances as a condition of employment. An employer may also be liable for harassment of an employee by a non-employee on the same basis as harassment between two co-workers.

**Employer Liability – Hostile Environment.** Another form of sexual harassment is where the environment unreasonably interferes with an employee's work performance or creates an intimidating, hostile or offensive work environment. Further, where an employee is afforded job benefits on the basis of his or her acquiescence to sexual demands, a qualified employee who is deprived of an opportunity to which he or she is entitled also has a sexual harassment claim against the employer. These are descriptions of “hostile environment” sexual harassment which results from unwelcome sexual advances even where the employee is not forced to participate against his or her will.

"Knowing" About Sexual Harassment. Once an employee directly complains to a supervisor about sexual harassment, then the employer knows about it. There is knowledge even if the
supervisor doesn’t take the complaint seriously, discourages the employee from complaining or doesn’t make sure the complaint is investigated.

**Employer “Should Have Known” About Sexual Harassment.** As stated above, employers are liable for sexual harassment situations that they should have known existed where they did not take action to determine if sexual harassment was occurring and did not stop it when it was.

The following are examples of ways that employers could get knowledge of potential sexual harassment situations that meet the “should have known” standard:

- An anonymous letter is mailed to the president of the company that states a certain supervisor sexually harasses his employees.
- An employee tells his or her manager that he or she has heard rumors that a certain sales manager makes sexual advances towards all of the new female sales representatives.
- A supervisor sees sexual visuals and hears sexual jokes and comments that are derogatory about women in his workplace.

**Company Policy on Sexual Harassment.** Incidents of sexual harassment should be reported to an employee’s supervisor, the Human Resources Vice President or director where the employee works, the Company’s Senior Vice President-Human Resources, the Company's General Counsel, the Company’s Chief Compliance Officer who is its Senior Vice President - Compliance & Ethics or the Company’s Hotline at (1-888-895-9945), for a full investigation of this matter. If supervisors are consulted, they should immediately contact the Human Resources Senior Vice President at the corporate office or the Human Resources Vice President or director where they work. Anyone engaging in sexual harassment will be subject to disciplinary action, up to and including termination of employment.
22. STARK SELF-REFERRAL STATUTES

Under these Federal statutes, a physician may not make a referral to an entity in which he or she (or an immediate family member) has an ownership/investment interest or with which he or she has a compensation arrangement for the furnishing of Designated Health Services paid for by Medicare or Medicaid, unless the investment or compensation arrangement is covered by a statutory or regulatory exception. 42 U.S.C.1395 nn. These statutes and regulations cover much more than referrals from physicians. *These statutes and regulations cover virtually all payments from hospitals and other providers to physicians and make illegal all hospital joint ventures with physicians in Designated Health Services.*

*Phase I Final Regulations.* On January 4, 2001, CMS (then HCFA) published Phase I of the final Stark regulations. These regulations became effective on January 4, 2002.

*Phase II Final Regulations.* CMS published Phase II of the rulemaking (which sets forth provisions not addressed in Phase I and responds to comments received in response to the Phase I rulemaking) on March 26, 2004. These regulations became effective on July 26, 2004.

*Phase III Final Regulations and Subsequent Changes.* On September 5, 2007, CMS published Phase III of the final Stark regulations. These regulations became effective on December 4, 2007. Subsequent to December 2007 CMS is using various Medicare fee schedule rules to propose or implement revisions to the Stark regulations. For example, significant Stark regulation changes were made in the 2009 Hospital Inpatient Prospective Payment Systems final rule published on August 19, 2008, but effective October 1, 2008 as to certain changes and October 1, 2009 as to certain other changes. *In addition, in the August 2008 final Stark rule CMS indicated that it will continue to enact further regulations tightening aspects of the Stark Law that it perceives allow for Medicare program abuse, especially those regulations that still permit physicians to profit from their referrals of ancillary services.*

**What Are Designated Health Services?** The law defines Designated Health Services (“DHS”) as the following services:

- (a) Clinical laboratory services
- (b) Radiology services, including MRI, CT scans and non-invasive ultrasounds
- (c) Physical therapy services
- (d) Occupational therapy services
- (e) Radiation therapy services and supplies
- (f) Durable medical equipment and supplies
- (g) Parenteral and enteral nutrients, equipment and supplies
- (h) Prosthetics, orthotics and prosthetic devices and supplies
- (i) Home health services
- (j) Outpatient prescription drugs
- (k) Inpatient and outpatient hospital services

