CALIFORNIA: Summary of Fraud and Abuse Statutes and Regulations

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1) ANTI-KICKBACK

Business & Professions § 650
Under Section 650(a), California’s principal anti-kickback statute, the offer, delivery, receipt, or acceptance by specified licensees of any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for referring patients, clients, or customers to any person is unlawful.

An exception at Section 650(b) provides that the payment or receipt of consideration for services other than the referral of patients that is based on a percentage of gross revenue or similar type of contractual arrangement shall not be unlawful if the consideration is commensurate with the value of the services furnished or with the fair rental value of any premises or equipment leased or provided by the recipient to the payer.

An exception is provided by Section 650(c) for remuneration between a federally qualified health center and any individual or entity providing goods, items, services, donations, loans, or a combination thereof, to the health center entity. This exception mirrors the similar exception that is provided by federal law.

An exception at Section 650(d) for certain ownership interests provides that it shall not be unlawful for any person to refer a person to any laboratory, pharmacy, clinic or health care facility solely because the licensee has a proprietary interest or co-ownership in the laboratory, pharmacy, clinic, or health care facility; provided,
however, that the licensee’s return on investment for that proprietary interest or co-ownership shall be based upon the amount of the capital investment or proportional ownership of the licensee which ownership interest is not based on the number or value of any patients referred, and there must be a valid medical need for the referral.

Under Section 650(e), remuneration in the form of hardware, software, or information technology and training services, as described in subsections (x) and (y) of Section 1001.952 of Title 42 of the Code of Federal Regulations, is permitted. Under Section 650(g), advertising of health services through a third-party advertiser shall not constitute a referral of patients where the advertiser does not itself recommend, endorse, or otherwise select a licensee, and the fee paid to the advertiser is commensurate with the advertising service provided, as well as meeting additional requirements.

Penalties are stated by Section 650(h), which provides that a violation of Section 650 is a public offense and is punishable upon a first conviction by imprisonment in the county jail for not more than one year, or by imprisonment in the state prison, or by a fine not exceeding $50,000, or by both such imprisonment and fine. A second or subsequent conviction is punishable by imprisonment in the state prison or by imprisonment in the state prison and a fine of $50,000.

Business & Professions Code §§ 652 and 652.5 make it clear that unlicensed persons may be liable under Section 650 so long as one party to the arrangement is licensed.

**Business & Professions § 650.1**
Pharmacy lease or rental arrangements with hospitals or licensed medical professionals may not be determined as a percentage of patient charges, revenues, or costs.

**Business & Professions § 654**
Licensed medical professionals may not have shared ownership or partnership interests, nor profit-sharing arrangements with opticians to whom patients, clients, or customers are referred.

**Business & Professions § 657(b), (c)**
Notwithstanding Business & Professions Code § 650, physicians and other health care providers are expressly authorized by Section 657(b) to grant discounts in health or medical claims when payment is made promptly within the time limits prescribed by the providers rendering the services or treatment.

In addition, Section 657(c) allows discounts to be provided to patients for services for which they are neither eligible for nor entitled to insurance coverage, and provides that such discounted fees will not be considered to be the provider’s usual, customary, or reasonable fee.
Business & Professions § 2273(a)
Except as otherwise allowed by law, the employment of runners, cappers, steerers, or other persons by physicians to procure patients constitutes unprofessional conduct.

Health & Safety § 445
This statute prohibits referring or recommending a person for profit to a physician, hospital, health-related facility, or dispensary for any form of medical care or treatment of any ailment or physical condition. The imposition of a fee or charge for any such referral or recommendation creates a presumption that the referral or recommendation is for profit. A physician, hospital, health-related facility, or dispensary shall not enter into a contract or other form of agreement to accept for medical care or treatment any person referred or recommended for such care or treatment by a medical referral service business located in or doing business in another state if the medical referral service business would be prohibited if located in California. This prohibition does not apply to referrals or recommendations that are made under the crippled children services program or prepaid health plans. A violation is a misdemeanor punishable by imprisonment in the county jail for not longer than one year, or a fine of not more than $5,000, or by both. Violation may be enjoined in a civil action brought in the name of the people of the state of California by the Attorney General, except that the plaintiff shall not be required to allege facts necessary to show or tending to show lack of adequate remedy at law or to show or tending to show irreparable damage or loss.

Health & Safety § 1348.6
No contract between a health care service plan and a physician, physician group, or other licensed health care practitioner shall contain any incentive plan that includes specific payment made directly, in any type or form, to a physician, physician group, or other licensed health care practitioner as an inducement to deny, reduce, limit, or delay specific, medically necessary, and appropriate services provided with respect to a specific enrollee or groups of enrollees with similar medical conditions.

Exception for contracts that contain incentive plans that involve general payments, such as capitation payments or shared-risk arrangements that are not tied to specific medical decisions involving specific enrollees or groups of enrollees with similar medical conditions.

Insurance Code § 1871.7(a)
It is unlawful to knowingly employ runners, cappers, steerers, or other persons to procure clients or patients to perform or obtain services or benefits pursuant to the California Workers’ Compensation Program or to procure clients or patients to perform or obtain services or benefits under a contract of insurance or that will be the basis for a claim against an insured individual or his or her insurer.

Insurance Code § 750
Under Insurance Code § 750(a), any person acting individually or through his or her employees or agents who engages in the practice of processing, presenting, or
negotiating claims, including claims under policies of insurance, and who offers, delivers, receives, or accepts any rebate, refund, commission, or other consideration, whether in the form of money or otherwise, as compensation or inducement to or from any person for the referral or procurement of clients, cases, patients, or customers, is guilty of a crime.

Section 750(b) provides that such crime is punishable upon a first conviction by imprisonment in the county jail for not more than one year, or by imprisonment in the state prison, or by a fine up to $50,000, or by both. A second or subsequent conviction is punishable by imprisonment in the state prison or by imprisonment in the state prison and a fine of $50,000.

Section 750(c) permits a licensed collection or lien agency to receive a commission on the collection of delinquent debts nor prohibits the agency from paying its employees a commission for obtaining clients seeking collection on delinquent debts.

Section 750(d) provides that the statute is not intended to limit, restrict, or in any way apply to the rebating of commissions by insurance agents or brokers, as authorized by Proposition 103, enacted by the people at the November 8, 1988, general election.

Additional exceptions relating to attorneys and law firms are outlined in Insurance Code § 750.5.

**Insurance Code § 754(a)**

It is unlawful for any person to solicit, receive, offer, or pay any referral fee for the referral of an individual for the furnishing of services or goods for which the person knows or should have known whole or partial reimbursement is or may be made, directly or indirectly, by any insurer. As used in this section, a referral fee is a fee paid by a person furnishing goods or services to another in return for the referral of an individual to that person for the furnishing of services or goods. It includes any referral fee, kickback, bribe, or rebate, whether made directly or indirectly, overtly or covertly, or in cash or in kind.

