

**Anti-Kickback Statute and Civil Monetary Penalty Regulations**  
**Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective**  
**January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
<b>Exceptions (proposed changes to Anti-Kickback Statute regulations at 42 CFR § 1001.952)</b>				
<b>§ 1001.952 (d) Exceptions – Personal Services and Management Contracts</b> [Renamed to “Personal Services and Management Contracts and Outcomes-Based Payment Arrangements”]	<p>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:</p> <p>(1) The agency agreement is set out in writing and signed by the parties.</p> <p>(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.</p> <p>(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.</p> <p>(4) The term of the agreement is for not less than one year.</p>	<p>(1) 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 standards are met:</p> <p>(i) The agency agreement is set out in writing and signed by the parties.</p> <p>(ii) 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.</p> <p>(iii) The term of the agreement is not less than one year.</p> <p>(iv) The methodology for determining the compensation paid to the agent over the term of the agreement is set in advance, is consistent with fair market value in arm’s-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</p>	<p>(1) 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 standards are met:</p> <p>(i) The agency agreement is set out in writing and signed by the parties.</p> <p>(ii) 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.</p> <p>(iii) The term of the agreement is not less than 1 year.</p> <p>(iv) The methodology for determining the compensation paid to the agent over the term of the agreement is set in advance, is consistent with fair market value in arm’s-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</p>	<p>The final rule: (i) replaces the requirement that aggregate compensation be set in advance with a requirement that the methodology for determining compensation be set in advance; and (ii) eliminates the requirement that agreements that provide for services on a periodic, sporadic or part-time basis must specify the schedule, length, and the exact charge for such intervals.</p> <p>It also adds a new paragraph (d)(2) to protect certain outcomes-based payments. This new paragraph differs from the proposed rule, in that it now the outcome measure must be used to quantify quality improvements, reductions in payor costs, or both. The final rule also adds to the list of entities that were excluded from safe harbor protection under the new outcomes-based payment arrangements provision.</p>

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
	<p>(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, Medicaid or other Federal health care programs.</p> <p>(6) The services performed under the agreement do not involve the counselling or promotion of a business arrangement or other activity that violates any State or Federal law.</p> <p>(7) The aggregate services contracted for do not exceed those which are reasonably necessary to accomplish the commercially reasonable business purpose of the services.</p> <p>For purposes of paragraph (d) of this section, an agent of a principal is any person, other</p>	<p>be made in whole or in part under Medicare, Medicaid, or other Federal health care programs.</p> <p>(v) 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.</p> <p>(vi) The aggregate services contracted for do not exceed those which are reasonably necessary to accomplish the commercially reasonable business purpose of the services.</p> <p>(2) As used in section 1128B of the Act, “remuneration” does not include any outcomes-based payment as long as all of the standards in paragraphs (d)(2)(i) through (ix) of this section are met:</p> <p>(i) The outcomes-based payment is made between or among parties that are collaborating to:</p> <p>A. Measurably improve (or maintain improvement in) quality of patient care; or</p> <p>B. Appropriately and materially reduce costs to,</p>	<p>be made in whole or in part under Medicare, Medicaid, or other Federal health care programs.</p> <p>(v) 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.</p> <p>(vi) The aggregate services contracted for do not exceed those which are reasonably necessary to accomplish the commercially reasonable business purpose of the services.</p> <p>(2) As used in section 1128B of the Act, “remuneration” does not include any outcomes-based payment as long as all of the standards in paragraphs (d)(2)(i) through (viii) of this section are met:</p> <p>(i) To receive an outcomes-based payment, the agent achieves one or more legitimate outcome measures that:</p> <p>(A) Are selected based on clinical evidence or credible medical support; and</p>	

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
	<p>than a bona fide employee of the principal, who has an agreement to perform services for, or on behalf of, the principal.</p>	<p>or growth in expenditures of, payors while improving, or maintaining the improved, quality of care for patients.</p> <p>(ii) To receive an outcomes-based payment, the agent satisfies one or more specific evidence-based, valid outcome measures that are:</p> <p>A. Related to:</p> <ol style="list-style-type: none"> <li>1. Measurably improving, or maintaining the improved, quality of patient care;</li> <li>2. Appropriately and materially reducing costs to, or growth in expenditures of, payors while improving, or maintaining the improved quality of care for patients; or</li> <li>3. Both; and</li> </ol> <p>B. Selected based upon clinical evidence or credible medical support.</p> <p>(iii) The methodology for determining the aggregate compensation (including any outcomes-based payments) paid between or among the parties over the term of the agreement</p>	<p>(B) Have benchmarks that are used to quantify:</p> <ol style="list-style-type: none"> <li>1. Improvements in, or the maintenance of improvements in, the quality of patient care;</li> <li>2. A material reduction in costs to or growth in expenditures of payors while maintaining or improving quality of care for patients; or</li> <li>3. Both.</li> </ol> <p>(ii) The methodology for determining the aggregate compensation (including any outcomes-based payments) paid between or among the parties over the term of the agreement is: set in advance; commercially reasonable; consistent with fair market value; and not determined in a manner that directly 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 by a Federal health care program.</p> <p>(iii) The agreement between the parties is set out in writing and</p>	

