

**§ 1001.952**

**42 CFR Ch. V (10-1-00 Edition)**

or paid any remuneration in the manner and for the purposes described therein, irrespective of whether the individual or entity may be able to prove that the remuneration was also intended for some other purpose; and

(ii) Will not exclude any individual or entity if that individual or entity can prove that the remuneration that is the subject of the exclusion is exempted from serving as the basis for an exclusion.

(b) *Length of exclusion.* (1) The following factors will be considered in determining the length of exclusion in accordance with this section—

(i) The nature and circumstances of the acts and other similar acts;

(ii) The nature and extent of any adverse physical, mental, financial or other impact the conduct had on program beneficiaries or other individuals or the Medicare or State health programs;

(iii) Whether the individual or entity has a documented history of criminal, civil or administrative wrongdoing (The lack of any prior record is to be considered neutral);

(iv) The individual or entity has been the subject of any other adverse action by any Federal, State or local government agency or board, if the adverse action is based on the same set of circumstances that serves as the basis for the imposition of the exclusion; or

(v) Any other facts bearing on the nature and seriousness of the individual's or entity's misconduct.

(2) It will be considered a mitigating factor if—

(i) The individual had a documented mental, emotional, or physical condition before or during the commission of the prohibited act(s) that reduced the individual's culpability for the acts in question;

(ii) The individual's or entity's cooperation with Federal or State officials resulted in the—

(A) Sanctioning of other individuals or entities, or

(B) Imposition of a civil money penalty against others; or

(iii) Alternative sources of the type of health care items or services pro-

vided by the individual or entity are not available.

[57 FR 3330, Jan. 29, 1992, as amended at 63 FR 46689, Sept. 2, 1998]

**§ 1001.952 Exceptions.**

The following payment practices shall not be treated as a criminal offense under section 1128B of the Act and shall not serve as the basis for an exclusion:

(a) *Investment interests.* As used in section 1128B of the Act, "remuneration" does not include any payment that is a return on an investment interest, such as a dividend or interest income, made to an investor as long as all of the applicable standards are met within one of the following three categories of entities:

(1) If, within the previous fiscal year or previous 12 month period, the entity possesses more than \$50,000,000 in undepreciated net tangible assets (based on the net acquisition cost of purchasing such assets from an unrelated entity) related to the furnishing of health care items and services, all of the following five standards must be met—

(i) With respect to an investment interest that is an equity security, the equity security must be registered with the Securities and Exchange Commission under 15 U.S.C. 781 (b) or (g).

(ii) The investment interest of an investor in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity must be obtained on terms (including any direct or indirect transferability restrictions) and at a price equally available to the public when trading on a registered securities exchange, such as the New York Stock Exchange or the American Stock Exchange, or in accordance with the National Association of Securities Dealers Automated Quotation System.

(iii) The entity or any investor must not market or furnish the entity's items or services (or those of another entity as part of a cross referral agreement) to passive investors differently than to non-investors.

(iv) The entity or any investor (or other individual or entity acting on behalf of the entity or any investor in the

entity) must not loan funds to or guarantee a loan for an investor who is in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity if the investor uses any part of such loan to obtain the investment interest.

(v) The amount of payment to an investor in return for the investment interest must be directly proportional to the amount of the capital investment of that investor.

(2) If the entity possesses investment interests that are held by either active or passive investors, all of the following eight applicable standards must be met—

(i) No more than 40 percent of the value of the investment interests of each class of investment interests may be held in the previous fiscal year or previous 12 month period by investors who are in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity. (For purposes of paragraph (a)(2)(i) of this section, equivalent classes of equity investments may be combined, and equivalent classes of debt instruments may be combined.)

(ii) The terms on which an investment interest is offered to a passive investor, if any, who is in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity must be no different from the terms offered to other passive investors.

(iii) The terms on which an investment interest is offered to an investor who is in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity must not be related to the previous or expected volume of referrals, items or services furnished, or the amount of business otherwise generated from that investor to the entity.

(iv) There is no requirement that a passive investor, if any, make referrals to, be in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity as a condition for remaining as an investor.

(v) The entity or any investor must not market or furnish the entity's items or services (or those of another entity as part of a cross referral agree-

ment) to passive investors differently than to non-investors.

(vi) No more than 40 percent of the entity's gross revenue related to the furnishing of health care items and services in the previous fiscal year or previous 12-month period may come from referrals or business otherwise generated from investors.

(vii) The entity or any investor (or other individual or entity acting on behalf of the entity or any investor in the entity) must not loan funds to or guarantee a loan for an investor who is in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity if the investor uses any part of such loan to obtain the investment interest.

(viii) The amount of payment to an investor in return for the investment interest must be directly proportional to the amount of the capital investment (including the fair market value of any pre-operational services rendered) of that investor.

(3)(i) If the entity possesses investment interests that are held by either active or passive investors and is located in an underserved area, all of the following eight standards must be met—

(A) No more than 50 percent of the value of the investment interests of each class of investments may be held in the previous fiscal year or previous 12-month period by investors who are in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for, the entity. (For purposes of paragraph (a)(3)(i)(A) of this section, equivalent classes of equity investments may be combined, and equivalent classes of debt instruments may be combined.)

(B) The terms on which an investment interest is offered to a passive investor, if any, who is in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity must be no different from the terms offered to other passive investors.

(C) The terms on which an investment interest is offered to an investor who is in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity must not be related to

the previous or expected volume of referrals, items or services furnished, or the amount of business otherwise generated from that investor to the entity.

(D) There is no requirement that a passive investor, if any, make referrals to, be in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity as a condition for remaining as an investor.

(E) The entity or any investor must not market or furnish the entity's items or services (or those of another entity as part of a cross-referral agreement) to passive investors differently than to non-investors.

(F) At least 75 percent of the dollar volume of the entity's business in the previous fiscal year or previous 12-month period must be derived from the service of persons who reside in an underserved area or are members of medically underserved populations.

(G) The entity or any investor (or other individual or entity acting on behalf of the entity or any investor in the entity) must not loan funds to or guarantee a loan for an investor who is in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity if the investor uses any part of such loan to obtain the investment interest.

(H) The amount of payment to an investor in return for the investment interest must be directly proportional to the amount of the capital investment (including the fair market value of any pre-operational services rendered) of that investor.

(ii) If an entity that otherwise meets all of the above standards is located in an area that was an underserved area at the time of the initial investment, but subsequently ceases to be an underserved area, the entity will be deemed to comply with paragraph (a)(3)(i) of this section for a period equal to the lesser of:

(A) The current term of the investment remaining after the date upon which the area ceased to be an underserved area or

(B) Three years from the date the area ceased to be an underserved area.

(4) For purposes of paragraph (a) of this section, the following terms apply. *Active investor* means an investor either

who is responsible for the day-to-day management of the entity and is a bona fide general partner in a partnership under the Uniform Partnership Act or who agrees in writing to undertake liability for the actions of the entity's agents acting within the scope of their agency. *Investment interest* means a security issued by an entity, and may include the following classes of investments: shares in a corporation, interests or units in a partnership or limited liability company, bonds, debentures, notes, or other debt instruments. *Investor* means an individual or entity either who directly holds an investment interest in an entity, or who holds such investment interest indirectly by, including but not limited to, such means as having a family member hold such investment interest or holding a legal or beneficial interest in another entity (such as a trust or holding company) that holds such investment interest. *Passive investor* means an investor who is not an active investor, such as a limited partner in a partnership under the Uniform Partnership Act, a shareholder in a corporation, or a holder of a debt security. *Underserved area* means any defined geographic area that is designated as a Medically Underserved Area (MUA) in accordance with regulations issued by the Department. *Medically underserved population* means a Medically Underserved Population (MUP) in accordance with regulations issued by the Department.