**Labor Code § 139.3(c)(2)**

This provision, which is found within California’s workers’ compensation self-referral statute, is the secondary anti-kickback prohibition which provides that physicians and surgeons holding an MD or DO degree, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners, may not offer, deliver, receive, or accept any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for a referred evaluation or consultation, for a workers’ compensation patient.
**Labor Code § 3215**
This is California’s primary workers’ compensation specific Anti-Kickback Statute, which provides that except as otherwise permitted by law, any person acting individually or through his or her employees or agents who offers, delivers, receives, or accepts any rebate, refund, commission, preference, patronage, dividend, discount or other consideration, whether in the form of money or otherwise, as compensation or inducement for referring clients or patients to perform or obtain services or benefits payable under California’s workers’ compensation program is guilty of a crime.

Labor Code § 3217(d) provides that Section 3215 shall not be construed to prohibit the payment or receipt of consideration or services that is lawful pursuant to Section 650 of the Business & Professions Code.

Labor Code § 3218 provides that a violation of Section 3215 is punishable by incarceration for not more than one year, fine up to $10,000, or both.

**Welf. & Inst. § 14107.2**
This is California’s Medicaid-specific analog to the federal Anti-Kickback Statute, which prohibits any person from soliciting or receiving, offering or paying any remuneration in any form directly or indirectly, overtly or covertly in cash or in kind, in return for the referral or promised referral of any individual to a person for furnishing any services or merchandise that is paid by California's Medi-Cal program. These provisions also prohibit remuneration in return for purchasing, leasing, ordering, or arranging for or recommending the purchasing, leasing, or ordering of any goods, facility, service, or merchandise for which payment may be made by Medi-Cal.

Section 14107.2(c) provides that the prohibition does not apply to payment to a bona fide employee; a discount or other reduction in price obtained by a provider of services or other entity if the reduction in price is properly disclosed and reflected in the costs claimed or charges made to the Medi-Cal program by the provider or entity (the exception does not apply to consultant pharmaceutical services rendered to nursing facilities or intermediate care facilities for the developmentally disabled); certain practices or transactions between a federally qualified health center and any individual or entity to the extent sanctioned or permitted by federal law; and the provision of nonmonetary remuneration in the form of hardware, software, or information technology and training services, as described in subsections (x) and (y) of Section 1001.952 of Title 42 of the Code of Federal Regulations, as amended October 4, 2007, as published in the Federal Register (72 Fed. Reg. 56631, 56644), and subsequently amended versions.

Violations of this statute are punishable upon a first conviction by imprisonment in the county jail for not longer than one year or state prison, or by a fine not exceeding $10,000, or by both. A second or subsequent conviction shall be punishable by imprisonment in the state prison. The enforcement remedies provided under this
section are not exclusive and shall not preclude the use of any other criminal or civil remedy.

Unlike the federal Anti-Kickback Statute, there are no regulatory “safe harbors” under the Medi-Cal statute protecting arrangements not protected by the statutory exceptions, and Medi-Cal does not require violations to be knowing and willful.

**Welf. & Inst. § 14107.3**
This anti-supplementation statute prohibits any person from knowingly and willfully charging, soliciting, accepting, or receiving, in addition to any amount payable under the Medi-Cal program any gift, money, contribution, donation, or other consideration as a precondition to providing services or merchandise to a Medi-Cal beneficiary for any service or merchandise in the Medi-Cal program’s scope of benefits in addition to a claim submitted to the Medi-Cal program except either to collect payments due under a contractual or legal entitlement, bill a long term care patient or representative for the amount of the patient's share of the cost, or return payment to a beneficiary who has paid for service. Violation is punishable upon a first conviction by imprisonment in the county jail for not longer than one year or state prison, or by a fine not to exceed $10,000, or both. A second or subsequent conviction shall be punishable by imprisonment in the state prison.

**Cal. Code Reg. tit. 22, § 51478**
Prohibits providers from offering, giving, furnishing, delivering, soliciting, requesting, accepting, or receiving any rebate, refund, commission preference, patronage dividend, discount, or any other gratuitous consideration in connection with the rendering of health care services to any Medi-Cal beneficiary.

**Attorney General Opinions:**

The practice of rebating, whereby patients were charged excessive prices for drugs, medications, and auxiliary services by pharmacists, laboratories, opticians and others in order for the treating physicians to secure additional hidden fees led to the enactment of BUS. & PROF. § 650.

Professional courtesy services violate BUS. & PROF. § 650 if given with the intent of inducing referrals.

Arrangement by which physicians would mark up radiologists’ services was found to be prohibited by BUS. & PROF. § 650.

Pharmaceutical company may not pay physicians to refer patients to its research program.
BUS. & PROF. § 650 prohibits chiropractors from participating in an Internet marketing plan in which they agree to promote the naturopathic products of an Internet company and to refer their patients to the company’s website in exchange for fees equaling 20% of the price of the products purchased by their patients from the company.

BUS. & PROF. § 650 would prohibit a podiatry referral service that operated for-profit from directing callers on the following basis: (1) to a service subscriber who pays $500 monthly for a nonexclusive listing according to geographic proximity; (2) to a service subscriber who pays $750 monthly for a semi-exclusive listing within a five-mile radius; and (3) to a service subscriber who pays $1,000 monthly for an exclusive listing within a five-mile radius, where the caller may, during the call, request and select an alternative referral.

A corporation may not charge an annual subscription fee, including a reasonable profit, for furnishing a list of physicians willing to provide medical services at discounted rates to uninsured indigent persons.

A physician may order a medical device for a patient that is distributed by a company in which the physician holds an ownership interest. However, any return on investment must be based upon the physician’s proportional ownership and required disclosures must be made.

Key State Health Care Cases:

Mast v. State Board of Optometry (1956) 139 Cal.App.2d 78; 293 P.2d 148
BUS. & PROF. § 650 can be violated even when there is no excessive charge to patients.

Blank v. Palo Alto-Stanford Hospital Center (1965) 234 Cal.App.2d 377; 44 Cal.Rptr. 572
Hospital’s arrangement splitting global radiology fees with hospital-based radiologist did not violate BUS. & PROF. § 650 where amounts retained by hospital were commensurate with its expenses of providing the facility component of such services.

A hospital administrator who was paid by a medical group for recommending that hospitals contract with the medical group for the staffing of their emergency departments was found to have thereby violated BUS. & PROF. § 650.
Sales representative for incontinence supply products sold to nursing homes was found to have been unlawfully paid by supplier for each Medi-Cal sticker submitted with the supply order in violation of WELF. & INST. § 14107.2. Substantial evidence supported the defendant’s status as an independent contractor and not a bona fide employee for the purpose of exemptions from the prohibitions of the Medi-Cal Anti-Kickback Statute.

**People v. Duz-Mor Diagnostics Laboratory, Inc. (1998) 68 Cal.App. 4th 654; 80 Cal.Rptr. 2d 419**  
The state sued a clinical laboratory under the Unfair Competition Act and the False Claims Act in connection with marketing and billing practices. The laboratory offered discounts to physicians’ private pay patients. The court found that the laboratory did not violate Unfair Competition Act by offering discounts for tests performed for physician’s private pay patients and discounts did not violate regulations governing billing for Medi-Cal patients. The court applied an exception under BUS. & PROF. § 650 and concluded that the clinical laboratory’s payment of sales commissions to the independent contractor who marketed laboratory’s services to physicians did not violate the criminal statute prohibiting a licensed health care provider from offering consideration as compensation or inducement for referring patients, clients, or customers, as the marketer did not refer patients, but instead solicited clients or customers. There was no evidence of any other benefit to a doctor as compensation or inducement for referring patients. Specific intent to violate the law is not required under the criminal statute prohibiting payment of remuneration to recommend the ordering of services for which payment may be made by Medi-Cal.