A list published on an annual basis in the Federal Register and on CMS’ web cite identifies specific CPT and HCPCS codes for certain categories of DHS and for certain excepted services. The list applies to physical therapy, occupational therapy, speech-language, pathology, clinical laboratory services, radiology, echocardiography and vascular, ultrasound, radiation therapy services and supplies, preventive screening tests, immunizations and vaccines, and drugs for patients undergoing dialysis.
The regulations carve out:
   a. Implants in ASC
   b. Preventive screening/immunizations
   c. Eyeglasses and contact lenses
   d. EPO and other related out-patient drugs furnished in ESRD facilities
   e. DHS paid as part of a composite payment under another Medicare benefit
   f. Lithotripsy is not an “inpatient or outpatient hospital service”

EKGs, ECGs and pulmonary function tests:
   a. Pulmonary function testing and EKGs and ECGs are not DHS, unless furnished in a hospital setting.
   b. If the referring physician performs the professional reading personally, no referral occurs; but there could still be a referral for the technical component.
   c. If the reading is performed by another physician, the physician services exception and the in-office ancillary exception may apply.
   d. Subject to these exceptions and according to the group practice definition, the physician may be paid directly based on his or her personal performance of professional services.

DHS components of physician services implicate statute.
   a. Not all physician services are excluded from the scope of the statute.
   b. DHS that include a physician component are within scope of the statute.

Radiology does not include
   a. X-ray, fluoroscopy or ultrasound requiring insertion of a needle, catheter, tube or probe through the skin or into a body orifice.
   b. Radiological procedures integral to a non-radiological medical procedure and performed (1) during such medical procedure or (2) immediately following such procedure when necessary to confirm placement of an item during such procedure.

What Is a Compensation Arrangement? A compensation arrangement is an arrangement pursuant to which a physician receives any remuneration; for example, an employment relationship, an independent contractor relationship, a lessor/lessee relationship. The term “compensation arrangement” means, “any arrangement involving any remuneration between a physician and an entity.”

What Does Referral Mean? The term “referral” is defined very broadly in Stark. Specifically, a referral, in the case of Medicare Part B services, means “the request by a physician for the item or service including the request by a physician for a consultation with another physician (or any test or procedure ordered by, or performed or … supervised by that other physician).” It does not, however, include personally performed services by a physician. However, technical components of personally performed services are referrals. For all other Medicare and Medicaid services, a referral is a request for, ordering of, or certifying medical necessity for any DHS (including tests ordered pursuant to consult). An exception applies for certain requests for DHS made by pathologists, radiologists, and radiation oncologists pursuant to a consultation requested by another physician. To qualify as a consultation:
   (1) The consulting physician’s opinion must be sought by the referring physician;
   (2) The request must be documented on a chart; and
   (3) The consulting physician must prepare a written report provided to the referring physician.
Physician. The term physician includes the physician’s immediate family members. Therefore, if a physician’s husband or wife owns an investment in an entity, the physician may not refer patients to that entity for the provision of a DHS unless an exception applies. The term physician also includes a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a doctor of chiropractics.

Ownership/Investment Interests. Ownership/Investment interests may be held in any form of secured debt or equity: stock, mortgages, general partnership interest, etc. It does not include unsecured loans, stock options or contacts “under arrangements”.

Exceptions. The Stark Law and its regulations set forth several exceptions to its provisions which have the effect of permitting a physician with an ownership/investment interest or compensation arrangement to refer Medicare or Medicaid patients to such entity for the provision of DHS. Unlike safe harbors under the Anti-Kickback Statute with which compliance is voluntary, an arrangement must comply with every requirement of a Stark Law exception or the arrangement is in violation of the Stark Law. The exceptions are broken down into two categories: exceptions relating to ownership/investment interests and exceptions related to compensation arrangements.

1. Ownership/Investment Interest Exceptions.

(A) A physician may refer a Medicare or Medicaid patient for physician’s services to another physician in his or her Group Practice. To qualify as a Group Practice, the Group is subject to various requirements including that, when taken as a whole, the amount of time physician members of the Group spend in work dedicated to the Group must average at least 75%.