(b) *Space rental*. As used in section 1128B of the Act, "remuneration" does not include any payment made by a lessee to a lessor for the use of premises, as long as all of the following six standards are met—

(1) The lease agreement is set out in writing and signed by the parties.

(2) The lease covers all of the premises leased between the parties for the term of the lease and specifies the premises covered by the lease.

(3) If the lease is intended to provide the lessee with access to the premises for periodic intervals of time, rather than on a full-time basis for the term of the lease, the lease specifies exactly the schedule of such intervals, their precise length, and the exact rent for such intervals.

(4) The term of the lease is for not less than one year.

(5) The aggregate rental charge is set in advance, is consistent with fair market value in arms-length transactions and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under Medicare or a State health care program.

(6) The aggregate space rented does not exceed that which is reasonably necessary to accomplish the commercially reasonable business purpose of the rental.

For purposes of paragraph (b) of this section, the term *fair market value* means the value of the rental property for general commercial purposes, but shall not be adjusted to reflect the additional value that one party (either the prospective lessee or lessor) would attribute to the property as a result of its proximity or convenience to sources of referrals or business otherwise generated for which payment may be made in whole or in part under Medicare or a State health care program.

(c) *Equipment rental.* As used in section 1128B of the Act, “remuneration” does not include any payment made by a lessee of equipment to the lessor of the equipment for the use of the equipment, as long as all of the following six standards are met—

(1) The lease agreement is set out in writing and signed by the parties.

(2) The lease covers all of the equipment leased between the parties for the term of the lease and specifies the equipment covered by the lease.

(3) If the lease is intended to provide the lessee with use of the equipment for periodic intervals of time, rather than on a full-time basis for the term of the lease, the lease specifies exactly the schedule of such intervals, their precise length, and the exact rent for such interval.

(4) The term of the lease is for not less than one year.

(5) The aggregate rental charge is set in advance, is consistent with fair market value in arms-length transactions and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise

generated between the parties for which payment may be made in whole or in part under Medicare or a State health care program.

(6) The aggregate equipment rental does not exceed that which is reasonably necessary to accomplish the commercially reasonable business purpose of the rental.

For purposes of paragraph (c) of this section, the term *fair market value* means the value of the equipment when obtained from a manufacturer or professional distributor, but shall not be adjusted to reflect the additional value one party (either the prospective lessee or lessor) would attribute to the equipment as a result of its proximity or convenience to sources of referrals or business otherwise generated for which payment may be made in whole or in part under Medicare or a State health care program.

(d) *Personal services and management contracts.* As used in section 1128B of the Act, “remuneration” does not include any payment made by a principal to an agent as compensation for the services of the agent, as long as all of the following seven standards are met—

(1) The agency agreement is set out in writing and signed by the parties.

(2) The agency agreement covers all of the services the agent provides to the principal for the term of the agreement and specifies the services to be provided by the agent.

(3) If the agency agreement is intended to provide for the services of the agent on a periodic, sporadic or part-time basis, rather than on a full-time basis for the term of the agreement, the agreement specifies exactly the schedule of such intervals, their precise length, and the exact charge for such intervals.

(4) The term of the agreement is for not less than one year.

(5) The aggregate compensation paid to the agent over the term of the agreement is set in advance, is consistent with fair market value in arms-length transactions and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under

Medicare or a State health care program.

(6) The services performed under the agreement do not involve the counseling or promotion of a business arrangement or other activity that violates any State or Federal law.

(7) The aggregate services contracted for do not exceed those which are reasonably necessary to accomplish the commercially reasonable business purpose of the services.

For purposes of paragraph (d) of this section, an agent of a principal is any person, other than a bona fide employee of the principal, who has an agreement to perform services for, or on behalf of, the principal.

(e) *Sale of practice.* (1) As used in section 1128B of the Act, "remuneration" does not include any payment made to a practitioner by another practitioner where the former practitioner is selling his or her practice to the latter practitioner, as long as both of the following two standards are met—

(i) The period from the date of the first agreement pertaining to the sale to the completion of the sale is not more than one year.

(ii) The practitioner who is selling his or her practice will not be in a professional position to make referrals to, or otherwise generate business for, the purchasing practitioner for which payment may be made in whole or in part under Medicare or a State health care program after one year from the date of the first agreement pertaining to the sale.

(2) As used in section 1128B of the Act, "remuneration" does not include any payment made to a practitioner by a hospital or other entity where the practitioner is selling his or her practice to the hospital or other entity, so long as the following four standards are met:

(i) The period from the date of the first agreement pertaining to the sale to the completion date of the sale is not more than three years.

(ii) The practitioner who is selling his or her practice will not be in a professional position after completion of the sale to make or influence referrals to, or otherwise generate business for, the purchasing hospital or entity for which payment may be made in whole

or in part under Medicare or a State health care program.

(iii) The practice being acquired must be located in a Health Professional Shortage Area (HPSA), as defined in Departmental regulations, for the practitioner's specialty area.

(iv) Commencing at the time of the first agreement pertaining to the sale, the purchasing hospital or entity must diligently and in good faith engage in commercially reasonable recruitment activities that:

(A) May reasonably be expected to result in the recruitment of a new practitioner to take over the acquired practice within a one year period and

(B) Will satisfy the conditions of the practitioner recruitment safe harbor in accordance with paragraph (n) of this section.

(f) *Referral services.* As used in section 1128B of the Act, "remuneration" does not include any payment or exchange of anything of value between an individual or entity ("participant") and another entity serving as a referral service ("referral service"), as long as all of the following four standards are met—

(1) The referral service does not exclude as a participant in the referral service any individual or entity who meets the qualifications for participation.

(2) Any payment the participant makes to the referral service is assessed equally against and collected equally from all participants, and is only based on the cost of operating the referral service, and not on the volume or value of any referrals to or business otherwise generated by either party for the other party for which payment may be made in whole or in part under Medicare or a State health care program.

(3) The referral service imposes no requirements on the manner in which the participant provides services to a referred person, except that the referral service may require that the participant charge the person referred at the same rate as it charges other persons not referred by the referral service, or that these services be furnished free of charge or at reduced charge.

(4) The referral service makes the following five disclosures to each person

seeking a referral, with each such disclosure maintained by the referral service in a written record certifying such disclosure and signed by either such person seeking a referral or by the individual making the disclosure on behalf of the referral service—

(i) The manner in which it selects the group of participants in the referral service to which it could make a referral;

(ii) Whether the participant has paid a fee to the referral service;

(iii) The manner in which it selects a particular participant from this group for that person;

(iv) The nature of the relationship between the referral service and the group of participants to whom it could make the referral; and

(v) The nature of any restrictions that would exclude such an individual or entity from continuing as a participant.

(g) *Warranties.* As used in section 1128B of the Act, “remuneration” does not include any payment or exchange of anything of value under a warranty provided by a manufacturer or supplier of an item to the buyer (such as a health care provider or beneficiary) of the item, as long as the buyer complies with all of the following standards in paragraphs (g)(1) and (g)(2) of this section and the manufacturer or supplier complies with all of the following standards in paragraphs (g)(3) and (g)(4) of this section—

(1) The buyer must fully and accurately report any price reduction of the item (including a free item), which was obtained as part of the warranty, in the applicable cost reporting mechanism or claim for payment filed with the Department or a State agency.

(2) The buyer must provide, upon request by the Secretary or a State agency, information provided by the manufacturer or supplier as specified in paragraph (g)(3) of this section.

(3) The manufacturer or supplier must comply with either of the following two standards—

(i) The manufacturer or supplier must fully and accurately report the price reduction of the item (including a free item), which was obtained as part of the warranty, on the invoice or statement submitted to the buyer, and

inform the buyer of its obligations under paragraphs (a)(1) and (a)(2) of this section.

(ii) Where the amount of the price reduction is not known at the time of sale, the manufacturer or supplier must fully and accurately report the existence of a warranty on the invoice or statement, inform the buyer of its obligations under paragraphs (g)(1) and (g)(2) of this section, and, when the price reduction becomes known, provide the buyer with documentation of the calculation of the price reduction resulting from the warranty.