**People v. Hering (1999) 20 Cal. 4th 440; 84 Cal. Rptr. 2d 839; 976 P. 2d 210**  
A physician was convicted of violating BUS. & PROF. § 650 and INS. § 750 by offering rebates on medical fees as inducement for the referral of patients. The court held that BUS. & PROF. § 650 did not require the defendant to have a particular mental state beyond intent to commit the proscribed acts, and this intention is deemed to be a general criminal intent. The gravamen of the crime is the motive for the rebate, regardless of whether the offeror actually intends eventual payment.

**Epic Medical Management, LLC v. Paquette (2015) 244 Cal.App. 4th 504; 198 Cal.Rptr. 3d 28**  
A medical management services company’s compensation of 12.8% of profit was found commensurate with services provided to a physician where compensation was based on percentage of gross revenues and did not violate BUS. & PROF. § 650 or the corporate practice of medicine. The only basis on which the contract between a doctor and a management company could be found illegal is if a finding were made that the consideration was not commensurate with the services rendered and facilities and equipment provided.
The court found that a chiropractor’s alleged payment of patient referral fees to her landlord would violate Ins. § 1871.7(a) prohibition on the employment of runners, cappers, steerers, or other persons to procure clients or patients, even if the landlord made no patient referrals and even if the insurer suffered no loss. The insurer alleged that the referral payments were masked as a varying percentage of her monthly gross collections.

2) PROHIBITIONS ON SELF-REFERRAL

Business & Professions Code §§ 650.01- 650.02
BUS. & PROF. § 650.01 is California’s primary self-referral statute. Separate self-referral restrictions, at LAB. §§ 139 and 139.31 below apply only to the workers’ compensation program. BUS. & PROF. § 650.01(a) prohibits a licensee (broadly defined to include physicians and surgeons holding an MD or DO degree, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners licensed by California state law) from referring a person for laboratory, diagnostic nuclear medicine, radiation oncology, physical therapy, physical rehabilitation, psychometric testing, home infusion therapy, or diagnostic imaging goods or services if the licensee or his or her immediate family has a financial interest, as defined in the statute, with the person or in the entity that receives the referral.

BUS. & PROF. § 650.01(b), provides definitions, including a complex definition of financial interest.

BUS. & PROF. § 650.01(c) makes it unlawful for a licensee to enter into an arrangement or scheme, such as a cross-referral arrangement, that the licensee knows, or should know, has a principal purpose of ensuring referrals by the licensee to a particular entity that, if the licensee directly made referrals to that entity, would be in violation of BUS. & PROF. § 650.01.

BUS. & PROF. § 650.01(d) prohibits claims for payments presented by an entity to any individual, third party payer, or other entity for a good or service furnished pursuant to a prohibited referral, and BUS. & PROF. § 650.01(e) prohibits payers from paying such claims.

Where the referral is not prohibited, BUS. & PROF. § 650.01(f) requires a licensee who refers a person to, or seeks consultation from, an organization in which the licensee has a financial interest to disclose the financial interest to the patient, or the parent or legal guardian of the patient, in writing, at the time of the referral or request for consultation. Under certain circumstances, the disclosure statement may be posted or disclosure shall be made to the Department of Corrections or California Youth Authority.
BUS. & PROF. § 650.01(g) provides penalties. A violation of BUS. & PROF. § 650.01(a) is a misdemeanor and may subject the physician to disciplinary action by the Medical Board of California and civil penalties of up to $5,000 for each offense, which may be enforced by the Insurance Commissioner, attorney general, or a district attorney. A violation of Subsections (c), (d), or (e) is a public offense and is punishable upon conviction by a fine not exceeding $15,000 for each violation and appropriate disciplinary action, including revocation of professional licensure by the Medical Board of California or other appropriate governmental agency.

Numerous exceptions are provided by BUS. & PROF. § 650.02 when enumerated requirements are satisfied, including exceptions for where there is no alternative provider, and for loans, leases of space or equipment, ownership in public companies, one-time transactions, personal services contracts, referrals to health facilities, certain nonprofit clinics, universities, in-office services, cardiac rehabilitation services, certain multispecialty clinics, health plan patients, requests by pathologists, radiologists, or radiation oncologists.

**Business & Professions Code § 654.1**
Disclosure required in connection with self-referrals to clinical laboratories. Largely superseded by the above BUS. & PROF. § 650.01.

**Business & Professions Code § 654.2**
This is California’s primary disclosure statute, which makes it unlawful for any person licensed in the healing arts to charge, bill, or otherwise solicit payment from a patient on behalf of, or refer a patient to, an organization in which the licensee, or the licensee’s immediate family, has a significant beneficial interest, unless the licensee first discloses in writing to the patient that there is such an interest and advises the patient that the patient may choose any organization for the purpose of obtaining the services ordered or requested by the licensee. Prescribes disclosure requirements to patients and third party payers and provides exceptions to the disclosure requirements.

**Labor Code §§ 139.3-139.31**
These statutes are a workers’ compensation-specific version of California’s self-referral law. They are similar, but not identical to, the above-discussed BUS. & PROF. §§ 650.01 and 650.02. For example, they are broader than the general self-referral prohibition in that they apply to outpatient surgery and defined pharmacy goods not covered under that statute.

LAB. § 139.3(a) prohibits a licensee (broadly defined to include physicians and surgeons holding an MD or DO degree, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners licensed by California state law) from referring a person for laboratory, diagnostic nuclear medicine, radiation oncology, physical therapy, physical rehabilitation, psychometric testing, home infusion therapy, outpatient surgery, diagnostic imaging goods or services or pharmacy goods if the licensee or his or her immediate family has a financial
interest, as defined in the statute, with the person or in the entity that receives the referral.

LAB. § 139.3(b), provides definitions, including a complex definition of financial interest.

LAB. § 139.3(c)(1) makes it unlawful for a licensee to enter into an arrangement or scheme, such as a cross-referral arrangement, that the licensee knows, or should know, has a principal purpose of ensuring referrals by the licensee to a particular entity that, if the licensee directly made referrals to that entity, would be in violation of Bus. & Prof. § 650.01. LAB. § 139.3(c)(2) provides that a licensee may not offer, deliver, receive, or accept any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for a referred evaluation or consultation.

LAB. § 139.31(d) prohibits claims for payments presented by an entity to any individual, third-party payer, or other entity for a good or service furnished pursuant to a prohibited referral, and LAB. § 139.31(f) prohibits payers from paying such claims.

Where the referral is not prohibited, LAB. § 139.31(e) requires a licensee who refers a person to, or seeks consultation from, an organization in which the licensee has a financial interest to disclose the financial interest to the patient, or the parent or legal guardian of the patient, in writing, at the time of the referral or request for consultation. Under certain circumstances, the disclosure statement may be posted or disclosure shall be made to the Department of Corrections or California Youth Authority.