(B) A physician may refer a Medicare or Medicaid patient for the provision of DHS which are ancillary services to another physician in his or her Group Practice if certain requirements are met, including that (1) the service must be personally furnished by the referring physician, a physician who is a member of the referring physician’s Group Practice, or individuals directly supervised by the referring physician or Group Practice member and (2) the service must be provided in a centralized building or a building in which the referring physician furnishes substantial physician services unrelated to the furnishing of DHS.

(C) A physician may refer Medicare and Medicaid patients for the provision of DHS to an entity in which he or she owns an interest if the entity is publicly traded and has at least $75,000,000 in shareholders’ equity.

(D) A very important exception, applicable until March 2010 when the Health Reform Act was enacted, is that a physician may refer patients for the provision of DHS to a hospital so long as the ownership is in the hospital entity as a whole and not a particular portion of the hospital (the so-called “Whole Hospital Exemption”). The Health Reform Law now prohibits newly created physician-owned hospitals from billing for Medicare patients referred by their physician owners. As a result, the new law effectively prevents the formation of physician-owned hospitals after December 31, 2010. While the new law grandfathers existing physician-owned hospitals as of March 2010, it does not allow these hospitals to increase the percentage of physician ownership and significantly restricts their ability to expand services.
2. **Compensation Arrangement Exceptions.** There are several exceptions to the prohibition against referring Medicare or Medicaid patients to an entity with which a physician has a compensation arrangement.

(A) **Leases.** A physician may refer a Medicare or Medicaid patient to an entity from which the physician leases space or equipment or to which the physician leases space or equipment if each of the following requirements are met:

(i) The lease is in writing and for a term of at least one year (and if terminated during its first year, the parties cannot enter into a new lease during the first year of the original term).

(ii) The space or equipment leased is for a legitimate business purpose and it is used exclusively by the lessee (the "exclusive use" test meaning that the lessee does not share the space or equipment with the lessor during the time it is being rented by the lessee).

(iii) The rental charges are set in advance, are consistent with fair market value and do not take into account the volume or value of referrals.

(iv) The lease is commercially reasonable even if no referrals are made.

(v) Month-to-month holdover leases are allowed for up to 6 months if they continue on the same terms and conditions as the original lease.

(B) **Employment Relationships.** A physician who is employed by an entity may refer Medicare or Medicaid patients for the provision of DHS to such entity as long as each of the following requirements are met:

(i) The employment is for identifiable services;

(ii) The amount of the remuneration is consistent with fair market value and is not determined in a manner that takes into account the volume or value of referrals (not prohibited is a productivity bonus based on services personally performed by the physician); and

(iii) The remuneration would be commercially reasonable even if no referrals were made.

(C) **Independent Contractor/Personal Services Relationships.** A physician who is an independent contractor for an entity and providing personal services to the entity may refer a Medicare or Medicaid patient to such entity for the provision of DHS so long as each of the following requirements is met:

(i) The arrangement must be set out in writing, signed by the parties and specify the services covered by the arrangement.

(ii) The arrangement covers all services to be provided by the physician to the entity (through use of incorporation by reference or by reference of a master list maintained centrally).

(iii) The aggregate services do not exceed those that are reasonable and necessary for the legitimate business purposes of the arrangement.

(iv) The term of the arrangement is for at least one year (and not re-entered into during its first year if terminated during such first year).

(v) The compensation to be paid is “set in advance”, does not exceed fair market value, and is not determined in a manner that takes into account the volume or value of referrals or business otherwise generated between the parties. (The "set in advance" requirement does not prohibit percentage compensation as long as the formula is established prospectively, is objectively verifiable, and is not changed over the course of the agreement based on the volume or value of
(vi) Month-to-month holdover service agreements are allowed for up to 6 months if they continue on the same terms and conditions as the original agreement.

(D) **Recruitment.** A physician may refer a Medicare or Medicaid patient for the provision of DHS to a hospital which has recruited the physician if the incentive payments made to the recruited physician meet each of the following requirements:

(i) The arrangement is set out in writing and signed by both parties.