(4) The manufacturer or supplier must not pay any remuneration to any individual (other than a beneficiary) or entity for any medical, surgical, or hospital expense incurred by a beneficiary other than for the cost of the item itself.

For purposes of paragraph (g) of this section, the term *warranty* means either an agreement made in accordance with the provisions of 15 U.S.C. 2301(6), or a manufacturer’s or supplier’s agreement to replace another manufacturer’s or supplier’s defective item (which is covered by an agreement made in accordance with this statutory provision), on terms equal to the agreement that it replaces.

(h) *Discounts.* As used in section 1128B of the Act, “remuneration” does not include a discount, as defined in paragraph (h)(5) of this section, on an item or service for which payment may be made, in whole or in part, under Medicare or a State health care program for a *buyer* as long as the buyer complies with the applicable standards of paragraph (h)(1) of this section; a *seller* as long as the seller complies with the applicable standards of paragraph (h)(2) of this section; and an *offeror* of a discount who is not a seller under paragraph (h)(2) of this section so long as such offeror complies with the applicable standards of paragraph (h)(3) of this section:

(1) With respect to the following three categories of buyers, the buyer must comply with all of the applicable standards within one of the three following categories—

(i) If the buyer is an entity which is a health maintenance organization (HMO) or a competitive medical plan

(CMP) acting in accordance with a risk contract under section 1876(g) or 1903(m) of the Act, or under another State health care program, it need not report the discount except as otherwise may be required under the risk contract.

(ii) If the buyer is an entity which reports its costs on a cost report required by the Department or a State health care program, it must comply with all of the following four standards—

(A) The discount must be earned based on purchases of that same good or service bought within a single fiscal year of the buyer;

(B) The buyer must claim the benefit of the discount in the fiscal year in which the discount is earned or the following year;

(C) The buyer must fully and accurately report the discount in the applicable cost report; and

(D) the buyer must provide, upon request by the Secretary or a State agency, information provided by the seller as specified in paragraph (h)(2)(ii) of this section, or information provided by the offeror as specified in paragraph (h)(3)(ii) of this section.

(iii) If the buyer is an individual or entity in whose name a claim or request for payment is submitted for the discounted item or service and payment may be made, in whole or in part, under Medicare or a State health care program (not including individuals or entities defined as buyers in paragraph (h)(1)(i) or (h)(1)(ii) of this section), the buyer must comply with both of the following standards—

(A) The discount must be made at the time of the sale of the good or service or the terms of the rebate must be fixed and disclosed in writing to the buyer at the time of the initial sale of the good or service; and

(B) the buyer (if submitting the claim) must provide, upon request by the Secretary or a State agency, information provided by the seller as specified in paragraph (h)(2)(iii)(B) of this section, or information provided by the offeror as specified in paragraph (h)(3)(iii)(A) of this section.

(2) The seller is an individual or entity that supplies an item or service for which payment may be made, in whole or in part, under Medicare or a State

health care program to the buyer and who permits a discount to be taken off the buyer's purchase price. The seller must comply with all of the applicable standards within the following three categories—

(i) If the buyer is an entity which is an HMO a CMP acting in accordance with a risk contract under section 1876(g) or 1903(m) of the Act, or under another State health care program, the seller need not report the discount to the buyer for purposes of this provision.

(ii) If the buyer is an entity that reports its costs on a cost report required by the Department or a State agency, the seller must comply with either of the following two standards—

(A) Where a discount is required to be reported to Medicare or a State health care program under paragraph (h)(1) of this section, the seller must fully and accurately report such discount on the invoice, coupon or statement submitted to the buyer; inform the buyer in a manner that is reasonably calculated to give notice to the buyer of its obligations to report such discount and to provide information upon request under paragraph (h)(1) of this section; and refrain from doing anything that would impede the buyer from meeting its obligations under this paragraph; or

(B) Where the value of the discount is not known at the time of sale, the seller must fully and accurately report the existence of a discount program on the invoice, coupon or statement submitted to the buyer; inform the buyer in a manner reasonably calculated to give notice to the buyer of its obligations to report such discount and to provide information upon request under paragraph (h)(1) of this section; when the value of the discount becomes known, provide the buyer with documentation of the calculation of the discount identifying the specific goods or services purchased to which the discount will be applied; and refrain from doing anything which would impede the buyer from meeting its obligations under this paragraph.

(iii) If the buyer is an individual or entity not included in paragraph (h)(2)(i) or (h)(2)(ii) of this section, the

seller must comply with either of the following two standards—

(A) Where the seller submits a claim or request for payment on behalf of the buyer and the item or service is separately claimed, the seller must provide, upon request by the Secretary or a State agency, information provided by the offeror as specified in paragraph (h)(3)(iii)(A) of this section; or

(B) Where the buyer submits a claim, the seller must fully and accurately report such discount on the invoice, coupon or statement submitted to the buyer; inform the buyer in a manner reasonably calculated to give notice to the buyer of its obligations to report such discount and to provide information upon request under paragraph (h)(1) of this section; and refrain from doing anything that would impede the buyer from meeting its obligations under this paragraph.

(3) The offeror of a discount is an individual or entity who is not a seller under paragraph (h)(2) of this section, but promotes the purchase of an item or service by a buyer under paragraph (h)(1) of this section at a reduced price for which payment may be made, in whole or in part, under Medicare or a State health care program. The offeror must comply with all of the applicable standards within the following three categories—

(i) If the buyer is an entity which is an HMO or a CMP acting in accordance with a risk contract under section 1876(g) or 1903(m) of the Act, or under another State health care program, the offeror need not report the discount to the buyer for purposes of this provision.

(ii) If the buyer is an entity that reports its costs on a cost report required by the Department or a State agency, the offeror must comply with the following two standards—

(A) The offeror must inform the buyer in a manner reasonably calculated to give notice to the buyer of its obligations to report such a discount and to provide information upon request under paragraph (h)(1) of this section; and

(B) The offeror of the discount must refrain from doing anything that would impede the buyer's ability to meet its obligations under this paragraph.

(iii) If the buyer is an individual or entity in whose name a request for payment is submitted for the discounted item or service and payment may be made, in whole or in part, under Medicare or a State health care program (not including individuals or entities defined as buyers in paragraph (h)(1)(i) or (h)(1)(ii) of this section), the offeror must comply with the following two standards—

(A) The offeror must inform the individual or entity submitting the claim or request for payment in a manner reasonably calculated to give notice to the individual or entity of its obligations to report such a discount and to provide information upon request under paragraphs (h)(1) and (h)(2) of this section; and

(B) The offeror of the discount must refrain from doing anything that would impede the buyer's or seller's ability to meet its obligations under this paragraph.

(4) For purposes of this paragraph, a *rebate* is any discount the terms of which are fixed and disclosed in writing to the buyer at the time of the initial purchase to which the discount applies, but which is not given at the time of sale.

(5) For purposes of this paragraph, the term *discount* means a reduction in the amount a buyer (who buys either directly or through a wholesaler or a group purchasing organization) is charged for an item or service based on an arms-length transaction. The term *discount* does not include—

(i) Cash payment or cash equivalents (except that rebates as defined in paragraph (h)(4) of this section may be in the form of a check);

(ii) Supplying one good or service without charge or at a reduced charge to induce the purchase of a different good or service, unless the goods and services are reimbursed by the same Federal health care program using the same methodology and the reduced charge is fully disclosed to the Federal health care program and accurately reflected where appropriate, and as appropriate, to the reimbursement methodology;

(iii) A reduction in price applicable to one payer but not to Medicare or a State health care program;

(iv) A routine reduction or waiver of any coinsurance or deductible amount owed by a program beneficiary;

(v) Warranties;

(vi) Services provided in accordance with a personal or management services contract; or

(vii) Other remuneration, in cash or in kind, not explicitly described in paragraph (h)(5) of this section.