LAB. § 139.31(g) provides penalties. A violation of subdivision 139.31(a) shall be a misdemeanor. The appropriate licensing board shall review the facts and circumstances of any conviction pursuant to subdivision (a) and take appropriate disciplinary action if the licensee has committed unprofessional conduct. Violations may also be subject to civil penalties of up to $5,000 for each offense, which may be enforced by the Insurance Commissioner, attorney general, or a district attorney. A violation of subdivisions 139.3(c), (d), (e), or (f) is a public offense and is punishable upon conviction by a fine not exceeding $15,000 for each violation and appropriate disciplinary action, including revocation of professional licensure, by the Medical Board of California or other appropriate governmental agency.

Numerous exceptions are provided by LAB. § 139.31 when enumerated requirements are satisfied, including exceptions for where there is no alternative provider, and for loans, leases of space or equipment, ownership in public companies (there is no exception for one-time transactions), personal services contracts, referrals to health facilities (there is no exception for certain nonprofit clinics), universities, in-office services, with pre-authorization required for certain imaging services (there is no exception for cardiac rehabilitation services), certain
multispecialty clinics, health plan patients (there is no exception for requests by pathologists, radiologists or radiation oncologists), outpatient surgical centers, and certain pharmacies.

**Labor Code § 139.32**

This statute, effective January 1, 2013, has greatly expanded California’s self-federal law as it applies to workers’ compensation patients. Under Lab. § 139.32(c), it is unlawful for an interested party other than a claims administrator or a network service provider to refer a person for services provided by another entity or to use services provided by another entity if the other entity will be paid for those services pursuant to Division 4 (commencing with Section 3200), and the interested party has a financial interest in the other entity.

Under subsection (d), it is unlawful (i) for an interested party to enter into an arrangement or scheme, such as a cross-referral arrangement, that the interested party knows, or should know, has a purpose of ensuring referrals by the interested party to a particular entity that, if the interested party directly made referrals to that other entity, would be in violation of this section or (ii) for an interested party to offer, deliver, receive, or accept any rebate, refund, commission, preference, patronage, dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement to refer a person for services.

Subsection (e) provides that a claim for payment shall not be presented by an entity to any interested party, individual, third-party payer, or other entity for any services furnished pursuant to a referral prohibited under this section and subsection (f) provides that an insurer, self-insurer, or other payer shall not knowingly pay a charge or lien for any services resulting from a referral for services or use of services in violation of this section.

Under subsection (g), a violation of the statute shall be misdemeanor. If an interested party is a corporation, any director or officer of the corporation who knowingly concurs in a violation of this section shall be guilty of a misdemeanor. The appropriate licensing authority for any person subject to this section shall review the facts and circumstances of any conviction pursuant to this section and take appropriate disciplinary action if the licensee has committed unprofessional conduct, provided that the appropriate licensing authority may act on its own discretion independent of the initiation or completion of a criminal prosecution. Violations of this section are also subject to civil penalties of up to $15,000 for each offense, which may be enforced by the insurance commissioner, attorney general, or a district attorney. In addition, for an interested party, a practice of violating this section shall constitute a general business practice that discharges or administers compensation obligations in a dishonest manner, which shall be subject to a civil penalty under subdivision (e) of Section 129.5. For an interested party who is an attorney, a violation of subdivision (b) or (c) shall be referred to the Board of Governors of the State Bar of California, which shall review the facts and circumstances of any violation pursuant to subdivision (b) or (c) and take appropriate disciplinary action if the licensee has committed unprofessional conduct. Any determination regarding an
employee’s eligibility for compensation shall be void if that service was provided in violation of the statute. Under subsection (b) all interested parties shall disclose any financial interest in any entity providing services.

The following definitions are laid out by Subsection (a):
(1) “Financial interest in another entity” includes (A) any type of ownership, interest, debt, loan, lease, compensation, remuneration, discount, rebate, refund, dividend, distribution, subsidy, or other form of direct or indirect payment, whether in money or otherwise, between the interested party and the other entity to which the employee is referred for services; and (B) an agreement, debt instrument, or lease or rental agreement between the interested party and the other entity that provides compensation based upon, in whole or in part, the volume or value of the services provided as a result of referrals.

(2) “Interested party” means any of the following: (A) an injured employee; (B) the employer of an injured employee, and, if the employer is insured, its insurer; (C) a claims administrator, which includes, but is not limited to, a self-administered workers’ compensation insurer, a self-administered self-insured employer, a self-administered joint powers authority, a self-administered legally uninsured employer, a third-party claims administrator for an insurer, a self-insured employer, a joint powers authority, or a legally uninsured employer or a subsidiary of a claims administrator; (D) an attorney-at-law or law firm that is representing or advising an employee regarding a claim for compensation under Division 4 (commencing with Section 3200); (E) a representative or agent of an interested party, including either of the following: (i) an employee of an interested party or (ii) any individual acting on behalf of an interested party, including the immediate family of the interested party or of an employee of the interested party. For purposes of this clause, immediate family includes spouses, children, parents, and spouses of children; (F) a provider of any medical services or products.

(3) “Services” means, but is not limited to, any of the following: (A) a determination regarding an employee's eligibility for compensation under Division 4 (commencing with Section 3200), that includes both of the following: (i) a determination of a permanent disability rating under Section 4660 and (ii) an evaluation of an employee’s future earnings capacity resulting from an occupational injury or illness; (B) services to review the itemization of medical services set forth on a medical bill submitted under Section 4603.2; (C) copy and document reproduction services; (D) interpreter services; (E) medical services, including the provision of any medical products such as surgical hardware or durable medical equipment; (F) transportation services; (G) services in connection with utilization review pursuant to Section 4610.

Limited exceptions are provided by subsections (h) and (i), which provide that the following arrangements between an interested party and another entity do not constitute a “financial interest in another entity” for purposes of this section: (1) a loan between an interested party and another entity, if the loan has commercially reasonable terms, bears interest at the prime rate or a higher rate that does not
constitute usury, and is adequately secured, and the loan terms are not affected by either the interested party's referral of any employee or the volume of services provided by the entity that receives the referral; (2) a lease of space or equipment between an interested party and another entity, if the lease is written, has commercially reasonable terms, has a fixed periodic rent payment, has a term of one year or more, and the lease payments are not affected by either the interested party's referral of any person or the volume of services provided by the entity that receives the referral; (3) an interested party's ownership of the corporate investment securities of another entity, including shares, bonds, or other debt instruments that were purchased on terms that are available to the general public through a licensed securities exchange or NASDAQ; (4) services performed by, or determinations of compensation issues made by, employees of an interested party in the course of that employment; (5) a referral for legal services if that referral is not prohibited by the Rules of Professional Conduct of the State Bar; and (6) a physician's referral that is exempted by Section 139.31 from the prohibitions prescribed by Section 139.3.

**Welfare & Institutions Code § 14022**
The “Medi-Cal Conflict of Interest Law” is operative only upon the date on which Section 1902(a)(4)(C) of the federal Social Security Act—as added by Pub. L. No. 95-559—is repealed, held invalid by a court of appeal, or otherwise made inoperative. No Medi-Cal payment may be made to a provider of service or to any facility or organization in which he or his immediate family has a significant beneficial interest, for services rendered in connection with any referral of a recipient, unless there is on file with the director and the Advisory Health Council a statement of the nature and extent of such interest.