(ii) The physician relocates his or her practice to the geographic area served by the hospital (which is defined as the area composed of the lowest number of contiguous zip codes from which the hospital draws at least 75% of its inpatients). A physician will be considered to have relocated the practice if (i) the physician moves his practice at least 25 miles or (ii) at least 75% of practice revenues in the new practice come from patients whom the physician did not see in the prior medical practice during the previous three (3) years. Residents and physician who have been in practice 1 year or less are not subject to this relocation requirement.

(iii) The physician is not required to refer patients to the hospital and is allowed to establish privileges at any other hospital.

(iv) The amount of the remuneration under the arrangement is not determined in a manner that takes into account (directly or indirectly) the volume or value of referrals or other business generated between the parties.

If the recruited physician joins a group practice, the additional requirements to the recruitment are:

(i) If the incentives are paid directly to the group, the group must also execute the written agreement.

(ii) Except for actual recruitment costs incurred by the group, the incentive payments must be passed through to the recruit.

(iii) The costs allocated by the group practice to the recruit cannot exceed the actual additional incremental costs attributable to the recruit.

(iv) The amount of the remuneration under the arrangement is not determined in a manner that takes into account (directly or indirectly) the volume or value of referrals or other business generated by the recruit or any member of the group practice.

(v) The group practice may not impose additional restrictions upon the recruit (such as non-competes), other than conditions related to quality of care.

(E) **Remuneration Unrelated to Provision of DHS.** A physician may refer a Medicare or Medicaid patient to the entity with which he has the compensation arrangement if the remuneration does not relate to the provision of DHS. The regulations construe this exception very narrowly, specifying that the parties must be able to demonstrate that the remuneration does not in any way relate to DHS nor reflect the volume or value of a physician’s referrals in any way. The regulations state that remuneration relates to DHS if (1) it is a cost that could be allocated to Medicare or Medicaid under cost reporting principles, (2) is furnished in a selective way to medical staff in a position to make or
influence referrals, or (3) otherwise takes into account the volume or value of referrals or other business generated by the physician.

(F) One Time Sale of a Practice or Isolated Transaction. A physician whose practice was purchased by a hospital or who entered into another type of isolated transaction with a hospital may refer patients to such hospital for the provision of DHS only if the transaction was consistent with fair market value, not determined in a manner that takes referrals into account and would be commercially reasonable even if no referrals were made. The regulations also provide that the isolated transaction exception is available only once every 6 months. Post-closing adjustments and installment payments are permitted if the total aggregate payment is (1) set before the first payment is made; and (2) does not take into account, directly or indirectly, referrals or other business generated by the referring physician. Additionally, the outstanding balance must be guaranteed by a third party, secured by a negotiable promissory note, or subject to a similar mechanism to assure payment in the event of default by the purchaser or obligated party.

(G) Payments Made by a Physician for Items and Services. A physician who has a compensation arrangement with an entity pursuant to which he or she makes payments for items or services provided to him or her is not prohibited from making referrals to such entity so long as the items or services are furnished at a price that is consistent with fair market value.

(H) Fair Market Value Compensation. This exception has the following requirements and may be used even if another exception could apply, but all of the requirements of the other exception are not met:
1. The arrangement must be pursuant to an agreement that:
   a. Is in writing, signed by the parties and covers only identifiable items or services, all of which are specified in the agreement;
   b. Specifies the timeframe for the arrangement
      (1) Can be any period of time, provided that the parties only enter into one arrangement during the course of one year; and
      (2) An arrangement for less than one year can be renewed if the terms do not change;
   c. Specifies the compensation to be provided
      (1) Must be set in advance,
      (2) Must be consistent with fair market value and
      (3) Cannot be determined in any way that takes into account the volume or value of referrals or any other business generated by the referring physician
2. The arrangement must involve a transaction that is commercially reasonable and furthers the legitimate business purposes of the parties.

(I) Medical Staff Incidental Benefits. This exception requires the following:
1. Compensation must be in the form of items or services (not cash or cash equivalents).
2. Compensation must be given or offered by a hospital to all members of the hospital’s medical staff practicing in the same specialty.
3. Item or services provided must be used on the hospital’s campus provided internet access, pagers or two-way radios used away from
campus only to access hospital on campus medical records, information, patients or hospital personnel are also allowed.

4. Incentives must be offered to medical staff members without regard to referrals or other business generated by the physicians.