(i) *Employees.* As used in section 1128B of the Act, “remuneration” does not include any amount paid by an employer to an employee, who has a bona fide employment relationship with the employer, for employment in the furnishing of any item or service for which payment may be made in whole or in part under Medicare or a State health care program. For purposes of paragraph (i) of this section, the term *employee* has the same meaning as it does for purposes of 26 U.S.C. 3121(d)(2).

(j) *Group purchasing organizations.* As used in section 1128B of the Act, “remuneration” does not include any payment by a vendor of goods or services to a group purchasing organization (GPO), as part of an agreement to furnish such goods or services to an individual or entity as long as both of the following two standards are met—

(1) The GPO must have a written agreement with each individual or entity, for which items or services are furnished, that provides for either of the following—

(i) The agreement states that participating vendors from which the individual or entity will purchase goods or services will pay a fee to the GPO of 3 percent or less of the purchase price of the goods or services provided by that vendor.

(ii) In the event the fee paid to the GPO is not fixed at 3 percent or less of the purchase price of the goods or services, the agreement specifies the amount (or if not known, the maximum amount) the GPO will be paid by each vendor (where such amount may be a fixed sum or a fixed percentage of the value of purchases made from the vendor by the members of the group under the contract between the vendor and the GPO).

(2) Where the entity which receives the goods or service from the vendor is a health care provider of services, the

GPO must disclose in writing to the entity at least annually, and to the Secretary upon request, the amount received from each vendor with respect to purchases made by or on behalf of the entity.

For purposes of paragraph (j) of this section, the term *group purchasing organization* (GPO) means an entity authorized to act as a purchasing agent for a group of individuals or entities who are furnishing services for which payment may be made in whole or in part under Medicare or a State health care program, and who are neither wholly-owned by the GPO nor subsidiaries of a parent corporation that wholly owns the GPO (either directly or through another wholly-owned entity).

(k) *Waiver of beneficiary coinsurance and deductible amounts.* As used in section 1128B of the Act, “remuneration” does not include any reduction or waiver of a Medicare or a State health care program beneficiary’s obligation to pay coinsurance or deductible amounts as long as all of the standards are met within either of the following two categories of health care providers:

(1) If the coinsurance or deductible amounts are owed to a hospital for inpatient hospital services for which Medicare pays under the prospective payment system, the hospital must comply with all of the following three standards—

(i) The hospital must not later claim the amount reduced or waived as a bad debt for payment purposes under Medicare or otherwise shift the burden of the reduction or waiver onto Medicare, a State health care program, other payers, or individuals.

(ii) The hospital must offer to reduce or waive the coinsurance or deductible amounts without regard to the reason for admission, the length of stay of the beneficiary, or the diagnostic related group for which the claim for Medicare reimbursement is filed.

(iii) The hospital’s offer to reduce or waive the coinsurance or deductible amounts must not be made as part of a price reduction agreement between a hospital and a third-party payer (including a health plan as defined in paragraph (l)(2) of this section), unless the agreement is part of a contract for

the furnishing of items or services to a beneficiary of a Medicare supplemental policy issued under the terms of section 1882(t)(1) of the Act.

(2) If the coinsurance or deductible amounts are owed by an individual who qualifies for subsidized services under a provision of the Public Health Services Act or under titles V or XIX of the Act to a federally qualified health care center or other health care facility under any Public Health Services Act grant program or under title V of the Act, the health care center or facility may reduce or waive the coinsurance or deductible amounts for items or services for which payment may be made in whole or in part under part B of Medicare or a State health care program.

(l) *Increased coverage, reduced cost-sharing amounts, or reduced premium amounts offered by health plans.* (1) As used in section 1128B of the Act, “remuneration” does not include the additional coverage of any item or service offered by a health plan to an enrollee or the reduction of some or all of the enrollee’s obligation to pay the health plan or a contract health care provider for cost-sharing amounts (such as coinsurance, deductible, or copayment amounts) or for premium amounts attributable to items or services covered by the health plan, the Medicare program, or a State health care program, as long as the health plan complies with all of the standards within one of the following two categories of health plans:

(i) If the health plan is a risk-based health maintenance organization, competitive medical plan, prepaid health plan, or other health plan under contract with HCFA or a State health care program and operating in accordance with section 1876(g) or 1903(m) of the Act, under a Federal statutory demonstration authority, or under other Federal statutory or regulatory authority, it must offer the same increased coverage or reduced cost-sharing or premium amounts to all Medicare or State health care program enrollees covered by the contract unless otherwise approved by HCFA or by a State health care program.

(ii) If the health plan is a health maintenance organization, competitive medical plan, health care prepayment

plan, prepaid health plan or other health plan that has executed a contract or agreement with HCFA or with a State health care program to receive payment for enrollees on a reasonable cost or similar basis, it must comply with both of the following two standards—

(A) The health plan must offer the same increased coverage or reduced cost-sharing or premium amounts to all Medicare or State health care program enrollees covered by the contract or agreement unless otherwise approved by HCFA or by a State health care program; and

(B) The health plan must not claim the costs of the increased coverage or the reduced cost-sharing or premium amounts as a bad debt for payment purposes under Medicare or a State health care program or otherwise shift the burden of the increased coverage or reduced cost-sharing or premium amounts to the extent that increased payments are claimed from Medicare or a State health care program.

(2) For purposes of paragraph (l) of this section, the terms—

*Contract health care provider* means an individual or entity under contract with a health plan to furnish items or services to enrollees who are covered by the health plan, Medicare, or a State health care program.

*Enrollee* means an individual who has entered into a contractual relationship with a health plan (or on whose behalf an employer, or other private or governmental entity has entered into such a relationship) under which the individual is entitled to receive specified health care items and services, or insurance coverage for such items and services, in return for payment of a premium or a fee.

*Health plan* means an entity that furnishes or arranges under agreement with contract health care providers for the furnishing of items or services to enrollees, or furnishes insurance coverage for the provision of such items and services, in exchange for a premium or a fee, where such entity:

(i) Operates in accordance with a contract, agreement or statutory demonstration authority approved by HCFA or a State health care program;

(ii) Charges a premium and its premium structure is regulated under a State insurance statute or a State enabling statute governing health maintenance organizations or preferred provider organizations;

(iii) Is an employer, if the enrollees of the plan are current or retired employees, or is a union welfare fund, if the enrollees of the plan are union members; or

(iv) Is licensed in the State, is under contract with an employer, union welfare fund, or a company furnishing health insurance coverage as described in conditions (ii) and (iii) of this definition, and is paid a fee for the administration of the plan which reflects the fair market value of those services.

(m) *Price reductions offered to health plans.* (1) As used in section 1128B of the Act, "remuneration" does not include a reduction in price a contract health care provider offers to a health plan in accordance with the terms of a written agreement between the contract health care provider and the health plan for the sole purpose of furnishing to enrollees items or services that are covered by the health plan, Medicare, or a State health care program, as long as both the health plan and contract health care provider comply with all of the applicable standards within one of the following four categories of health plans:

(i) If the health plan is a risk-based health maintenance organization, competitive medical plan, or prepaid health plan under contract with HCFA or a State agency and operating in accordance with section 1876(g) or 1903(m) of the Act, under a Federal statutory demonstration authority, or under other Federal statutory or regulatory authority, the contract health care provider must not claim payment in any form from the Department or the State agency for items or services furnished in accordance with the agreement except as approved by HCFA or the State health care program, or otherwise shift the burden of such an agreement to the extent that increased payments are claimed from Medicare or a State health care program.