**Title 22 California Code of Regulations § 51466**
This regulation prohibits a provider from billing or submitting a claim for services involving the referral of a Medi-Cal beneficiary to or from another provider unless each provider has disclosed to the Department any “significant beneficial interest” existing between the providers. The regulation defines a significant beneficial interest as an interest that is equal to or greater than the lesser of 5% of the whole or $25,000.00. Interests held by a provider and members of that provider’s immediate family shall be combined and valued as a single interest, and additional rules are provided for valuing interests. Disclosure shall be accomplished by completing and submitting a Medi-Cal Personal Disclosure Statement of Significant Beneficial Interest form as provided by the Department.

**Atty. Gen. Opinion No. 05-614, February 27, 2006**
A physician generally may prescribe for a patient a medical device that is distributed by a company in which the physician has an ownership interest, provided that a return on investment is based upon the physician’s proportional ownership share an requisite disclosures are made.
3) FALSE CLAIMS/FRAUD & ABUSE

California has extensive statutes and regulations prohibiting and punishing fraud and abuse. While many important provisions are included here, other provisions may be omitted that may also be material. In addition, these statutes and regulations are subject to frequent modification and augmentation.

**Penal Code § 550**
California’s main criminal provision prohibiting false claims to private insurers is Penal Code § 550(a)(1), which makes it a crime to knowingly present or cause to be presented any false or fraudulent claim for the payment of a loss or injury, including payment of a loss or injury under a contract of insurance (or to aid, abet, solicit, or conspire with any person to do so). Penal Code § 550(c)(1) provides that every person who violates Section 550(a)(1) is guilty of a felony punishable by imprisonment for two, three, or five years, and by a fine not exceeding $50,000, or double the amount of the fraud, whichever is greater.

**Insurance Code § 1871.7**
This statute piggybacks off of the above Penal Code § 550 to provide California’s main civil provision prohibiting false claims to private insurers. Insurance Code § 1871.7(b) provides that every person who violates any provision of this section or Sections 549, 550, or 551 of the Penal Code shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not less than $5,000 nor more than $10,000, plus an assessment of not more than three times the amount of each claim for compensation. The court shall have the power to grant other equitable relief, including temporary injunctive relief, as is necessary to prevent the transfer, concealment, or dissipation of illegal proceeds, or to protect the public. The penalty prescribed in this paragraph shall be assessed for each fraudulent claim presented to an insurance company by a defendant, and not for each violation. The statute contains detailed procedural provisions, only some of which are summarized below.

Section 1871.7(d) provides that the district attorney or Insurance Commissioner may bring a civil action under this section. In addition, under Section 1871.7(e)(1), any interested persons, including an insurer, may bring a civil action for a violation of this section for the person and for the State of California. If the district attorney or commissioner elects not to proceed with the action, the person who initiated the action shall have the right to conduct the action. If the district attorney proceeds with an action brought by an interested person under subdivision, that person generally shall receive at least 30% but not more than 40% of the proceeds of the action or settlement of the claim, depending upon the extent to which the person substantially contributed to the prosecution of the action. However, where the action is one that the court finds to be based primarily on disclosures of specific information, other than information provided by the person bringing the action, relating to allegations or transactions in a criminal, civil, or administrative hearing, in a legislative or administrative report, hearing, audit, or investigation, or from the news media, the
court may award those sums that it considers appropriate, but in no case more than 10% of the proceeds, taking into account the significance of the information and the role of the person bringing the action in advancing the case to litigation.

If the district attorney or commissioner does not proceed with an action under this section, the person bringing the action or settling the claim shall receive an amount that the court decides is reasonable for collecting the civil penalty and damages. Such amount generally shall not be less than 40% and not more than 50% of the proceeds of the action or settlement and shall be paid out of the proceeds. That person shall also receive an amount for reasonable expenses that the court finds to have been necessarily incurred, plus reasonable attorneys’ fees and costs. However, if the person bringing the action, as a result of a violation of this section has paid money to the defendant or to an attorney acting on behalf of the defendant in the underlying claim, then he or she shall be entitled to up to double the amount paid to the defendant or the attorney if that amount is greater than 50% of the proceeds.

Whether or not the district attorney or commissioner proceeds with the action, if the court finds that the action was brought by a person who planned and initiated the violation of this section, that person shall be dismissed from the civil action and shall not receive any share of the proceeds of the action. The dismissal shall not prejudice the right of the district attorney or commissioner to continue the action on behalf of the state.

No court shall have jurisdiction over an action under Section 1871.1 based upon the public disclosure of allegations or transactions in a criminal, civil, or administrative hearing in a legislative or administrative report, hearing, audit, or investigation, or from the news media, unless the action is brought by the attorney general or the person bringing the action is an original source of the information.

**Government Code §§ 12650-12652**

These provisions constituting the California False Claims Act are California’s most important antifraud provisions involving government programs. Government Code § 12651(a) prohibits a person from knowingly making false claims or causing false claims to be made for money, property, or services to the state or any of its political subdivisions, or to any contractor, grantee, or other recipient, whether under contract or not, if any portion of the money, property, or services requested or demanded issued from, or was provided by, the state (state funds) or by any political subdivision. Additional prohibitions are included that parallel those of the federal False Claims Act. Knowledge is defined by Government Code § 12650(b)(2) as having actual knowledge of the information, acting in deliberate ignorance of the truth or falsity of the information, or acting in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required. Liability to the state or a political subdivision for violation is for up to treble damages, the costs of a civil action for recovery for recovery of penalty or damages, and may include a civil penalty of not less than $5,500 and not more than $11,000 for each false claim, as
such amounts may be adjusted by the Federal Civil Penalties Inflation Adjustment Act. Penalties may be reduced if the person cooperates with the fraud investigation. Does not apply to any controversy involving an amount of less than $500 in value. Actions by qui tam plaintiffs (whistleblowers) are authorized and governed by Government Code § 12652.

**Government Code § 12528**
Establishes in the Office of the Attorney General the Bureau of Medi-Cal Fraud authorized to conduct a statewide program for investigating and prosecuting, and referring for prosecution, violations of all applicable laws pertaining to fraud in the administration of the Medi-Cal program, the provision of medical assistance or medical supplies, or the activities of providers of medical assistance or medical suppliers under the Medi-Cal plan. The Bureau of Medi-Cal Fraud is also authorized to review complaints alleging abuse or neglect of patients in health care facilities receiving payments under the Medi-Cal plan, and may review complaints of the misappropriation of patient's private funds in such facilities and complaints of discriminatory treatment of Medi-Cal beneficiaries by such facilities. The Bureau works in collaboration with federal investigators and the California Department of Health Services, Audits and Investigations Division.

**Government Code § 12528.1**
Provides broad authority to any agent, investigator, or auditor of the Bureau of Medi-Cal Fraud within the Office of the Attorney General to inspect, at any time, the business location of any Medi-Cal provider for the purpose of fraud investigation. Requires the Bureau of Medi-Cal Fraud to train inspectors and develop protocols to ensure that inspections conducted pursuant to this section are conducted during normal business hours and are completed in the least intrusive manner possible.

**Health & Safety Code § 1348**
Requires health plans to adopt an antifraud plan as a condition of licensure in California and specifies related requirements, including provision to the Director of the Department of Health Services of an annual written report describing the plan’s efforts to deter, detect, investigate, and report fraud.