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
		<p>is: set in advance; commercially reasonable; consistent with fair market value; and not determined in a manner that directly 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 by a Federal health care program.</p> <p>(iv) The agreement neither limits any party’s ability to make decisions in their patients’ best interest nor induces any party to reduce or limit medically necessary items or services.</p> <p>(v) The term of the agreement is not less than 1 year.</p> <p>(vi) 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.</p> <p>(vii) For each outcome measure under the agreement, the parties:</p> <p>(A) regularly monitor and assess the agent’s performance, including the impact of the</p>	<p>signed by the parties in advance of, or contemporaneous with, the commencement of the terms of the outcomes-based payment arrangement. The writing states at a minimum: a general description of the services to be performed by the parties for the term of the agreement; the outcome measure(s) the agent must achieve to receive an outcomes-based payment; the clinical evidence or credible medical support relied upon by the parties to select the outcome measure(s); and the schedule for the parties to regularly monitor and assess the outcome measure(s).</p> <p>(iv) The agreement neither limits any party’s ability to make decisions in their patients’ best interest nor induces any party to reduce or limit medically necessary items or services.</p> <p>(v) The term of the agreement is not less than 1 year.</p> <p>(vi) The services performed under the agreement do not involve the counseling or promotion of a business arrangement or other activity</p>	

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



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		<p>outcomes-based payment arrangement on patient quality of care; and (B) periodically rebase during the term of the agreement, to the extent applicable.</p> <p>(viii) The parties set forth in a signed writing, in advance of, or contemporaneous with, the commencement of the terms of the outcomes-based payment arrangement. The writing states, at a minimum: the services to be performed by the parties for the term of the agreement; the outcome measure(s) the agent must satisfy to receive an outcomes-based payment; the clinical evidence or credible medical support relied upon by the parties to select the outcome measure(s); and the schedule for the parties to regularly monitor and assess the outcome measure(s).</p> <p>(ix) The principal has policies and procedures to promptly address and correct identified material performance failures or material deficiencies in quality of care resulting from the outcomes-based payment arrangement.</p>	<p>that violates any State or Federal law.</p> <p>(vii) For each outcome measure under the agreement, the parties:</p> <p>(A) Regularly monitor and assess the agent’s performance, including the impact of the outcomes-based payment arrangement on patient quality of care; and (B) Periodically assess, and as necessary revise, benchmarks and remuneration under the arrangement to ensure that the remuneration is consistent with fair market value in an arm’s length transaction as required by paragraph (d)(2)(ii) of this section during the term of the agreement.</p> <p>(viii) The principal has policies and procedures to promptly address and correct identified material performance failures or material deficiencies in quality of care resulting from the outcomes-based payment arrangement.</p> <p>(3) For purposes of this paragraph (d):</p>	

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
		<p>(3) For purposes of this paragraph (d):</p> <ul style="list-style-type: none"> <li>i. An agent of a principal is any person, other than a <i>bona fide</i> employee of the principal, who has an agreement to perform services for, or on behalf of, the principal.</li> <li>ii. Outcomes-based payments are limited to payments from a principal to an agent that: <ul style="list-style-type: none"> <li>A. reward the agent for improving (or maintaining improvement in) patient or population health by achieving one or more outcome measures that effectively and efficiently coordinate care across care settings; or</li> <li>B. achieve one or more outcome measures that appropriately reduce payor costs while improving, or maintaining the</li> </ul> </li> </ul>	<p>(i) 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.</p> <p>(ii) Outcomes-based payments are limited to payments between or among a principal and an agent that:</p> <p>(A) Reward the agent for successfully achieving an outcome measure described in paragraph (d)(2)(i) of this section; or</p> <p>(B) Recoup from or reduce payment to an agent for failure to achieve an outcome measure described in paragraph (d)(2)(i) of this section.</p> <p>(iii) Outcomes-based payments exclude any payments:</p> <p>(A) Made directly or indirectly by the following entities:</p> <p>(1) A pharmaceutical manufacturer, distributor, or wholesaler;</p> <p>(2) A pharmacy benefit manager;</p>	