(ii) If the health plan is a health maintenance organization, competitive medical plan, health care prepayment

plan, prepaid health plan, or other health plan that has executed a contract or agreement with HCFA or a State health care program to receive payment for enrollees on a reasonable cost or similar basis, the health plan and contract health care provider must comply with all of the following four standards—

(A) The term of the agreement between the health plan and the contract health care provider must be for not less than one year;

(B) The agreement between the health plan and the contract health care provider must specify in advance the covered items and services to be furnished to enrollees, and the methodology for computing the payment to the contract health care provider;

(C) The health plan must fully and accurately report, on the applicable cost report or other claim form filed with the Department or the State health care program, the amount it has paid the contract health care provider under the agreement for the covered items and services furnished to enrollees; and

(D) The contract health care provider must not claim payment in any form from the Department or the State health care program for items or services furnished in accordance with the agreement except as approved by HCFA or the State health care program, or otherwise shift the burden of such an agreement to the extent that increased payments are claimed from Medicare or a State health care program.

(iii) If the health plan is not described in paragraphs (m)(1)(i) or (m)(1)(ii) of this section and the contract health care provider is not paid on an at-risk, capitated basis, both the health plan and contract health care provider must comply with all of the following six standards—

(A) The term of the agreement between the health plan and the contract health care provider must be for not less than one year;

(B) The agreement between the health plan and the contract health care provider must specify in advance the covered items and services to be furnished to enrollees, which party is to file claims or requests for payment with Medicare or the State health care

program for such items and services, and the schedule of fees the contract health care provider will charge for furnishing such items and services to enrollees;

(C) The fee schedule contained in the agreement between the health plan and the contract health care provider must remain in effect throughout the term of the agreement, unless a fee increase results directly from a payment update authorized by Medicare or the State health care program;

(D) The party submitting claims or requests for payment from Medicare or the State health care program for items and services furnished in accordance with the agreement must not claim or request payment for amounts in excess of the fee schedule;

(E) The contract health care provider and the health plan must fully and accurately report on any cost report filed with Medicare or a State health care program the fee schedule amounts charged in accordance with the agreement and, upon request, will report to the Medicare or a State health care program the terms of the agreement and the amounts paid in accordance with the agreement; and

(F) The party to the agreement, which does not have the responsibility under the agreement for filing claims or requests for payment, must not claim or request payment in any form from the Department or the State health care program for items or services furnished in accordance with the agreement, or otherwise shift the burden of such an agreement to the extent that increased payments are claimed from Medicare or a State health care program.

(iv) If the health plan is not described in paragraphs (m)(1)(i) or (m)(1)(ii) of this section, and the contract health care provider is paid on an at-risk, capitated basis, both the health plan and contract health care provider must comply with all of the following five standards—

(A) The term of the agreement between the health plan and the contract health provider must be for not less than one year;

(B) The agreement between the health plan and the contract health provider must specify in advance the

covered items and services to be furnished to enrollees and the total amount per enrollee (which may be expressed in a per month or other time period basis) the contract health care provider will be paid by the health plan for furnishing such items and services to enrollees and must set forth any co-payments, if any, to be paid by enrollees to the contract health care provider for covered services;

(C) The payment amount contained in the agreement between the health care plan and the contract health care provider must remain in effect throughout the term of the agreement;

(D) The contract health care provider and the health plan must fully and accurately report to the Medicare and State health care program upon request, the terms of the agreement and the amounts paid in accordance with the agreement; and

(E) The contract health care provider must not claim or request payment in any form from the Department, a State health care program or an enrollee (other than copayment amounts described in paragraph (m)(2)(iv)(B) of this section) and the health plan must not pay the contract care provider in excess of the amounts described in paragraph (m)(2)(iv)(B) of this section for items and services covered by the agreement.

(2) For purposes of this paragraph, the terms *contract health care provider*, *enrollee*, and *health plan* have the same meaning as in paragraph (l)(2) of this section.

(n) *Practitioner recruitment*. As used in section 1128B of the Act, “remuneration” does not include any payment or exchange of anything of value by an entity in order to induce a practitioner who has been practicing within his or her current specialty for less than one year to locate, or to induce any other practitioner to relocate, his or her primary place of practice into a HPSA for his or her specialty area, as defined in Departmental regulations, that is served by the entity, as long as all of the following nine standards are met—

(1) The arrangement is set forth in a written agreement signed by the parties that specifies the benefits provided by the entity, the terms under which

the benefits are to be provided, and the obligations of each party.

(2) If a practitioner is leaving an established practice, at least 75 percent of the revenues of the new practice must be generated from new patients not previously seen by the practitioner at his or her former practice.

(3) The benefits are provided by the entity for a period not in excess of 3 years, and the terms of the agreement are not renegotiated during this 3-year period in any substantial aspect; provided, however, that if the HPSA to which the practitioner was recruited ceases to be a HPSA during the term of the written agreement, the payments made under the written agreement will continue to satisfy this paragraph for the duration of the written agreement (not to exceed 3 years).

(4) There is no requirement that the practitioner make referrals to, be in a position to make or influence referrals to, or otherwise generate business for the entity as a condition for receiving the benefits; provided, however, that for purposes of this paragraph, the entity may require as a condition for receiving benefits that the practitioner maintain staff privileges at the entity.

(5) The practitioner is not restricted from establishing staff privileges at, referring any service to, or otherwise generating any business for any other entity of his or her choosing.

(6) The amount or value of the benefits provided by the entity may not vary (or be adjusted or renegotiated) in any manner based on the volume or value of any expected referrals to or business otherwise generated for the entity by the practitioner for which payment may be made in whole or in part under Medicare or a State health care program.

(7) The practitioner agrees to treat patients receiving medical benefits or assistance under any Federal health care program in a nondiscriminatory manner.

(8) At least 75 percent of the revenues of the new practice must be generated from patients residing in a HPSA or a Medically Underserved Area (MUA) or who are part of a Medically Underserved Population (MUP), all as defined in paragraph (a) of this section.

(9) The payment or exchange of anything of value may not directly or indirectly benefit any person (other than the practitioner being recruited) or entity in a position to make or influence referrals to the entity providing the recruitment payments or benefits of items or services payable by a Federal health care program.

(o) *Obstetrical malpractice insurance subsidies.* As used in section 1128B of the Act, "remuneration" does not include any payment made by a hospital or other entity to another entity that is providing malpractice insurance (including a self-funded entity), where such payment is used to pay for some or all of the costs of malpractice insurance premiums for a practitioner (including a certified nurse-midwife as defined in section 1861(gg) of the Act) who engages in obstetrical practice as a routine part of his or her medical practice in a primary care HPSA, as long as all of the following seven standards are met—

(1) The payment is made in accordance with a written agreement between the entity paying the premiums and the practitioner, which sets out the payments to be made by the entity, and the terms under which the payments are to be provided.

(2)(i) The practitioner must certify that for the initial coverage period (not to exceed one year) the practitioner has a reasonable basis for believing that at least 75 percent of the practitioner's obstetrical patients treated under the coverage of the malpractice insurance will either—

(A) Reside in a HPSA or MUA, as defined in paragraph (a) of this section; or

(B) Be part of a MUP, as defined in paragraph (a) of this section.

(ii) Thereafter, for each additional coverage period (not to exceed one year), at least 75 percent of the practitioner's obstetrical patients treated under the prior coverage period (not to exceed one year) must have—

(A) Resided in a HPSA or MUA, as defined in paragraph (a) of this section; or

(B) Been part of a MUP, as defined in paragraph (a) of this section.

(3) There is no requirement that the practitioner make referrals to, or otherwise generate business for, the entity as a condition for receiving the benefits.

(4) The practitioner is not restricted from establishing staff privileges at, referring any service to, or otherwise generating any business for any other entity of his or her choosing.

(5) The amount of payment may not vary based on the volume or value of any previous or expected referrals to or business otherwise generated for the entity by the practitioner for which payment may be made in whole or in part under Medicare or a State health care program.

(6) The practitioner must treat obstetrical patients who receive medical benefits or assistance under any Federal health care program in a non-discriminatory manner.