5. Compensation must be offered only when medical staff members are performing services for the hospital or its patients on campus, except for identification of medical staff on a hospital Web site or in hospital advertising.

6. Compensation must be reasonably related (directly or indirectly) to the delivery of medical services.

7. Value of the compensation must be less than $25 for each occurrence (as such amount may be increased by CMS to reflect increases in the consumer price index, such amount being set at $30 by CMS for calendar 2011).

(J) Non-monetary Compensation Up to $300 Per Year. This exception requires:
1. Compensation must be in the form of items or services (not cash or cash equivalent).
2. Value of compensation may not exceed aggregate of $300 annually (as such amount may be increased by CMS to reflect increases in the consumer price index; in calendar 2011 this amount is $359 per year).
3. Compensation may not take into account the volume or value of referrals or other business.
4. Compensation may not be solicited by the physician.
5. Compensation arrangement may not violate Anti-Kickback statute.

(K) Compliance Training. The training must be provided by a hospital only to physicians (or their office staffs) and meet the following additional conditions:
1. Recipients must practice in the hospital’s local community/service area.
2. The training must be held in the local community or service area.
3. The compliance training must involve training regarding
   (a) Basic elements of a compliance program; and
   (b) Specific requirements of the federal health care programs (i.e., billing, coding, reasonable and necessary services, documentation, unlawful referral arrangements) or training regarding other laws or regulations governing the conduct of the person trained.
4. The compliance training can include programs that offer continuing medical education credit, provided that the compliance training is the primary purpose of the training.

(L) Professional Courtesy. Commencing in 2004 there is an exception for professional courtesy waivers or discounts offered to physicians, family members, and the physician’s office staff. See Legal Department Policy LEGL.018 for its conditions.

Penalties for Violations of Stark. First, an entity to which a prohibited referral was made may not bill Medicare for services rendered. Therefore, if an entity provides DHS to a patient referred by a physician who has a compensation arrangement which does not meet the requirements discussed earlier, the entity will not be paid by Medicare for providing those services. In addition,
an entity which received payment pursuant to illegal referral must refund the payment. In addition to having to return the money, both the physician who referred and the entity who accepted the prohibited referral may be subject to civil monetary penalties of up to $15,000 for each such service plus two times the reimbursement claimed and exclusion from the Medicare and Medicaid programs for making such illegal referrals. Additionally, a civil monetary penalty of up to $100,000 and exclusion can be imposed on persons who enter into circumvention schemes (such as a cross-referral arrangement).

State Non-Referral Statutes. Some states have adopted statutes like, or even more expansive than, the Stark Self-Referral Statutes. Before consummating physician transactions, Vanguard employees should discuss with the Vanguard Legal Department whether a state statute applies.

Most Significant Recent Changes in the Stark Regulations. In the last few years, here are the most significant changes or additions in the Stark regulations:

A. Under Arrangements. Effective October 1, 2009, the definition of “entity . . . furnishing DHS” includes entities that perform DHS, not just entities that submit claims for DHS. This causes physician practices and other entities that provide services under arrangements with hospitals to be deemed to be furnishing DHS. This change also prohibits physicians having ownership interests or compensation arrangements with such practices from making referrals for the under arrangements services, or for other DHS, unless the physicians’ relationships with the billing hospital and the practice satisfy the terms of an exception. While employees or contractors of physician groups providing services under arrangements may be able to qualify for an exception, exceptions available to group owners are very limited and most “under arrangements” situations no longer satisfy the Stark regulations. Vanguard employees must contact the Vanguard Legal Department in respect of all “under arrangements” proposals.

B. Percentage-Based or Per-Click Compensation in Leases. Effective October 1, 2009, the lease exceptions, fair market value exception, and indirect compensation exception prohibit the use of percentage-based (i.e., percent of billings or collections) or per-click compensation in space or equipment leases between physicians and DHS entities—or in certain circumstances between two entities interposed in a chain of relationships between physicians and DHS entities (e.g., between a physician-owned leasing company and a hospital-owned ambulatory surgery center)—even if the leases do not directly involve DHS. Limited at this time to leases, this change does not affect gainsharing or other non-lease compensation arrangements.

