COSMOS
Navigate the Compliance Universe

Complete Healthcare Compliance Manual 2024
Anti-Kickback Statute

By Gabriel Imperato,[1] Esq., CHC; Anne Novick Branan,[2] Esq., CHC; Richard Sena[3] ; and Megan Speltz,[4] JD

Fast Facts

Title of law: The Anti-Kickback Statute, Criminal penalties for acts involving Federal health care programs

Categories:

- Fraud and abuse
- Medicare
- Medicaid

U.S. Code: 42 U.S.C. § 1320a-7b(b)

Year enacted: 1972

Major amendments: 1977, 1980, 1987 (safe harbors implemented), 1996, 1997, 2003, 2010, 2015, 2018

Enforcement agencies: U.S. Department of Justice (DOJ), U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), Centers for Medicare & Medicaid Services (CMS)

Link to full text of law: https://www.govinfo.gov/content/pkg/USCODE-2018-title42/pdf/USCODE-2018-title42-chap7-subchapXI-partA-sec1320a-7b.pdf

Applies to: Any medical providers accepting payment through government healthcare programs.

What Is the Anti-Kickback Statute?

The Anti-Kickback Statute (AKS) is a federal criminal statute prohibiting transactions intended to induce or reward referrals for items or services reimbursed by federal healthcare programs. It provides both criminal and civil penalties for violations of the statute. If "one purpose" of the transaction is to induce referrals, then the entire transaction is tainted. This statute is designed to protect federal healthcare program beneficiaries from referral decisions based on monetary influence.

The purposes of the statute include:

- To prevent inappropriate medical referrals by providers who may be unduly influenced by financial incentives.
- To prevent overutilization and increased federal healthcare program costs.
- To prevent unfair competition.
- To ensure the proper reporting of costs to the government.

Safe Harbors

The law includes safe harbors, which are forms of payment and business practices that may appear to violate the Anti-Kickback Statute but are protected if the party in question meets various tests to qualify. Examples of protected practices include:

- Space rental
- Equipment rental
- Electronic health records items and services
- Electronic prescribing items and services
- Discounts
- Health centers
- Payments made to bona fide employees
- Personal services and management contracts
- Warranties
- Investment interests
- Referral services
- Practitioner recruitment
- Ambulatory surgical centers[5]

History

The Anti-Kickback Statute was originally enacted as part of the Social Security Amendments of 1972. Before 1972, only one provision prohibited false claims and misrepresentation to the government, and the statute's language made it difficult to prosecute Medicare and Medicaid fraud. Despite the update to the AKS, Medicare and Medicaid abuse continued to rise, resulting in new amendments being added to further discourage fraudulent activity.

The original statute made the receipt of kickbacks, bribes, or rebates in connection with items or services covered by Medicare and Medicaid programs a misdemeanor punishable by a fine, imprisonment, or both. In 1977, the Medicare-Medicaid Anti-Fraud and Abuse Amendments increased the penalty for violating the AKS from a misdemeanor to a felony to discourage Medicare and Medicaid fraud. In 1980, the statute was updated to require proof that the defendant acted "knowingly and willfully."[6]

The Medicare and Medicaid Patient and Program Protection Act (MMPPPA) was passed in 1987, which also made two important changes to the AKS.[7] First, the OIG was granted authority to exclude violators of the AKS from participating in federal health care programs. Second, the legislation directed HHS to promulgate regulations that created additional exceptions to the AKS, which would become known as "safe harbors." The first series of "safe harbor" regulations were implemented in 1991. In 1996, Congress further amended the AKS through the Health Insurance Portability and Accountability Act (HIPAA), primarily by expanding the law to cover all federal health care programs rather than just Medicare and state health care programs, adding a new exception relating to certain risk-sharing organizations, and enhancing communication between the OIG and public about the applicability of the AKS to certain transactions. One year later, Congress added a civil monetary penalty. Finally, the Patient Protection and Affordable Care Act of 2010 amended the intent requirement to clarify that the government no longer had to prove that the defendant intended to violate the law.[8]

Related Laws

Cal. Bus. & Prof. Code § 650 (West 2019)—Unearned rebates, refunds, and discounts.

- Prohibits state medical professionals to offer, deliver, or receive compensation for referring healthcare services.

Cal. Welf. & Inst. Code § 14107.2(a)-(b) (West 2019)—Renumeration for healthcare services.

- Prohibits anyone from receiving or paying any remuneration for referrals of healthcare services covered by the state healthcare system.

Cal. Health & Safety Code § 445 (West 2019)—Patient referrals.

- Prohibits anyone from profiting from referring patients to a healthcare provider.

Fla. Stat. § 456.054(2)(3)(a)—Renumeration and solicitation of patient referrals.

- Prohibits healthcare providers to "pay, solicit, or receive a kickback" as money or other compensation for referring or soliciting patients.
- Persons or entities are prohibited from paying or receiving commissions, bonuses, kickbacks, or rebates, and from engaging in split-fee arrangements with certain healthcare providers for referrals to clinical laboratories.

N.Y. Soc. Serv. Law § 366-d(2) (McKinney 2019)—Renumeration and solicitation of patients, facilities, goods.

- Prohibits healthcare providers from soliciting, receiving, or agreeing to receive or accept payment from persons for Medicaid patients or for the purchase, lease, or order of any goods, facility, service, or item covered under Medicaid.

Texas Occ. Code Ann. § 102.001(a) (West 2019)—Renumeration for solicitation of patients.

- Prohibits persons from offering to pay or accept, or paying or receiving renumeration, for soliciting patients for healthcare providers.