(7) The insurance is a bona fide malpractice insurance policy or program, and the premium, if any, is calculated based on a bona fide assessment of the liability risk covered under the insurance. For purposes of paragraph (o) of this section, *costs of malpractice insurance premiums* means:

(i) For practitioners who engage in obstetrical practice full-time, any costs attributable to malpractice insurance; or

(ii) For practitioners who engage in obstetrical practice on a part-time or sporadic basis, the costs:

(A) Attributable exclusively to the obstetrical portion of the practitioner's malpractice insurance and

(B) Related exclusively to obstetrical services provided in a primary care HPSA.

(p) *Investments in group practices.* As used in section 1128B of the Act, "remuneration" does not include any payment that is a return on an investment interest, such as a dividend or interest income, made to a solo or group practitioner investing in his or her own practice or group practice if the following four standards are met—

(1) The equity interests in the practice or group must be held by licensed health care professionals who practice in the practice or group.

(2) The equity interests must be in the practice or group itself, and not

some subdivision of the practice or group.

(3) In the case of group practices, the practice must:

(i) Meet the definition of "group practice" in section 1877(h)(4) of the Social Security Act and implementing regulations; and

(ii) Be a unified business with centralized decision-making, pooling of expenses and revenues, and a compensation/profit distribution system that is not based on satellite offices operating substantially as if they were separate enterprises or profit centers.

(4) Revenues from ancillary services, if any, must be derived from "in-office ancillary services" that meet the definition of such term in section 1877(b)(2) of the Act and implementing regulations.

(q) *Cooperative hospital service organizations.* As used in section 1128B of the Act, "remuneration" does not include any payment made between a cooperative hospital service organization (CHSO) and its patron-hospital, both of which are described in section 501(e) of the Internal Revenue Code of 1986 and are tax-exempt under section 501(c)(3) of the Internal Revenue Code, where the CHSO is wholly owned by two or more patron-hospitals, as long as the following standards are met—

(1) If the patron-hospital makes a payment to the CHSO, the payment must be for the purpose of paying for the bona fide operating expenses of the CHSO, or

(2) If the CHSO makes a payment to the patron-hospital, the payment must be for the purpose of paying a distribution of net earnings required to be made under section 501(e)(2) of the Internal Revenue Code of 1986.

(r) *Ambulatory surgical centers.* As used in section 1128B of the Act, "remuneration" does not include any payment that is a return on an investment interest, such as a dividend or interest income, made to an investor, as long as the investment entity is a certified ambulatory surgical center (ASC) under part 416 of this title, whose operating and recovery room space is dedicated exclusively to the ASC, patients referred to the investment entity by an investor are fully informed of the investor's investment interest, and all of

the applicable standards are met within one of the following four categories—

(1) *Surgeon-owned ASCs*—If all of the investors are general surgeons or surgeons engaged in the same surgical specialty, who are in a position to refer patients directly to the entity and perform surgery on such referred patients; surgical group practices (as defined in this paragraph) composed exclusively of such surgeons; or investors who are not employed by the entity or by any investor, are not in a position to provide items or services to the entity or any of its investors, and are not in a position to make or influence referrals directly or indirectly to the entity or any of its investors, all of the following six standards must be met—

(i) The terms on which an investment interest is offered to an investor must not be related to the previous or expected volume of referrals, services furnished, or the amount of business otherwise generated from that investor to the entity.

(ii) At least one-third of each surgeon investor's medical practice income from all sources for the previous fiscal year or previous 12-month period must be derived from the surgeon's performance of procedures (as defined in this paragraph).

(iii) The entity or any investor (or other individual or entity acting on behalf of the entity or any investor) must not loan funds to or guarantee a loan for an investor if the investor uses any part of such loan to obtain the investment interest.

(iv) The amount of payment to an investor in return for the investment must be directly proportional to the amount of the capital investment (including the fair market value of any pre-operational services rendered) of that investor.

(v) All ancillary services for Federal health care program beneficiaries performed at the entity must be directly and integrally related to primary procedures performed at the entity, and none may be separately billed to Medicare or other Federal health care programs.

(vi) The entity and any surgeon investors must treat patients receiving medical benefits or assistance under

any Federal health care program in a nondiscriminatory manner.

(2) *Single-Specialty ASCs*—If all of the investors are physicians engaged in the same medical practice specialty who are in a position to refer patients directly to the entity and perform procedures on such referred patients; group practices (as defined in this paragraph) composed exclusively of such physicians; or investors who are not employed by the entity or by any investor, are not in a position to provide items or services to the entity or any of its investors, and are not in a position to make or influence referrals directly or indirectly to the entity or any of its investors, all of the following six standards must be met—

(i) The terms on which an investment interest is offered to an investor must not be related to the previous or expected volume of referrals, services furnished, or the amount of business otherwise generated from that investor to the entity.

(ii) At least one-third of each physician investor's medical practice income from all sources for the previous fiscal year or previous 12-month period must be derived from the surgeon's performance of procedures (as defined in this paragraph).

(iii) The entity or any investor (or other individual or entity acting on behalf of the entity or any investor) must not loan funds to or guarantee a loan for an investor if the investor uses any part of such loan to obtain the investment interest.

(iv) The amount of payment to an investor in return for the investment must be directly proportional to the amount of the capital investment (including the fair market value of any pre-operational services rendered) of that investor.

(v) All ancillary services for Federal health care program beneficiaries performed at the entity must be directly and integrally related to primary procedures performed at the entity, and none may be separately billed to Medicare or other Federal health care programs.

(vi) The entity and any physician investors must treat patients receiving medical benefits or assistance under

any Federal health care program in a nondiscriminatory manner.

(3) *Multi-Specialty ASCs*—If all of the investors are physicians who are in a position to refer patients directly to the entity and perform procedures on such referred patients; group practices, as defined in this paragraph, composed exclusively of such physicians; or investors who are not employed by the entity or by any investor, are not in a position to provide items or services to the entity or any of its investors, and are not in a position to make or influence referrals directly or indirectly to the entity or any of its investors, all of the following seven standards must be met—

(i) The terms on which an investment interest is offered to an investor must not be related to the previous or expected volume of referrals, services furnished, or the amount of business otherwise generated from that investor to the entity.

(ii) At least one-third of each physician investor's medical practice income from all sources for the previous fiscal year or previous 12-month period must be derived from the physician's performance of procedures (as defined in this paragraph).

(iii) At least one-third of the procedures (as defined in this paragraph) performed by each physician investor for the previous fiscal year or previous 12-month period must be performed at the investment entity.

(iv) The entity or any investor (or other individual or entity acting on behalf of the entity or any investor) must not loan funds to or guarantee a loan for an investor if the investor uses any part of such loan to obtain the investment interest.

(v) The amount of payment to an investor in return for the investment must be directly proportional to the amount of the capital investment (including the fair market value of any pre-operational services rendered) of that investor.

(vi) All ancillary services for Federal health care program beneficiaries performed at the entity must be directly and integrally related to primary procedures performed at the entity, and none may be separately billed to Medi-

care or other Federal health care programs.

(vii) The entity and any physician investors must treat patients receiving medical benefits or assistance under any Federal health care program in a nondiscriminatory manner.

(4) *Hospital/Physician ASCs*—If at least one investor is a hospital, and all of the remaining investors are physicians who meet the requirements of paragraphs (r)(1), (r)(2) or (r)(3) of this section; group practices (as defined in this paragraph) composed of such physicians; surgical group practices (as defined in this paragraph); or investors who are not employed by the entity or by any investor, are not in a position to provide items or services to the entity or any of its investors, and are not in a position to refer patients directly or indirectly to the entity or any of its investors, all of the following eight standards must be met—

(i) The terms on which an investment interest is offered to an investor must not be related to the previous or expected volume of referrals, services furnished, or the amount of business otherwise generated from that investor to the entity.

(ii) The entity or any investor (or other individual or entity acting on behalf of the entity or any investor) must not loan funds to or guarantee a loan for an investor if the investor uses any part of such loan to obtain the investment interest.