C. Period of Disallowance. Effective October 1, 2008, the Stark regulations define the maximum period during which referrals and associated billings are barred due to noncompliance. In brief, the Stark bar may extend from the date of noncompliance until complete cure, which is deemed to be the date that non-financial noncompliance is corrected (e.g., lease is signed), excess compensation is refunded (e.g., physician returns compensation above fair market value), and insufficient compensation is paid (e.g., physician pays shortfall of rent below fair market value). Barring physicians’ referrals and hospitals’ billings for the full period from noncompliance until cure, this could lead to extended prohibition periods if noncompliance is not promptly cured (e.g., if a physician does not return excess compensation), and could preclude parties from making retroactive corrections in the event of inadvertent noncompliance. As indicated, the rule defines the maximum period of disallowance; in commentary, CMS noted that the rule “does not prevent parties from attempting to demonstrate that the period of disallowance ended on some earlier date.”
D. Alternative Method of Compliance. Effective October 1, 2008, arrangements that fail to satisfy a Stark exception solely due to noncompliance with a signature requirement may satisfy a new alternative method for compliance. Parties that “inadvertently” fail to sign an agreement prior to commencement may sign within 90 days and remain compliant. If parties’ failure to sign is not “inadvertent” (e.g., if a physician and hospital agree to sign a services agreement after services begin), they must sign within 30 days of commencement to remain in compliance. However, this provision may be used by a hospital only once every three years with respect to the same referring physician.

E. Stand in the Shoes. Since 2008 the Stark regulations have included a “stand in the shoes” provision under which referring physicians are treated as “standing in the shoes” of their physician organizations for purposes of applying the rules for direct and indirect compensation arrangements. A “physician organization” is defined as a physician (including a PC of which the physician is the owner), a physician practice, or a group practice. In 2009 CMS clarified when a physician must and when a physician may, “stand in the shoes” of his or her physician organization. Physicians who have an ownership or investment interest in a physician organization must be treated as standing in the shoes of that physician organization. In contrast, a physician with a titular ownership interest are not required to stand in the shoes or their physician organizations, although they are permitted to do so. CMS has defined a “titular” ownership or investment interest as an interest that does not include the ability or right to receive financial benefits or ownership or investment, including distribution or profits, dividends, proceeds of sale or similar returns on investment.

Comparing the Stark Self-Referral Statutes to the Anti-Kickback Statute. One of the major misunderstandings about the Stark Statutes is that they are the same as the Anti-Kickback Statute. Not only are they not the same law, they have a very different scope:

- Stark pertains only to physician referrals under Medicare and Medicaid ("physicians" includes chiropractors and dentists but not midlevel providers, such as nurse practitioners and PAs); the Anti-Kickback Statute is far broader and affects anyone engaging in business with a federal health care program.
- Stark does not require bad intent (i.e., a tainted financial relationship violates Stark regardless of good intentions); the Anti-Kickback Statute requires intent, but it must be specific intent (i.e., not intent that might merely be inferred from a pattern of behavior).
- The Stark exceptions define the boundaries of permissible behavior. The Stark Statutes are a prohibition that can only be overcome by complying explicitly with an exception. The Anti-Kickback "safe harbor" regulations describe transactions that may tend to induce referrals but don't necessarily violate the law. The safe harbor regulations state clearly that transactions that don't meet a safe harbor don't necessarily violate the statute; a prosecutor will evaluate the facts and circumstances to make that determination.
- A Stark violation is punishable solely by civil money penalties; an Anti-Kickback violation is punishable by criminal penalties of up to $25,000 in fines or up to five years in jail (or both) and a $50,000 civil money penalty for each violation.
- In most every situation where Stark applies, the Anti-Kickback Statute potentially applies too. If you survive the Stark analysis, you should conduct an Anti-Kickback analysis; if you don't survive the Stark analysis, an Anti-Kickback analysis is irrelevant because you shouldn't proceed with the transaction at all.
23. TREATMENT OF PATIENTS WITH EMERGENCY CONDITIONS