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
		<p>improved quality of care for patients.</p> <p>iii. Outcomes-based payments exclude any payments:</p> <p>A. Made, directly or indirectly, by a pharmaceutical manufacturer; a manufacturer, distributor, or supplier of durable medical equipment, prosthetics, orthotics, or supplies; or a laboratory; or</p> <p>B. That relate solely to the achievement of internal cost savings for the principal.</p>	<p>(3) A laboratory company;</p> <p>(4) A pharmacy that primarily compounds drugs or primarily dispenses compounded drugs;</p> <p>(5) A manufacturer of a device or medical supply as defined in paragraph (ee)(14)(iv) of this section;</p> <p>(6) A medical device distributor or wholesaler that is not otherwise a manufacturer of a device or medical supply, as defined in paragraph (ee)(14)(iv) of this section; or</p> <p>(7) An entity or individual that sells or rents durable medical equipment, prosthetics, orthotics, or supplies covered by a Federal health care program (other than a pharmacy or a physician, provider, or other entity that primarily furnishes services); or</p> <p>(B) Related solely to the achievement of internal cost savings for the principal; or</p> <p>(C) Based solely on patient satisfaction or patient convenience measures.</p>	

**Anti-Kickback Statute and Civil Monetary Penalty Regulations**  
**Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective**  
**January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
<p><b>§ 1001.952 (g)</b>  <b>Exceptions – Warranties</b></p>	<p>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:</p> <p>(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.</p> <p>(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.</p>	<p>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 one or more items and services (provided the warranty covers at least one item) to the buyer (such as a healthcare provider or beneficiary) of the items and services, as long as the buyer complies with all of the following standards in paragraphs (g)(1) and (2) of this section and the manufacturer or supplier complies with all of the following standards in paragraphs (g)(3) through (6) of this section:</p> <p>(1) The buyer (unless the buyer is a Federal health care program beneficiary) must fully and accurately report any price reduction of an item or service (including a free item or service) that 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.</p> <p>...</p> <p>(3)(i) The manufacturer or supplier must fully and accurately report any price</p>	<p>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 one or more items and services (provided the warranty covers at least one item) to the buyer (such as a health care provider or beneficiary) of the items and services, as long as the buyer complies with all of the following standards in paragraphs (g)(1) and (2) of this section and the manufacturer or supplier complies with all of the following standards in paragraphs (g)(3) through (6) of this section:</p> <p>(1) The buyer (unless the buyer is a Federal health care program beneficiary) must fully and accurately report any price reduction of an item or service (including a free item or service) that 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.</p> <p>...</p> <p>(3) The manufacturer or supplier must comply with either of the following standards:</p>	<p>The final rule extends protection to warranties for bundled items and related services if certain conditions are met and would exclude beneficiaries from the reporting requirements applicable to buyers. It also adds a definition of “warranty.” This final rule does not adopt the proposal that the manufacturer or supplier report price reductions as part of the warranty on the invoice or statement submitted to the buyer.</p>

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
	<p>(3) The manufacturer or supplier must comply with either of the following two standards -</p> <p>(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.</p> <p>(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.</p> <p>(4) The manufacturer or supplier must not pay any</p>	<p>reduction of an item or service (including free items and services) that the buyer obtained as part of the warranty on the invoice or statement submitted to the buyer and inform the buyer of its obligations under paragraphs (g)(1) and (2) of this section.</p> <p>(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 items and services subject to the warranty.</p> <p>(5) If a manufacturer or supplier offers a warranty for more than one item or one or more items and related services, the federally reimbursable items and services subject to the warranty must be reimbursed by the same Federal health care program and in the same Federal health care program payment.</p> <p>(6) The manufacturer or supplier must not condition a warranty on a buyer's exclusive use of, or a minimum purchase of, any of the</p>	<p>(i) The manufacturer or supplier must fully and accurately report any price reduction of an item or service (including free items and services) that the buyer obtained as part of the warranty on the invoice or statement submitted to the buyer and inform the buyer of its obligations under paragraphs (g)(1) and (2) of this section.</p> <p>(ii) When the amount of any 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 any price reduction becomes known, provide the buyer with documentation of the calculation of the price reduction resulting from the warranty.</p> <p>(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</p>	

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
	<p>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.</p> <p>For purposes of paragraph (g) of this section, the term <i>warranty</i> 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.</p>	<p>manufacturer's or supplier's items or services.</p> <p>(7) For purposes of this paragraph (g), the term <i>warranty</i> means:</p> <p>(i) Any written affirmation of fact or written promise made in connection with the sale of an item or bundle of items, or services in combination with one or more related items, by a manufacturer or supplier to a buyer, which affirmation of fact or written promise relates to the nature of the quality or workmanship and affirms or promises that such quality or workmanship is defect free or will meet a specified level of performance over a specified period of time;</p> <p>(ii) Any undertaking in writing in connection with the sale by a manufacturer or supplier of an item or bundle of items, or services in combination with one or more related items, to refund, repair, replace, or take other remedial action with respect to such item or bundle of items in the event that such item or bundle of items, or services in combination with one or more related items, fails to meet the</p>	<p>cost of the items and services subject to the warranty.</p> <p>(5) If a manufacturer or supplier offers a warranty for more than one item or one or more items and related services, the federally reimbursable items and services subject to the warranty must be reimbursed by the same Federal health care program and in the same Federal health care program payment.</p> <p>(6) The manufacturer or supplier must not condition a warranty on a buyer's exclusive use of, or a minimum purchase of, any of the manufacturer's or supplier's items or services.</p> <p>(7) For purposes of this paragraph (g), the term <i>warranty</i> means:</p> <p>(i) Any written affirmation of fact or written promise made in connection with the sale of an item or bundle of items, or services in combination with one or more related items, by a manufacturer or supplier to a buyer, which affirmation of fact or written promise relates to the nature of the quality of workmanship and affirms or</p>	