(iii) The amount of payment to an investor in return for the investment must be directly proportional to the amount of the capital investment (including the fair market value of any pre-operational services rendered) of that investor.

(iv) The entity and any hospital or physician investor must treat patients receiving medical benefits or assistance under any Federal health care program in a nondiscriminatory manner.

(v) The entity may not use space, including, but not limited to, operating and recovery room space, located in or owned by any hospital investor, unless such space is leased from the hospital in accordance with a lease that complies with all the standards of the space rental safe harbor set forth in

paragraph (b) of this section; nor may it use equipment owned by or services provided by the hospital unless such equipment is leased in accordance with a lease that complies with the equipment rental safe harbor set forth in paragraph (c) of this section, and such services are provided in accordance with a contract that complies with the personal services and management contracts safe harbor set forth in paragraph (d) of this section.

(vi) All ancillary services for Federal health care program beneficiaries performed at the entity must be directly and integrally related to primary procedures performed at the entity, and none may be separately billed to Medicare or other Federal health care programs.

(vii) The hospital may not include on its cost report or any claim for payment from a Federal health care program any costs associated with the ASC (unless such costs are required to be included by a Federal health care program).

(viii) The hospital may not be in a position to make or influence referrals directly or indirectly to any investor or the entity.

(5) For purposes of paragraph (r) of this section, *procedures* means any procedure or procedures on the list of Medicare-covered procedures for ambulatory surgical centers in accordance with regulations issued by the Department and *group practice* means a group practice that meets all of the standards of paragraph (p) of this section. *Surgical group practice* means a group practice that meets all of the standards of paragraph (p) of this section and is composed exclusively of surgeons who meet the requirements of paragraph (r)(1) of this section.

(s) *Referral agreements for specialty services*. As used in section 1128B of the Act, *remuneration* does not include any exchange of value among individuals and entities where one party agrees to refer a patient to the other party for the provision of a specialty service payable in whole or in part under Medicare or a State health care program in return for an agreement on the part of the other party to refer that patient back at a mutually agreed upon time

or circumstance as long as the following four standards are met—

(1) The mutually agreed upon time or circumstance for referring the patient back to the originating individual or entity is clinically appropriate.

(2) The service for which the referral is made is not within the medical expertise of the referring individual or entity, but is within the special expertise of the other party receiving the referral.

(3) The parties receive no payment from each other for the referral and do not share or split a global fee from any Federal health care program in connection with the referred patient.

(4) Unless both parties belong to the same group practice as defined in paragraph (p) of this section, the only exchange of value between the parties is the remuneration the parties receive directly from third-party payors or the patient compensating the parties for the services they each have furnished to the patient.

(t) *Price reductions offered to eligible managed care organizations*. (1) As used in section 1128(B) of the Act, “remuneration” does not include any payment between:

(i) An eligible managed care organization and any first tier contractor for providing or arranging for items or services, as long as the following three standards are met—

(A) The eligible managed care organization and the first tier contractor have an agreement that:

(1) Is set out in writing and signed by both parties;

(2) Specifies the items and services covered by the agreement;

(3) Is for a period of at least one year; and

(4) Specifies that the first tier contractor cannot claim payment in any form directly or indirectly from a Federal health care program for items or services covered under the agreement, except for:

(i) HMOs and competitive medical plans with cost-based contracts under section 1876 of the Act where the agreement with the eligible managed care organization sets out the arrangements in accordance with which the first tier contractor is billing the Federal health care program;

(ii) Federally qualified HMOs without a contract under sections 1854 or 1876 of the Act, where the agreement with the eligible managed care organization sets out the arrangements in accordance with which the first tier contractor is billing the Federal health care program; or

(iii) First tier contractors that are Federally qualified health centers that claim supplemental payments from a Federal health care program.

(B) In establishing the terms of the agreement, neither party gives or receives remuneration in return for or to induce the provision or acceptance of business (other than business covered by the agreement) for which payment may be made in whole or in part by a Federal health care program on a fee-for-service or cost basis.

(C) Neither party to the agreement shifts the financial burden of the agreement to the extent that increased payments are claimed from a Federal health care program.

(ii) A first tier contractor and a downstream contractor or between two downstream contractors to provide or arrange for items or services, as long as the following four standards are met—

(A) The parties have an agreement that:

(1) Is set out in writing and signed by both parties;

(2) Specifies the items and services covered by the agreement;

(3) Is for a period of at least one year; and

(4) Specifies that the party providing the items or services cannot claim payment in any form from a Federal health care program for items or services covered under the agreement.

(B) In establishing the terms of the agreement, neither party gives or receives remuneration in return for or to induce the provision or acceptance of business (other than business covered by the agreement) for which payment may be made in whole or in part by a Federal health care program on a fee-for-service or cost basis.

(C) Neither party shifts the financial burden of the agreement to the extent that increased payments are claimed from a Federal health care program.

(D) The agreement between the eligible managed care organization and first tier contractor covering the items or services that are covered by the agreement between the parties does not involve:

(1) A Federally qualified health center receiving supplemental payments;

(2) A HMO or CMP with a cost-based contract under section 1876 of the Act; or

(3) A Federally qualified HMO, unless the items or services are covered by a risk based contract under sections 1854 or 1876 of the Act.

(2) For purposes of this paragraph, the following terms are defined as follows:

(i) *Downstream contractor* means an individual or entity that has a sub-contract directly or indirectly with a first tier contractor for the provision or arrangement of items or services that are covered by an agreement between an eligible managed care organization and the first tier contractor.

(ii) *Eligible managed care organization*<sup>1</sup> means—

(A) A HMO or CMP with a risk or cost based contract in accordance with section 1876 of the Act;

(B) Any Medicare Part C health plan that receives a capitated payment from Medicare and which must have its total Medicare beneficiary cost sharing approved by HCFA under section 1854 of the Act;

(C) Medicaid managed care organizations as defined in section 1903(m)(1)(A) that provide or arrange for items or services for Medicaid enrollees under a contract in accordance with section 1903(m) of the Act (except for fee-for-service plans or medical savings accounts);

(D) Any other health plans that provide or arrange for items and services for Medicaid enrollees in accordance with a risk-based contract with a State agency subject to the upper payment limits in §447.361 of this title or an equivalent payment cap approved by the Secretary;

<sup>1</sup>The eligible managed care organizations in paragraphs (u)(2)(ii)(A)–(F) of this section are only eligible with respect to items or services covered by the contracts specified in those paragraphs.

(E) Programs For All Inclusive Care For The Elderly (PACE) under sections 1894 and 1934 of the Act, except for for-profit demonstrations under sections 4801(h) and 4802(h) of Pub. L. 105-33; or  
 (F) A Federally qualified HMO.

(iii) *First tier contractor* means an individual or entity that has a contract directly with an eligible managed care organization to provide or arrange for items or services.

(iv) *Items and services* means health care items, devices, supplies or services or those services reasonably related to the provision of health care items, devices, supplies or services including, but not limited to, non-emergency transportation, patient education, attendant services, social services (e.g., case management), utilization review and quality assurance. Marketing and other pre-enrollment activities are not "items or services" for purposes of this section.

(u) *Price reductions offered by contractors with substantial financial risk to managed care organizations.* (1) As used in section 1128(B) of the Act, "remuneration" does not include any payment between:

(i) A qualified managed care plan and a first tier contractor for providing or arranging for items or services, where the following five standards are met—

(A) The agreement between the qualified managed care plan and first tier contractor must:

(1) Be in writing and signed by the parties;

(2) Specify the items and services covered by the agreement;

(3) Be for a period of a least one year;

(4) Require participation in a quality assurance program that promotes the coordination of care, protects against underutilization and specifies patient goals, including measurable outcomes where appropriate; and

(5) Specify a methodology for determining payment that is commercially reasonable and consistent with fair market value established in an arms-length transaction and includes the intervals at which payments will be made and the formula for calculating incentives and penalties, if any.