It is Vanguard’s policy that all Vanguard hospitals will fully comply with both the letter and spirit of the federal EMTALA law with respect to patients presenting themselves at Vanguard hospitals claiming emergency medical conditions, and that its hospitals will humanely stabilize all such patients with emergency medical conditions before inquiring as to insurance status. This policy applies to all individuals presenting themselves anywhere on the main hospital campus, even if they present themselves at a location other than the Emergency Department or even on just the hospital’s parking lots, sidewalks and driveways, but excluding other areas or structures of the hospital’s main building that are not part of the hospital, such as physician offices, rural health centers, skilled nursing facilities, or other entities that participate separately under Medicare, or restaurants, shops or other non-medical facilities. EMTALA does not generally apply to patients admitted for inpatient services. Sanctions for violations of this statute include termination of a hospital’s Medicare provider agreement, exclusion of a physician from participation in Medicare and Medicaid programs and civil monetary penalties. In addition, the law creates private civil remedies that enable an individual who suffers personal harm as a direct result of a violation of the law, and a medical facility that suffers a financial loss as a direct result of another participating hospital’s violation of the law, to sue the offending hospital for damages and equitable relief.

**Medical Screening Exams for All Patients.** Vanguard hospitals must provide a medical screening examination by a qualified medical person to all individuals who come to the Emergency Department of a Vanguard hospital seeking an examination or medical treatment (whether or not such individuals are eligible for insurance benefits and regardless of ability to pay) to determine if the individual has an emergency medical condition.

**Patients with Emergency Medical Conditions.** If it is determined that the individual has an emergency medical condition, Vanguard hospitals must provide the individual with such further medical examination and treatment as is required to stabilize the medical condition, within the capabilities of the hospital, or arrange for the transfer of the individual to another medical facility.

**No Delay Allowed to Inquire about Insurance Status.** The hospital will not delay the provision of a medical screening examination, further medical examination and treatment, or appropriate transfer in order to inquire about the individual’s method of payment or insurance status. The hospital shall not seek, or direct an individual to seek, authorization from the individual’s insurance company for screening or stabilization services to be furnished to an individual until after the hospital has provided the appropriate medical screening examination and initiated any further medical examination and treatment that may be required to stabilize the emergency medical condition. Neither the performance of the medical screening examination nor the provision of stabilizing treatment will be conditioned on a patient’s completion of a financial responsibility form or payment of a co-payment.

**No Relevance of Race, Ability to Pay, etc.** In no event will the provision of emergency services and care be based upon, or affected by, an individual’s race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the individual.

FOR MORE DETAILED INFORMATION ON OUR EMTALA OBLIGATIONS, SEE THE LEGAL DEPARTMENT’S POLICIES LEGL.030 TO LEGL.037.
VANGUARD HEALTH SYSTEMS, INC. COMPLIANCE PROGRAM

CERTIFICATION FOR EMPLOYEES(1)
I certify that I have received, read, understood and will abide by the Vanguard Code of Business Conduct and Ethics and the Vanguard Corporate Compliance Manual.

Signature: ____________________________  Business Address: ____________________________

Name (Print): ____________________________  Date: ____________________________
Facility/Department: ____________________________

CERTIFICATION FOR CERTAIN CONTRACTORS, SUBCONTRACTORS OR AGENTS(1)
I certify that I have received, read, understood and will abide by the Vanguard Code of Business Conduct and Ethics and the Vanguard Corporate Compliance Manual.

Signature: ____________________________  Business Address: ____________________________

Name (Print): ____________________________  Date: ____________________________
Facility: ____________________________

ACKNOWLEDGEMENT OF RECEIPT BY ACTIVE MEDICAL STAFF MEMBERS
I acknowledge that I have received the Vanguard Code of Business Conduct and Ethics and the Vanguard Corporate Compliance Manual.

Signature: ____________________________  Business Address: ____________________________

Name (Print): ____________________________  Date: ____________________________
Facility: ____________________________

Please promptly return the signed copy of this Certification or Acknowledgement to your facility's Human Resource Department if you are based at or do business for a Vanguard health care facility, or to the Senior Vice President-Human Resources, at 20 Burton Hills Boulevard, Suite 100, Nashville, Tennessee 37215, if you are based at one of Vanguard's corporate offices.

1 This Certification is not required for part-time or per diem employees, contractors, subcontractors or agents who are not reasonably expected to work more than 160 hours per year; and such individuals are required to make the appropriate certification only at the point when they work more than 160 hours during the calendar year. Also, this Certification is also only required for contractors, subcontractors or other agents who provide patient care (other than medical staff members) or who perform billing or coding functions at a Vanguard facility.