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
		<p>specifications set forth in the undertaking, which written affirmation, promise, or undertaking becomes part of the basis of the bargain between a seller and a buyer for purposes other than resell of such item or bundle of items; or</p> <p>(iii) A manufacturer's or supplier's agreement to replace another manufacturer's or supplier's defective item or bundle of items (which is covered by an agreement made in accordance with this paragraph (g)), on terms equal to the agreement that it replaces.</p>	<p>promises that such quality or workmanship is defect free or will meet a specified level of performance over a specified period of time;</p> <p>(ii) Any undertaking in writing in connection with the sale by a manufacturer or supplier of an item or bundle of items, or services in combination with one or more related items, to refund, repair, replace, or take other remedial action with respect to such item or bundle of items in the event that such item or bundle of items, or services in combination with one or more related items, fails to meet the specifications set forth in the undertaking which written affirmation, promise, or undertaking becomes part of the basis of the bargain between a seller and a buyer for purposes other than resell of such item or bundle of items; or</p> <p>(iii) A manufacturer's or supplier's agreement to replace another manufacturer's or supplier's defective item or bundle of items (which is covered by an agreement made in accordance with this</p>	

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
<p><b>§ 1001.952 (y) Exceptions – Electronic Health Records Items and Services</b></p>	<p>As used in section 1128B of the Act, “remuneration” does not include nonmonetary remuneration (consisting of items and services in the form of software or information technology and training services) necessary and used predominantly to create, maintain, transmit, or receive electronic health records, if all of the following conditions are met:</p> <p>(1) The items and services are provided to an individual or entity engaged in the delivery of health care by:</p> <p>(i) An individual or entity, other than a laboratory company, that provides services covered by a Federal health care program and submits claims or requests for payment, either directly or through reassignment, to the Federal health care program; or</p> <p>(ii) A health plan.</p> <p>(2) The software is interoperable at the time it is provided to the recipient. For purposes of this subparagraph, software is deemed to be</p>	<p>As used in section 1128B of the Act, “remuneration” does not include nonmonetary remuneration (consisting of items and services in the form of software or information technology and training services, including certain cybersecurity software and services) necessary and used predominantly to create, maintain, transmit, receive, or protect electronic health records, if all of the conditions in paragraphs (y)(1) through (13) of this section are met:</p> <p>...</p> <p>(2) ...For purposes of this paragraph (y)(2), software is deemed to be interoperable if, on the date it is provided to the recipient, it is certified by a certifying body authorized by the National Coordinator for Health Information Technology to electronic health record certification criteria identified in 45 CFR part 170.</p> <p>(3) The donor (or any person on the donor's behalf) does not engage in a practice constituting</p>	<p>paragraph (g)), on terms equal to the agreement that it replaces.</p> <p>As used in section 1128B of the Act, “remuneration” does not include nonmonetary remuneration (consisting of items and services in the form of software or information technology and training services, including cybersecurity software and services) necessary and used predominantly to create, maintain, transmit, receive, or protect electronic health records, if all of the conditions in paragraphs (y)(1) through (13) of this section are met:</p> <p>(1) The items and services are provided to an individual or entity engaged in the delivery of health care by:</p> <p>(i) An individual or entity, other than a laboratory company, that:</p> <p>(A) Provides services covered by a Federal health care program and submits claims or requests for payment, either directly or through reassignment, to the Federal health care program; or</p> <p>(B) Is comprised of the types of individuals or entities in paragraph (y)(1)(i)(A) of this section; or</p>	<p>The final rule incorporates updates to the interoperability definition and “deeming” requirements, and the electronic health record definition. It clarifies that certain cybersecurity software and services are protected under this safe harbor. It adds that where the initial donation is of EHR items and services, the recipient must pay 15% of the donor’s cost before receiving the items and services. The final rule also eliminates the sunset provision at 42 C.F.R. 1001.952(y)(13).</p> <p>The final rule does not include the proposed language related to information blocking.</p>