(B) If a first tier contractor has an investment interest in a qualified managed care plan, the investment interest

must meet the criteria of paragraph (a)(1) of this section.

(C) The first tier contractor must have substantial financial risk for the cost or utilization of services it is obligated to provide through one of the following four payment methodologies:

(1) A periodic fixed payment per patient that does not take into account the dates services are provided, the frequency of services, or the extent or kind of services provided;

(2) Percentage of premium;

(3) Inpatient Federal health care program diagnosis-related groups (DRGs) (other than those for psychiatric services);

(4) Bonus and withhold arrangements, provided—

(i) The target payment for first tier contractors that are individuals or non-institutional providers is at least 20 percent greater than the minimum payment, and for first tier contractors that are institutional providers, i.e., hospitals and nursing homes, is at least 10 percent greater than the minimum payment;

(ii) The amount at risk, i.e., the bonus or withhold, is earned by a first tier contractor in direct proportion to the ratio of the contractor's actual utilization to its target utilization;

(iii) In calculating the percentage in accordance with paragraph (u)(1)(i)(C)(4)(i) of this section, both the target payment amount and the minimum payment amount include any performance bonus, e.g., payments for timely submission of paperwork, continuing medical education, meeting attendance, etc., at a level achieved by 75 percent of the first tier contractors who are eligible for such payments;

(iv) Payment amounts, including any bonus or withhold amounts, are reasonable given the historical utilization patterns and costs for the same or comparable populations in similar managed care arrangements; and

(v) Alternatively, for a first tier contractor that is a physician, the qualified managed care plan has placed the physician at risk for referral services in an amount that exceeds the substantial financial risk threshold set forth in 42 CFR 417.479(f) and the arrangement is in compliance with the stop-

loss and beneficiary survey requirements of 42 CFR 417.479(g).

(D) Payments for items and services reimbursable by Federal health care program must comply with the following two standards—

(1) The qualified managed care plan (or in the case of a self-funded employer plan that contracts with a qualified managed care plan to provide administrative services, the self-funded employer plan) must submit the claims directly to the Federal health care program, in accordance with a valid reassignment agreement, for items or services reimbursed by the Federal health care program. (Notwithstanding the foregoing, inpatient hospital services, other than psychiatric services, will be deemed to comply if the hospital is reimbursed by a Federal health care program under a DRG methodology.)

(2) Payments to first tier contractors and any downstream contractors for providing or arranging for items or services reimbursed by a Federal health care program must be identical to payment arrangements to or between such parties for the same items or services provided to other beneficiaries with similar health status, provided that such payments may be adjusted where the adjustments are related to utilization patterns or costs of providing items or services to the relevant population.

(E) In establishing the terms of an arrangement—

(1) Neither party gives or receives remuneration in return for or to induce the provision or acceptance of business (other than business covered by the arrangement) for which payment may be made in whole or in part by a Federal health care program on a fee-for-service or cost basis; and

(2) Neither party to the arrangement shifts the financial burden of such arrangement to the extent that increased payments are claimed from a Federal health care program.

(ii) A first tier contractor and a downstream contractor, or between downstream contractors, to provide or arrange for items or services, as long as the following three standards are met—

(A) Both parties are being paid for the provision or arrangement of items

or services in accordance with one of the payment methodologies set out in paragraph (u)(1)(i)(C) of this section;

(B) Payment arrangements for items and services reimbursable by a Federal health care program comply with paragraph (u)(1)(i)(D) of this section; and

(C) In establishing the terms of an arrangement—

(1) Neither party gives or receives remuneration in return for or to induce the provision or acceptance of business (other than business covered by the arrangement) for which payment may be made in whole or in part by a Federal health care program on a fee-for-service or cost basis; and

(2) Neither party to the arrangement shifts the financial burden of the arrangement to the extent that increased payments are claimed from a Federal health care program.

(2) For purposes of this paragraph, the following terms are defined as follows:

(i) *Downstream contractor* means an individual or entity that has a subcontract directly or indirectly with a first tier contractor for the provision or arrangement of items or services that are covered by an agreement between a qualified managed care plan and the first tier contractor.

(ii) *First tier contractor* means an individual or entity that has a contract directly with a qualified managed care plan to provide or arrange for items or services.

(iii) *Is obligated to provide* for a contractor refers to items or services:

(A) Provided directly by an individual or entity and its employees;

(B) For which an individual or entity is financially responsible, but which are provided by downstream contractors;

(C) For which an individual or entity makes referrals or arrangements; or

(D) For which an individual or entity receives financial incentives based on its own, its provider group's, or its qualified managed care plan's performance (or combination thereof).

(iv) *Items and services* means health care items, devices, supplies or services or those services reasonably related to the provision of health care items, devices, supplies or services including, but not limited to, non-emergency

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transportation, patient education, attendant services, social services (e.g., case management), utilization review and quality assurance. Marketing or other pre-enrollment activities are not "items or services" for purposes of this definition in this paragraph.

(v) *Minimum payment* is the guaranteed amount that a provider is entitled to receive under an agreement with a first tier or downstream contractor or a qualified managed care plan.

(vi) *Qualified managed care plan* means a health plan as defined in paragraph (1)(2) of this section that:

(A) Provides a comprehensive range of health services;

(B) Provides or arranges for—

(1) Reasonable utilization goals to avoid inappropriate utilization;

(2) An operational utilization review program;

(3) A quality assurance program that promotes the coordination of care, protects against underutilization, and specifies patient goals, including measurable outcomes where appropriate;

(4) Grievance and hearing procedures;

(5) Protection of enrollees from incurring financial liability other than copayments and deductibles; and

(6) Treatment for Federal health care program beneficiaries that is not different than treatment for other enrollees because of their status as Federal health care program beneficiaries; and

(C) Covers a beneficiary population of which either—

(1) No more than 10 percent are Medicare beneficiaries, not including persons for whom a Federal health care program is the secondary payer; or

(2) No more than 50 percent are Medicare beneficiaries (not including persons for whom a Federal health care program is the secondary payer), provided that payment of premiums is on a periodic basis that does not take into account the dates services are rendered, the frequency of services, or the extent or kind of services rendered, and provided further that such periodic payments for the non-Federal health care program beneficiaries do not take into account the number of Federal health care program fee-for-service beneficiaries covered by the agreement or the amount of services generated by such beneficiaries.

(vii) *Target payment* means the fair market value payment established through arms length negotiations that will be earned by an individual or entity that:

(A) Is dependent on the individual or entity's meeting a utilization target or range of utilization targets that are set consistent with historical utilization rates for the same or comparable populations in similar managed care arrangements, whether based on its own, its provider group's or the qualified managed care plan's utilization (or a combination thereof); and

(B) Does not include any bonus or fees that the individual or entity may earn from exceeding the utilization target.

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**§ 1001.1001 Exclusion of entities owned or controlled by a sanctioned person.**

(a) *Circumstance for exclusion.* (1) The OIG may exclude an entity if:

(i) A person with a relationship with such entity—

(A) Has been convicted of a criminal offense as described in sections 1128(a) and 1128(b) (1), (2) or (3) of the Act;

(B) Has had civil money penalties or assessments imposed under section 1128A of the Act; or

(C) Has been excluded from participation in Medicare or any of the State health care programs, and

(ii) Such a person—

(A)(1) Has a direct or indirect ownership interest (or any combination thereof) of 5 percent or more in the entity;

(2) Is the owner of a whole or part interest in any mortgage, deed of trust, note or other obligation secured (in whole or in part) by the entity or any of the property assets thereof, in which whole or part interest is equal to or exceeds 5 percent of the total property and assets of the entity;

(3) Is an officer or director of the entity, if the entity is organized as a corporation;

(4) Is partner in the entity, if the entity is organized as a partnership;

(5) Is an agent of the entity; or