**Business & Professions Code § 650.01(d)**
Prohibits claims for payments presented by an entity to any individual, third-party payer, or other entity for a good or service furnished pursuant to a referral prohibited by California’s general self-referral prohibitions.

**Labor Code § 139.3(d)**
Prohibits submitting claims for payment to any individual, third-party payer, or other entity for any goods or services furnished pursuant to a referral prohibited by California’s workers’ compensation specific self-referral restrictions.
**Welfare & Institutions Code § 14043.36**
Prohibits enrollment in the state Medicaid program (Medi-Cal) for any applicant that has been convicted of any felony or misdemeanor involving fraud or abuse in any government program, or related to neglect or abuse of a patient in connection with the delivery of a health care item or service, or in connection with the interference with or obstruction of any investigation into health care-related fraud or abuse or that has been found liable for fraud or abuse in any civil proceeding, or that has entered into a settlement in lieu of conviction for fraud or abuse in any government program, within the previous 10 years. The Medi-Cal program may also deny enrollment to any applicant that at the time of application is under investigation by the department or any state, local, or federal government law enforcement agency for fraud or abuse. The Medi-Cal program, may not deny enrollment to an otherwise-qualified applicant whose felony or misdemeanor charges did not result in a conviction solely on the basis of the prior charges. Providers are also subject to temporary suspension, pursuant to a 15-day notification, from the Medi-Cal program, which shall include temporary deactivation of all provider numbers, including all business addresses, used by the provider to obtain reimbursement from the Medi-Cal program, if it is discovered that a provider is under investigation for fraud or abuse.

**Welfare & Institutions Code § 14043.61**
A Medi-Cal provider is subject to suspension if claims for payment are submitted for the services, goods, supplies, or merchandise provided, directly or indirectly, to a Medi-Cal beneficiary by an individual or entity that is suspended, excluded, or otherwise ineligible for reimbursement from the Medi-Cal program and the individual or entity is listed on either the Suspended and Ineligible Provider List, published by the department or any list published by the federal Office of Inspector General regarding the suspension or exclusion of individuals or entities from the federal Medicare and Medicaid programs. The sanction is appealable.

**Welfare & Institutions Code § 14043.75**
Permits the Director of the Department of Health Services, in consultation with interested parties, by regulation, to adopt, readopt, repeal, or amend additional measures to prevent or curtail fraud and abuse as emergency regulations. Permits the Director to take regulatory action by means of a provider bulletin or similar instruction to implement, interpret or make specific certain sections of the Welfare & Institutions Code applicable to the Medi-Cal program. Imposes certain notice requirements on the Department.

**Welfare & Institutions Code § 14044**
Pursuant to notice, the Medi-Cal program may impose limits for up to 18 months on one or more standard billing codes, or combination of code for which any provider may bill, or for which reimbursement to any person or entity may be made by, the Medi-Cal program or other health care programs administered by the Department of Health Services, if the Department determines, by audit or other investigation, that excessive services or billings, or abuse, has occurred or a licensing authority or a court of competent jurisdiction limits a licensee’s practice of medicine or the
rendering of health care, and the limitation precludes the licensee from performing services that could otherwise be reimbursed by the Medi-Cal program or other health care programs administered by the Department. The provider has 45 days from the date of notice to appeal the limitation by providing to the Department reliable evidence that excessive services or billings, or abuse, did not occur. Provides a timeframe for when limits may take effect pursuant to notice or appeal of notice.

**Welfare & Institutions Code § 14107**
Prohibits a person, including an applicant or provider in the Medi-Cal program or a billing agent from engaging in certain activities under threat of punishment by imprisonment, by a fine not exceeding three times the amount of the fraud or improper reimbursement or value of the scheme or artifice, or by both, and shall be subject to the asset forfeiture provisions for criminal profiteering, and any other criminal or civil remedy. Prohibited activities are filing false or fraudulent claims for payment in the Medi-Cal program, with intent to defraud; knowingly submitting false information for the purpose of obtaining greater compensation than that to which he or she is legally entitled under the Medi-Cal program; knowingly submitting false information for the purpose of obtaining authorization for furnishing services or merchandise in the Medi-Cal program or knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud Medi-Cal or any other health care program administered by the department or its agents or contractors or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, the Medi-Cal program or any other health care program administered by the Department or its agents or contractors, in connection with the delivery of or payment for health care benefits, services, goods, supplies, or merchandise.

**Welfare & Institutions Code § 14107.11**
Permits the Department of Health Services to take certain actions against a provider upon receipt of reliable evidence of fraud or willful misrepresentation by the provider, or the commencement of a suspension of a provider, including collection of Medi-Cal program overpayments, or withholding payment, or any portion thereof, for any goods, services, supplies, or merchandise upon five days notice.

**Welfare & Institutions Code § 14107.13**
Requires the California Department of Health Services in conjunction with the Department of Justice to identify fee-for-service Medi-Cal program areas at greatest risk for fraud and abuse. Requires the Department of Health Services to either request confirmation of service from beneficiaries that services or goods were actually received or from referring and rendering providers that the referring providers actually authorized and the rendering providers actually delivered services or goods underlying claims for reimbursement, or both, by notice.
Welfare & Institutions Code § 14107.4
Makes it a public offense, punishable by imprisonment in the county jail for a period not to exceed one year or in the state prison, or by fine not to exceed $5,000, or by both such fine and imprisonment, for any person who, with the intent to defraud, certifies as true and correct any cost report, submitted by a hospital to a state agency for reimbursement in the Medi-Cal program, or who knowingly fails to disclose in writing on the cost report any significant beneficial interest, which the owners of the provider, or members of the provider governing board, or employees of the provider, or independent contractor of the provider, have in the contractors or vendors to the provider. Any person who, with the intent to defraud, knowingly causes any material false information to be included in any cost report submitted by a hospital to a state agency for reimbursement shall be guilty of an offense punishable by imprisonment in the state prison, or by a fine not exceeding $10,000, or both or by a fine and imprisonment, or by imprisonment in the county jail not exceeding one year, or by a fine not exceeding $5,000, or by both a fine and imprisonment.

Welfare & Institutions Code § 14123
Permits the director of the Department of Health Services to suspend a service provider indefinitely, with or without conditions, for violation of any provisions of the Medi-Cal statute or regulations and requires the director to suspend a provider for conviction of any felony or any misdemeanor involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of service. Suspension may be ordered after conviction, but before the time for appeal has elapsed or the judgment of conviction has been affirmed on appeal, if the Director believes that suspension would be in the best interests of the Medi-Cal program. Suspension following conviction is not subject to appeal by formal hearing. However, the director may grant an informal hearing at the request of the provider of service to determine in the director's sole discretion if the circumstances surrounding the conviction justify rescinding or otherwise modifying the suspension provided for in this subdivision. If the provider of service appeals the conviction and the conviction is reversed, the provider may apply for reinstatement, subject to a one-year waiting period, in the Medi-Cal program after the conviction is reversed. Requires the director to promptly suspend a physician or other individual practitioner whenever the director receives written notification from the Secretary of the U.S. Department of Health and Human Services, that the provider has been suspended from participation in the Medicare or Medicaid programs. As of January 1, 2017, the director is also required to notify the Administrative Director of the Division of Workers’ Compensation on the suspension. Automatic suspension is not subject to appeal by formal hearing. During suspension the provider of service is precluded from submitting claims for payment, either personally or through claims submitted by any clinic, group, corporation, or other association to the Medi-Cal program for any services or supplies the provider has provided under the program. Where the Medi-Cal statute or regulations are violated by a provider of service that is a clinic, group, corporation, or other association, the director may suspend the organization and any individual person within the
organization who is responsible for the violation. Notice of suspension must be sent to the state licensing, certifying, or registering authority, along with the evidence upon which the suspension was based.