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
	<p>interoperable if, on the date it is provided to the recipient, it has been certified by a certifying body authorized by the National Coordinator for Health Information Technology to an edition of the electronic health record certification criteria identified in the then-applicable version of 45 CFR part 170.</p> <p>(3) The donor (or any person on the donor's behalf) does not take any action to limit or restrict the use, compatibility, or interoperability of the items or services with other electronic prescribing or electronic health records systems (including, but not limited to, health information technology applications, products, or services).</p> <p>(4) Neither the recipient nor the recipient's practice (or any affiliated individual or entity) makes the receipt of items or services, or the amount or nature of the items or services, a condition of doing business with the donor.</p> <p>(5) Neither the eligibility of a recipient for the items or services, nor the amount or</p>	<p>information blocking, as defined in 45 CFR part 171, in connection with the donated items or services. ...</p> <p>(7) [Reserved] ...</p> <p>(13) [Reserved]</p> <p>(14) For purposes of this paragraph (y), the following definitions apply:                      (i) <i>Cybersecurity</i> means the process of protecting information by preventing, detecting, and responding to cyberattacks;                      (ii) <i>Health plan</i> shall have the meaning set forth at §1001.952(1)(2);                      (iii) <i>Interoperable</i> shall mean able to:                      (A) Securely exchange data with, and use data from other health information technology without special effort on the part of the user;                      (B) Allow for complete access, exchange, and use of all electronically accessible health information for authorized use under applicable State or Federal law; and                      (C) Does not constitute information blocking as defined in 45 CFR part 171; and</p>	<p>(ii) A health plan.</p> <p>(2) ... For purposes of this paragraph (y)(2) of this section, software is deemed to be interoperable if, on the date it is provided to the recipient, it is certified by a certifying body authorized by the National Coordinator for Health Information Technology to certification criteria identified in the then-applicable version of 45 CFR part 170.</p> <p>(3) Reserved. ...</p> <p>(7) Reserved. ...</p> <p>(11) The recipient pays 15 percent of the donor's cost for the items and services. The following conditions apply to such contribution:                      (i) If the donation is the initial donation of EHR items and services, or the replacement of part or all of an existing system of EHR items and services, the recipient must pay 15 percent of the donor's cost before receiving the items and services. The contribution for updates to previously donated EHR items and services need not be paid in</p>	

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
	<p>nature of the items or services, is determined in a manner that directly takes into account the volume or value of referrals or other business generated between the parties. For the purposes of this paragraph (y)(5), the determination is deemed not to directly take into account the volume or value of referrals or other business generated between the parties if any one of the following conditions is met:</p> <p>(i) The determination is based on the total number of prescriptions written by the beneficiary (but not the volume or value of prescriptions dispensed or paid by the donor or billed to a Federal health care program);</p> <p>(ii) The determination is based on the size of the recipient's medical practice (for example, total patients, total patient encounters, or total relative value units);</p> <p>(iii) The determination is based on the total number of hours that the recipient practices medicine;</p> <p>(iv) The determination is based on the recipient's overall use of automated technology in his or her medical practice (without</p>	<p>(iv) <i>Electronic health record</i> shall mean a repository of electronic health information that:</p> <p>(A) Is transmitted by or maintained in electronic media; and</p> <p>(B) Relates to the past, present, or future health or condition of an individual or the provision of healthcare to an individual.</p>	<p>advance of receiving the update; and</p> <p>(ii) The donor (or any affiliated individual or entity) does not finance the recipient's payment or loan funds to be used by the recipient to pay for the items and services.</p> <p style="text-align: center;">...</p> <p>(13) Reserved.</p> <p>(14) For purposes of this paragraph (y), the following definitions apply:</p> <p>(i) Cybersecurity means the process of protecting information by preventing, detecting, and responding to cyberattacks.</p> <p>(ii) Health plan shall have the meaning set forth at § 1001.952(1)(2).</p> <p>(iii) Interoperable shall mean able to:</p> <p style="padding-left: 20px;">(A) Securely exchange data with and use data from other health information technology; and</p> <p style="padding-left: 20px;">(B) Allow for complete access, exchange, and use of all electronically accessible health information for authorized use under applicable State or Federal law.</p>	

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
	<p>specific reference to the use of technology in connection with referrals made to the donor);</p> <p>(v) The determination is based on whether the recipient is a member of the donor's medical staff, if the donor has a formal medical staff;</p> <p>(vi) The determination is based on the level of uncompensated care provided by the recipient;</p> <p>or</p> <p>(vii) The determination is made in any reasonable and verifiable manner that does not directly take into account the volume or value of referrals or other business generated between the parties.</p> <p>(6) The arrangement is set forth in a written agreement that -</p> <p>(i) Is signed by the parties;</p> <p>(ii) Specifies the items and services being provided, the donor's cost of those items and services, and the amount of the recipient's contribution; and</p> <p>(iii) Covers all of the electronic health records items and services to be provided by the donor (or any affiliate). This requirement will be met if all separate agreements between the donor (and affiliated parties) and the beneficiary</p>		<p>(iv) Electronic health record shall mean a repository of consumer health status information in computer processable form used for clinical diagnosis and treatment for a broad array of clinical conditions.</p>	