Anti-Kickback Statute Compliance Risks

The Anti-Kickback Statute is important to compliance professionals because violations expose healthcare organizations to criminal liability, including prison time for persons directly involved in violations. Healthcare organizations found liable for illegal renumeration or illegal patient admittance and retention practices are subject to up to $100,000 in fines, and those involved may be imprisoned for up to 10 years. Additionally, the AKS includes liability for false claims, and healthcare organizations that violate the AKS are likely to have also violated the False Claims Act. The following are specific AKS risk areas that compliance professionals need to monitor closely.

Risk Area: Making False Statements or Representations

> Whoever—
>
> 1. knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a Federal health care program (as defined in subsection (f)),
> 2. at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,
> 3. having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized,
> 4. having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,
> 5. presents or causes to be presented a claim for a physician's service for which payment may be made under a Federal health care program and knows that the individual who furnished the service was not licensed as a physician, or
> 6. for a fee knowingly and willfully counsels or assists an individual to dispose of assets (including by any transfer in trust) in order for the individual to become eligible for medical assistance under a State plan under [Medicaid], if disposing the assets results in the imposition of a period of ineligibility for such assistance under [42 U.S.C. §] 1396p(c)],
>
> Shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under the program, be guilty of a felony and upon conviction thereof fined not

> more than $100,000 or imprisoned for not more than 10 years or both, or (ii) in the case of such a statement, representation, concealment, failure, conversion, or provision of counsel or assistance by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $20,000 or imprisoned not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a Federal health care program is convicted of an offense under the preceding provisions of this subsection, the administrator of such program may at its option (notwithstanding any other provision of such program) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.[9]

Context: The AKS overlaps some with the False Claims Act. Both statutes prohibit knowing and willful false statements for the procurement of federal funds; however, the AKS explicitly prohibits false claims made in regards to benefits or payments under a federal health program. Additionally, the AKS includes liability for healthcare organizations that misappropriate federal health program funds, present a claim for services furnished by a nonphysician, or assist a patient with disposing assets in order to become eligible for certain hospice and long-term care services.

Risk Area: Illegal Remunerations

> 1. Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—
>
>   A. in return for referring 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 party under a Federal health care program, or
>
>   B. 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 under a Federal health care program,
>
>   shall be guilty of a felony and upon conviction thereof, shall be fined not more than $100,000 or imprisoned for not more than 10 years, or both.
>
> 2. Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—
>
>   A. 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 a Federal health care program, or

B. to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $100,000 or imprisoned for not more than 10 years, or both.[10]

4. Whoever without lawful authority knowingly and willfully purchases, sells or distributes, or arranges for the purchase, sale, or distribution of a beneficiary identification number or unique health identifier for a health care provider under [Medicare, Medicaid, or the State Children's Health Insurance Program (SCHIP)] shall be imprisoned for not more than 10 years or fined not more than $500,000 ($1,000,000 in the case of a corporation), or both.[11]

Context: The AKS expressly prohibits anyone from knowingly and willfully soliciting patients, goods, facilities, and services covered under a federal healthcare program for compensation. Further, everyone, including healthcare organizations, is prohibited from offering or paying compensation for referrals of patients, goods, facilities, and services covered under a federal healthcare program. Lastly, attempting to buy, sell, or distribute patient beneficiary identification numbers or providers' health identifier numbers given under Medicare, Medicaid, or SCHIP is strictly prohibited.

Risk Area: False Statements or Representations with Respect to Condition or Operation of Institutions

Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution, facility, or entity in order that such institution, facility, or entity may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, nursing facility, intermediate care facility for the mentally retarded, home health agency, or other entity (including an eligible organization under [42 U.S.C. § 1395mm(b)]) for which certification is required under [Medicare] or a State health care program (as defined by [42 U.S.C. § 1320a-7(h)]), or with respect to information required to be provided under [42 U.S.C. § 1320a-3a], shall be guilty of a felony and upon conviction thereof shall be fined not more than $100,000 or imprisoned for not more than 10 years, or both.[12]

Context: Keeping with the AKS's prohibition of false claims, section 1320a-7b(c) of the statute prohibits the false claims relating to the operation of Medicare certified healthcare facilities.

Risk Area: Illegal Patient Admittance and Retention Practices

> Whoever knowingly and willfully—
>
> 1. charges, for any service provided to a patient under a State plan approved under [Medicaid], money or other consideration at a rate in excess of the rates established by the State (or, in the case of services provided to an individual enrolled with a medicaid managed care organization under [Medicaid] under a contract under [42 U.S.C. § 1396b(m)] or under a contractual, referral, or other arrangement under such contract, at a rate in excess of the rate permitted under such contract), or
>
> 2. charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under [Medicaid], any gift, money, donation, or other consideration (other than charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)—
>
>   A. as a precondition of admitting a patient to a hospital, nursing facility, or intermediate care facility for the mentally retarded, or
>
>   B. as a requirement for the patient's continued stay in such a facility,
>
>   when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan,
>
>   shall be guilty of a felony and upon conviction thereof shall be fined not more than $100,000 or imprisoned for not more than 10 years, or both.[13]

Context: Healthcare providers are prohibited from knowingly and willfully overcharging Medicaid patients under a state Medicaid plan or requiring a Medicaid patient to pay as a precondition to being admitted, or continuing to stay, at a hospital when the services are at least partially covered by a state Medicaid plan.

Risk Area: Violation of Assignment Terms

> Whoever accepts assignments described in [42 U.S.C. § 1395u(b)(3)(B)(ii)] or agrees to be a participating physician or supplier under [42 U.S.C. § 1395u(h)(1)] and knowingly, willfully, and repeatedly violates the term of such assignments or agreement, shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $4,000 or imprisoned for not more than six months, or both.[14]

Context: Healthcare providers agreeing to accept assignment of Medicare's reasonable charges must not intentionally and repeatedly violate the terms of the assignment.