**Welfare & Institutions Code § 14123.2**
Requires the director of the Department of Health Services to determine, in addition to any other penalties that may be prescribed by law, assessment of civil money penalties, of not more than three times the amount claimed for each item or service, and to collect penalties against any provider or person that presents or causes to be presented a claim for services that the director determines is for a medical or other item or service that the person knows or has reason to know (a) was not provided as claimed, or (b) payment for which may not be made under the program when the person or provider has been suspended from participation in the program; the Department determines that the services or items claimed are substantially in excess of the needs of individuals or are of a quality that fails to meet professionally recognized standards of health care; the Department determines that a person has demonstrated a pattern of abusive overbilling of the program; when the Department determines that a person has intentionally or negligently made a false statement or representation on any request for payment submitted to the Medi-Cal program; or (c) is submitted in violation of an agreement between the person and the state. The provider or person subjected to a civil money penalty may appeal any decision by the director to assess the penalty. Permits the imposition of civil money penalties for continuing intentional violations, in the amount of not more than three times the amount claimed for each item or service for each day the violation continues.

**Welfare & Institutions Code § 14123.25**
Authorizes the Department of Health Services to impose mandatory and permissive exclusions from the Medi-Cal program as authorized by federal regulations and impose civil money penalties against applicants and providers or against billing agents, as defined in statute, in lieu of, or in addition to, the imposition of any other sanctions available under state statute. Permits the Department to terminate, or refuse to enter into, a provider agreement for participation in the Medi-Cal program pursuant to federal law. Where the action is based upon a conviction for any crime involving fraud or abuse in the Medi-Cal, Medicaid, or Medicare programs, or an exclusion by the federal government from the Medicaid or Medicare programs, the action shall be automatic and not subject to appeal or hearing. Permits the Department to impose intermediate sanctions, as identified in federal law and regulations, against any provider that is a clinical laboratory. Permits the Department to issue a written warning notice of improper billing or improper cost report computation, which shall specifically identify the statute, regulation, or rule that is being violated, to a provider via certified mail, return receipt requested, whenever a review of the provider’s paid claims or a provider’s cost report demonstrates a pattern of improper billing or improper cost report computation. The warning notice shall provide the provider with the opportunity to contest the warning notice and explain to the department the correctness of the provider’s bill or cost report.
Permits the department to impose civil money penalties, subject to appeal, under the circumstances specified in the statute.

**Title 22 California Code of Regulations § 51000.50**
Provides procedures for processing and denial of applications for enrollment in the Medi-Cal program.

**Title 22 California Code of Regulations § 51200**
Lists grounds for suspension from the Medi-Cal program, including that a provider is discovered to be under investigation for fraud and abuse in any government program.

**Title 22 California Code of Regulations § 51458.1**
Requires Department of Health Services to recover overpayments to providers for any reason, including those enumerated in the regulation.

**Title 22 California Code of Regulations § 51460**
Upon a determination by the Department of Health Services that the provider had submitted "improper claims," including claims that incorrectly identify or code services provided, permits the Department to place any provider on special claims review, upon written notice to the provider, for specific services or all services provided. Not appealable. ("Improper claims" not defined.)

**Title 22 California Code of Regulations § 51484**
Prohibits a Medi-Cal provider from billing or submitting claims for or on behalf of any provider who has been suspended from participation in Medi-Cal for any services rendered in whole or in part by any such suspended provider during the term of such suspension.

**Title 22 California Code of Regulations §§ 51485-51485.1**
Prohibits a provider from submitting false or misleading information of material fact when complying with Medi-Cal regulations, or in connection with any claim for reimbursement, or any request for authorization of services. Permits the director of the Department of Health Services to impose civil money penalties, up to three times the amount claimed by the provider for each item or service, if Department determines that the provider knows or had reason to know that items or services were not provided as claimed, are not reimbursable under the Medi-Cal program, or were claimed in violation of an agreement with the state. An assessment of civil money penalties must be made upon written notice to the provider stating the grounds for the determination. The assessment is effective upon the 60th calendar day after the date of notice and is appealable.
Key State Health Care Cases:

People v. Duz-Mor Diagnostics Laboratory, Inc. (App. 2 Dist. 1998) 68 Cal. App. 4th 654; 80 Cal. Rptr. 2d 419 (See summary under Anti-Kickback)

People ex rel. Government Employees Insurance Company v. Cruz (2016) 244 Cal.App.4th 1184; 198 Cal.Rptr.2d 416, reh’g denied (Feb. 17, 2016)
The court held that the offense under Cal. Penal Code § 550 of presenting a false or fraudulent claim for the payment of a loss or injury is complete when a false claim for payment of loss is presented to an insurance company or a false writing is prepared or presented with intent to use it in connection with such a claim whether or not anything of value is taken or received; it is not necessary that anyone actually be defrauded or actually suffer a financial, legal, or property loss as a result of the defendant’s acts.

Chang Ho Yoo v. Shewry (2010) 186 Cal.App.4th 131; 111 Cal.Rptr.3d 322
The Department of Health Care Services was not required to pay interest on Medi-Cal payments withheld from a provider during a fraud investigation pursuant to Cal. Welf. & Inst. Code § 14107.11, since the withholdings were not considered “damages” under Cal. Civ. Code § 3287.

Allegations pertaining to federal FCA violations for defrauding the Medicare program were sufficient to plead claims under California’s False Claims Act, where the qui tam relator argued that California’s Medicaid program acted as co-insurance for patients, and was therefore defrauded in the same manner as the Medicare program.

4) UNFAIR BUSINESS PRACTICES

Business & Professions Code § 17000 et seq.
Prohibits unfair, dishonest, deceptive, destructive, fraudulent, and discriminatory practices by which fair and honest competition is destroyed or prevented. With limited exceptions, prohibits locality discriminations, sales below cost, and loss leaders. Section 17045 makes unlawful the secret payment or allowance of rebates, refunds, commissions, or unearned discounts, whether in the form of money or otherwise, or secretly extending to certain purchasers special services or privileges not extended to all purchasers purchasing upon like terms and conditions, to the injury of a competitor and where such payment or allowance tends to destroy competition. Section 17046 makes it unlawful for any person to use any threat, intimidation, or boycott, to effectuate any violation of the unfair business practices statute or for any manufacturer, wholesaler, distributor, jobber, contractor, broker, retailer, or other vendor, or any agent of any such person, to solicit any violation (Section 17047); jointly to participate or collude with any other such person in the violation (Section 17048); or enter into a contract with any service or repair agency...
for the performance of warranty service and repair for products manufactured, distributed, or sold by such person, below the cost to such service or repair agency of performing the warranty service or repair (Section 17048.5). Section 17051 voids any contract that violates these sections.