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
	<p>incorporate each other by reference or if they cross-reference a master list of agreements that is maintained and updated centrally and is available for review by the Secretary upon request. The master list should be maintained in a manner that preserves the historical record of agreements.</p> <p>(7) The donor does not have actual knowledge of, and does not act in reckless disregard or deliberate ignorance of, the fact that the beneficiary possesses or has obtained items or services equivalent to those provided by the donor.</p> <p>(8) For items or services that are of the type that can be used for any patient without regard to payor status, the donor does not restrict, or take any action to limit, the recipient's right or ability to use the items or services for any patient.</p> <p>(9) The items and services do not include staffing of the recipient's office and are not used primarily to conduct personal business or business unrelated to the recipient's</p>			

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
	<p>clinical practice or clinical operations.</p> <p>(10) [Reserved]</p> <p>(11) Before receipt of the items and services, the recipient pays 15 percent of the donor's cost for the items and services. The donor (or any affiliated individual or entity) does not finance the recipient's payment or loan funds to be used by the recipient to pay for the items and services.</p> <p>(12) The donor does not shift the costs of the items or services to any Federal health care program.</p> <p>(13) The transfer of the items and services occurs, and all conditions in this paragraph (y) have been satisfied, on or before December 31, 2021.</p>			
<p><b>§ 1001.952 (bb) Exceptions – Local Transportation</b></p>	<p>As used in section 1128B of the Act, “remuneration” does not include free or discounted local transportation made available by an eligible entity (as defined in this paragraph (bb)):</p> <p>(1) To Federal health care program beneficiaries if all the following conditions are met:</p>	<p>(1)(iv)(B) Within 25 miles of the healthcare provider or supplier to or from which the patient would be transported, or within 75 miles if the patient resides in a rural area, as defined in this paragraph (bb), except that, if the patient is being discharged from an inpatient facility and transported to the patient’s</p>	<p>(1)(iv)(B) Within 25 miles of the health care provider or supplier to or from which the patient would be transported, or within 75 miles if the patient resides in a rural area, as defined in this paragraph (bb) except that, if the patient is discharged from an inpatient facility following inpatient</p>	<p>The final rule expands the distance which rural area residents may be transported and eliminates mileage limits on transportation of a patient from a healthcare facility from which the patient has been discharged to the patient’s residence. It also moves definitions in the note to paragraph (bb) to a new paragraph (bb)(3).</p>

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
	<p>(i) The availability of the free or discounted local transportation services - (A) Is set forth in a policy, which the eligible entity applies uniformly and consistently; and (B) Is not determined in a manner related to the past or anticipated volume or value of Federal health care program business;</p> <p>(ii) The free or discounted local transportation services are not air, luxury, or ambulance-level transportation;</p> <p>(iii) The eligible entity does not publicly market or advertise the free or discounted local transportation services, no marketing of health care items and services occurs during the course of the transportation or at any time by drivers who provide the transportation, and drivers or others arranging for the transportation are not paid on a per-beneficiary-transported basis;</p> <p>(iv) The eligible entity makes the free or discounted transportation available only: (A) To an individual who is: (1) An established patient (as defined in this paragraph (bb)) of the eligible entity that is providing the free or discounted</p>	<p>residence, or another residence of the patient’s choice, the mileage limits in this paragraph (bb)(1)(iv)(B) shall not apply; and . . .</p> <p>(2)(iii) The eligible entity makes the shuttle service available only within the eligible entity’s local area, meaning there are no more than 25 miles from any stop on the route to any stop at a location where healthcare items or services are provided, except that if a stop on the route is in a rural area, the distance may be up to 75 miles between that stop and any providers or suppliers on the route;</p> <p>...</p> <p>(3) For purposes of this paragraph (bb), the following definitions apply:</p> <p>(i) An <i>eligible entity</i> is any individual or entity, except for individuals or entities (or family members or others acting on their behalf) that primarily supply healthcare items;</p>	<p>admission or released from a hospital after being placed in observation status for at least 24 hours and transported to the patient’s residence, or another residence of the patient’s choice, the mileage limits in this paragraph (bb)(1)(iv)(B) shall not apply; and...</p> <p>(2)(iii) The eligible entity makes the shuttle service available only within the eligible entity’s local area, meaning there are no more than 25 miles from any stop on the route to any stop at a location where health care items or services are provided, except that if a stop on the route is in a rural area, the distance may be up to 75 miles between that stop and any providers or suppliers on the route;</p> <p>...</p> <p>(3) For purposes of this paragraph (bb), the following definitions apply:</p> <p>(i) An <i>eligible entity</i> is any individual or entity, except for individuals or entities (or family members or others acting on their behalf) that primarily supply health care items.</p>	

