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Office of Legal Affairs

Fraud and Abuse Laws and Regulations

Numerous federal laws regulate the referral of patients by healthcare providers. These laws are intended to prevent conflicts of interest between provider financial incentives and best patient care practices. **Federal "fraud and abuse" law is actually a compilation of several laws, including the Federal Anti-Kickback Statute, the Stark Law, and the False Claims Act.**

A. The Federal Anti-Kickback Statute

The Federal Anti-Kickback Statute (42 U.S.C. § 1320a-7(b)) prohibits providers of services or goods covered by a federal healthcare program ("Federal Healthcare Program") from knowingly and willingly soliciting or receiving or providing any remuneration, directly or indirectly, in cash or in kind, to induce either the referral of an individual, or furnishing or arranging for a good or service for which payment may be made under a Federal Healthcare Program. The Federal Anti-Kickback Statute is an intent-based statute. For purposes of the Federal Anti-Kickback Statute, a "Federal Healthcare Program" is defined as "any plan or program that provides health benefits, whether directly through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government; or any State health care program . . ." (42 U.S.C. § 1320a-7(b)(f)). The Medicare, Medicaid, and TRICARE Programs are all Federal Healthcare Programs.

Certain transactions and arrangements are statutorily exempt from the Federal Anti-Kickback Statute (e.g., compensation paid pursuant to a bona fide employment relationship). In addition, transactions and arrangements that comply fully with established Safe Harbor regulations will not be prosecuted under the Federal Anti-Kickback Statute. Significantly, however, a transaction or arrangement that does not meet all the requirements of a Safe Harbor regulation is not per se illegal.

The Federal Anti-Kickback Statute is a criminal statute and the penalties for violations of the law can be severe. They include fines of up to $25,000 per violation, felony conviction punishable by imprisonment up to five years, or both, as well as possible exclusion from participation in Federal Healthcare Programs.

B. The Stark Law

The Stark Law, 42 U.S.C. § 1395nn (also known as the "Physician Self-Referral Statute"), generally prohibits the referral of Medicare and Medicaid beneficiaries by a physician to an entity for the provision of "designated health services" if the physician, or the physician's immediate family member, has a financial relationship with the entity, unless a statutory exception applies to that financial relationship. For purposes of the Stark Law, a "financial relationship" can include an ownership interest, an investment interest, and/or a compensation arrangement. Unlike the Anti-Kickback Statute, the Stark Law is a strict liability statute and thus, no proof of bad intent is required to violate the Stark law. As a result, any arrangement that does not satisfy all of the criteria of a statutorily-defined Stark Law exception is illegal.

The Stark law provides for significant civil sanctions for violations including, but not limited to: the denial of payment of a claim; refunds of amounts collected in violation of the statute; and civil monetary penalties up to $15,000 for each claim submitted in violation of the statute.

C. The False Claims Act

The False Claims Act, 31 U.S.C. § 3729, imposes liability upon any person who knowingly submits or causes the submission of false or fraudulent claims for payment or approval. Under the False Claims Act's qui tam provisions, a person with evidence of fraud against the government (known as a "relator" or a "whistle-blower") is authorized to file a case in federal court and sue on behalf of the government.

In the healthcare context, examples of conduct that can arguably lead to charges of violations of the statute include, but are not limited to: billing for medical services not rendered; misrepresenting the level of services rendered; falsely certifying compliance with federal laws; and submitting a claim for payment that is contrary to Medicare or Medicaid payment requirements.

The False Claims Act provides that a person who violates the statute is subject to civil penalties of not less than $5,000 or more than $10,000, plus potential treble damages, for each false claim filed.

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These fraud and abuse laws can be implicated in a variety of health care contracts and arrangements such as clinical services agreements, joint venture arrangements, and certain educational grants. Potential fraud and abuse issues may also arise within the context of certain David Geffen School of Medicine at UCLA faculty appointment/employment arrangements.

Please direct any questions regarding UCLA Health's compliance with fraud and abuse laws to the UCLA Health Office of Legal Affairs.