5) GENERAL WHISTLEBLOWER PROTECTIONS

**Government Code § 12653**
Prohibits employers from making, adopting, or enforcing any rule, regulation, or policy preventing an employee from disclosing information to a government or law enforcement agency or from acting in furtherance of a false claims action, including investigating, initiating, testifying, or assisting in an action filed or to be filed by the California Attorney General. Prohibits employers from discharging, demoting, suspending, threatening, harassing, denying promotion to, or in any other manner discriminating against an employee in the terms and conditions of employment because of lawful acts done by the employee on behalf of the employee or others in disclosing information to a government or law enforcement agency or in furthering a false claims action, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed by the California Attorney General. An employer is liable for all relief necessary to make the employee whole, including reinstatement with the same seniority status that the employee would have had but for the discrimination, two times the amount of back pay, interest on the back pay, compensation for any special damage sustained as a result of the discrimination, and, where appropriate, punitive damages. In addition, the defendant shall be required to pay litigation costs and reasonable attorneys' fees. An employee may bring an action in the appropriate superior court of the state for the relief provided in this subdivision. An employee who is discharged, demoted, suspended, harassed, denied promotion, or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of participation in conduct that directly or indirectly resulted in a false claim being submitted to the state or a political subdivision shall be entitled to the remedies provided if the employee voluntarily disclosed information to a government or law enforcement agency or acted in furtherance of a false claims action, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed, and the employee had been harassed, threatened with termination or demotion, or otherwise coerced by the employer or its management into engaging in the fraudulent activity in the first place.

**Insurance Code § 1871.1(k)**
Any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of lawful acts done by the employee on behalf of the employee or others in furtherance of an action under Insurance Code § 1871.1, including investigation for, initiation of, testimony for, or assistance in, an action filed or to be filed under this section, shall be entitled to all relief necessary to make the
employee whole. That relief shall include reinstatement with the same seniority status the employee would have had but for the discrimination, two times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys’ fees. An employee may bring an action in the appropriate superior court for the relief provided in this subdivision. The remedies under this section are in addition to any other remedies provided by existing law.

Government Code § 8547, et. seq.
The “California Whistleblower Protection Act” prohibits retaliation against state employees for reporting “improper governmental activity,” meaning any activity by a state agency or by an employee that is undertaken in the performance of the employee’s official duties, whether or not that action is within the scope of his or her employment, and that is in violation of any state or federal law or regulation, including, but not limited to, corruption, malfeasance, bribery, theft of government property, fraudulent claims, fraud, coercion, conversion, malicious prosecution, misuse of government property, or willful omission to perform duty, or is economically wasteful, or involves gross misconduct, incompetency, or inefficiency.

Health & Safety Code § 1278.5
Prohibits a health facility, or an entity that owns and operates a health facility, from discriminating or retaliating in any manner against any patient or employee of the health facility because that patient or employee, member of the medical staff or any other health care worker, has presented a grievance, complaint, to the facility, to an entity or agency responsible for accrediting or evaluating the facility, or the medical staff of the facility, or to any other governmental entity or initiated, participated, or cooperated in an investigation or administrative proceeding related to, the quality of care, services, or conditions at the facility that is carried out by an entity or agency responsible for accrediting or evaluating the facility or its medical staff, or governmental entity. Violation subjects the health facility to civil money penalties not to exceed $25,000 for violation of the statute, and any person who willfully violates the statute is guilty of a misdemeanor punishable by a fine of not more $75,000. Creates a rebuttable presumption that the action was taken by the health facility or the owner of the health facility in retaliation if any type of discriminatory treatment of a patient by whom, or upon whose behalf, a grievance or complaint has been submitted, directly or indirectly, to a governmental entity or received by a health facility administrator within 180 days of the filing of the grievance or complaint; or discriminatory action was taken against an employee, member of the medical staff, or any other health care worker of the facility, if responsible staff at the facility or the entity that owns or operates the facility had knowledge of the actions, participation, or cooperation of the person responsible, and the discriminatory action occurs within 120 days of the filing of the grievance or complaint by the employee, member of the medical staff or any other health care worker of the facility. Provides for remedies for a person who is the subject of prohibited discrimination including reinstatement, reimbursement for lost wages and work benefits caused by the acts of the employer, and the legal costs associated with pursuing the case. Does not apply to an inmate.
of a correctional facility of either the Department of the Youth Authority or the Department of Corrections or to an inmate housed in a local detention facility including a county jail or a juvenile hall, juvenile camp, or other juvenile detention facility. Does not apply to a long term health care facility That is subject to Health & Safety Code § 1432.

**Labor Code §§ 1102.5-1103**
Prohibits an employer from retaliation against an employee for disclosing information to a government or law enforcement agency, where the employee has reasonable cause to believe that the information discloses a violation of state or federal statute, or a violation or noncompliance with a state or federal rule or regulation. Prohibits an employer from adopting any rules or policies to prevent employees from making such disclosures. Prohibits employers from retaliating against employees for refusing to take part in an activity that would result in a violation of state or federal statute, rule, or regulation. Any employer who violates this chapter is guilty of a misdemeanor punishable, in the case of an individual, by imprisonment in the county jail not to exceed one year or a fine of not to exceed $1,000 or both and, in the case of a corporation, by a fine of not to exceed $5,000. In addition to other penalties an employer that is a corporation or a limited liability company is liable for a civil penalty not to exceed $10,000 for each violation.

**Welfare & Institutions Code § 14107.12**
Permits the Department of Justice to provide a reward to any person who furnishes information leading to the recovery of not less than $100 of public funds paid for services or goods rendered under the Medi-Cal program if there is a conviction for violation of a criminal statute within the jurisdiction of the Bureau of Medi-Cal Fraud and Elder Abuse. The reward shall not exceed 10% of the restitution recovered or $1,000, whichever is less, and may not be paid until recovery of funds is made.

The “whistleblower” statutory protections applicable to employees of state and local public entities do not supersede the statutes and rules governing the attorney-client privilege. The statutory provisions relating to the disclosure of false claims actions, communications with the Legislature, and the filing of complaints or claims or the institution of proceedings pertaining to the rights of employment by employees of state and local public entities do not supersede the statutes and rules governing the attorney-client privilege.

**Ferrick v. Santa Clara University (2014) 231 Cal.App. 4th 1337; 181 Cal.Rptr. 3d 68**
A former employee alleging wrongful termination under the whistleblower protections of Cal. Gov. Code § 12653 is required to have reasonably based suspicions of a false claim to support the action.
Fahlen v. Sutter Central Valley Hospitals (2014) 58 Cal.4th 655; 318 Cal.Rptr. 3d 165

The whistleblower protections under Health & Safety Code § 1278.5 encompass quasi-judicial hospital peer review proceedings as potentially retaliatory acts.

6) HELPFUL LINKS

- California Department of Health Care Services (DHCS)
- DHCS Audits & Investigations Division Medi-Cal Fraud Program (provides Medi-Cal Fraud hotline and examples of fraud)
- California's Medi-Cal Program
- Bureau of Medi-Cal Fraud
- California Department of Insurance (CDI)