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
	<p>transportation, if the eligible entity is a provider or supplier of health care services; and</p> <p>(2) An established patient of the provider or supplier to or from which the individual is being transported;</p> <p>(B) Within 25 miles of the health care provider or supplier to or from which the patient would be transported, or within 50 miles if the patient resides in a rural area, as defined in this paragraph (bb); and</p> <p>(C) For the purpose of obtaining medically necessary items and services.</p> <p>(v) The eligible entity that makes the transportation available bears the costs of the free or discounted local transportation services and does not shift the burden of these costs onto any Federal health care program, other payers, or individuals; and</p> <p>(2) In the form of a “shuttle service” (as defined in this paragraph (bb)) if all of the following conditions are met:</p>	<p>(ii) An <i>established patient</i> is a person who has selected and initiated contact to schedule an appointment with a provider or supplier, or who previously has attended an appointment with the provider or supplier;</p> <p>(iii) A <i>shuttle service</i> is a vehicle that runs on a set route, on a set schedule;</p> <p>(iv) A <i>rural area</i> is an area that is not an urban area, as defined in paragraph (bb)(3)(v) of this section; and</p> <p>(v) An <i>urban area</i> is:</p> <p>(A) A Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA), as defined by the Executive Office of Management and Budget; or</p> <p>(B) The following New England counties, which are deemed to be parts of urban areas under section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98-21, 42 U.S.C. 1395ww (note)): Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack</p>	<p>(ii) An <i>established patient</i> is a person who has selected and initiated contact to schedule an appointment with a provider or supplier, or who previously has attended an appointment with the provider or supplier.</p> <p>(iii) A <i>shuttle service</i> is a vehicle that runs on a set route, on a set schedule.</p> <p>(iv) A <i>rural area</i> is an area that is not an urban area, as defined in paragraph (bb)(3)(v) of this section.</p> <p>(v) An <i>urban area</i> is:</p> <p>(A) A Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA), as defined by the Executive Office of Management and Budget; or</p> <p>(B) The following New England counties, which are deemed to be parts of urban areas under section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98-21, 42 U.S.C. 1395ww (note)): Litchfield County, Connecticut; York County, Maine; Sagadahoc</p>	

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
	<p>(i) The shuttle service is not air, luxury, or ambulance-level transportation;</p> <p>(ii) The shuttle service is not marketed or advertised (other than posting necessary route and schedule details), no marketing of health care items and services occurs during the course of the transportation or at any time by drivers who provide the transportation, and drivers or others arranging for the transportation are not paid on a per-beneficiary-transported basis;</p> <p>(iii) The eligible entity makes the shuttle service available only within the eligible entity's local area, meaning there are no more than 25 miles from any stop on the route to any stop at a location where health care items or services are provided, except that if a stop on the route is in a rural area, the distance may be up to 50 miles between that stop and all providers or suppliers on the route; and</p> <p>(iv) The eligible entity that makes the shuttle service available bears the costs of the free or discounted shuttle</p>	<p>County, New Hampshire; and Newport County, Rhode Island.</p>	<p>County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island.</p>	

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
	services and does not shift the burden of these costs onto any Federal health care program, other payers, or individuals.			
<b>§ 1001.952 (ee) Exceptions – Care coordination arrangements to improve quality, health outcomes, and efficiency</b>	N/A	<p>As used in section 1128B of the Act, “remuneration” does not include the exchange of anything of value pursuant to a value-based arrangement if all of the standards in paragraphs (ee)(1) through (12) are met:</p> <p>(1) The VBE participants establish one or more specific evidence-based, valid outcome measures against which the recipient will be measured and which the parties reasonably anticipate will advance the coordination and management of care of the target patient population.</p> <p>(2) The value-based arrangement is commercially reasonable, considering both the arrangement itself and all value-based arrangements within the VBE.</p> <p>(3) In advance of, or contemporaneous with, the commencement of the value-based arrangement or any material change to the value-based arrangement, the offeror</p>	<p>As used in section 1128B of the Act, “remuneration” does not include the exchange of anything of value between a VBE and VBE participant or between VBE participants pursuant to a value-based arrangement if all of the standards in paragraphs (ee)(1) through (13) of this section are met:</p> <p>(1) The remuneration exchanged:</p> <p>(i) Is in-kind;</p> <p>(ii) Is used predominantly to engage in value-based activities that are directly connected to the coordination and management of care for the target patient population and does not result in more than incidental benefits to persons outside of the target patient population; and</p> <p>(iii) Is not exchanged or used:</p> <p>(A) More than incidentally for the recipient’s billing or financial management services; or</p> <p>(B) For the purpose of marketing items or services</p>	<p>Proposed rule introduces protection for certain value-based arrangements meeting the requirements for care coordination arrangements. It protects in-kind remuneration exchanged between a VBE and VBE participant or between VBE participants pursuant to a value-based arrangement that satisfies all of the proposed safe harbor’s requirements. The final rule modifies and clarifies many of the safe harbor requirements from the proposed rule.</p> <p>The safe harbor includes conditions related to commercial reasonableness, outcomes measures, written documentation, record retention, monitoring, termination, marketing and patient recruitment, and diversion and reselling of remuneration.</p> <p>The final rule carves out patients and certain entities from the safe harbor; those entities are listed at paragraph (13).</p> <p>It includes definitions for key terms, including “value-based arrangement,” “value-based activity,” “value-based purpose,” “coordination</p>

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
		<p>of the remuneration and any recipient(s) of such remuneration have set forth the terms of the value-based arrangement in a signed writing. The writing states, at a minimum:</p> <p>(i) The value-based activities to be undertaken by the parties to the value-based arrangement;</p> <p>(ii) The term of the value-based arrangement;</p> <p>(iii) The target patient population;</p> <p>(iv) A description of the remuneration;</p> <p>(v) The offeror’s cost for the remuneration;</p> <p>(vi) The percentage of the offeror’s cost contributed by the recipient;</p> <p>(vii) If applicable, the frequency of the recipient’s contribution payments for ongoing costs; and</p> <p>(viii) The specific evidence-based, valid outcome measure(s) against which the recipient will be measured.</p> <p>(4) The remuneration exchanged:</p> <p>(i) Is in-kind;</p> <p>(ii) Is used primarily to engage in value-based activities that are directly connected to the coordination and management of</p>	<p>furnished by the VBE or a VBE participant to patients or for patient recruitment activities.</p> <p>(2) The value-based arrangement is commercially reasonable, considering both the arrangement itself and all value-based arrangements within the VBE.</p> <p>(3) The terms of the value-based arrangement are set forth in writing and signed by the parties in advance of, or contemporaneous with, the commencement of the value-based arrangement and any material change to the value-based arrangement. The writing states at a minimum:</p> <p>(i) The value-based purpose(s) of the value-based activities provided for in the value-based arrangement;</p> <p>(ii) The value-based activities to be undertaken by the parties to the value-based arrangement;</p> <p>(iii) The term of the value-based arrangement;</p> <p>(iv) The target patient population;</p> <p>(v) A description of the remuneration;</p>	<p>and management of care,” and other terms related to value based arrangements in paragraph (14).</p>

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
		<p>care for the target patient population;</p> <p>(iii) Does not induce VBE participants to furnish medically unnecessary items or services or reduce or limit medically necessary items or services furnished to any patient; and</p> <p>(iv) Is not funded by, and does not otherwise result from the contributions of, any individual or entity outside of the applicable VBE.</p> <p>(5) The offeror of the remuneration does not take into account the volume or value of, or condition the remuneration on:</p> <p>(i) Referrals of patients who are not part of the target patient population; or</p> <p>(ii) Business not covered under the value-based arrangement.</p> <p>(6) The recipient pays at least 15 percent of the offeror’s cost for the in-kind remuneration. If a one-time cost, the recipient makes such contribution in advance of receiving the in-kind remuneration. If an ongoing cost, the recipient makes such contribution at reasonable, regular intervals.</p>	<p>(vi) Either the offeror’s cost for the remuneration and the reasonable accounting methodology used by the offeror to determine its cost, or the fair market value of the remuneration;</p> <p>(vii) The percentage and amount contributed by the recipient;</p> <p>(viii) If applicable, the frequency of the recipient’s contribution payments for ongoing costs; and</p> <p>(ix) The outcome or process measure(s) against which the recipient will be measured.</p> <p>(4) The parties to the value-based arrangement establish one or more legitimate outcome or process measures that:</p> <p>(i) The parties reasonably anticipate will advance the coordination and management of care for the target patient population based on clinical evidence or credible medical or health sciences support;</p> <p>(ii) Include one or more benchmarks that are related to improving or maintaining improvements in the coordination and management of care for the target patient population;</p>	

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
		<p>(7) The value-based arrangement:</p> <p>(i) Is directly connected to the coordination and management of care of the target patient population;</p> <p>(ii) Does not place any limitation on VBE participants' ability to make decisions in the best interest of their patients;</p> <p>(iii) Does not direct or restrict referrals to a particular provider, practitioner, or supplier if:</p> <p>(A) A patient expresses a preference for a different practitioner, provider, or supplier;</p> <p>(B) The patient's payor determines the provider, practitioner, or supplier; or</p> <p>(C) Such direction or restriction is contrary to applicable law or regulations under titles XVIII and XIX of the Act; and</p> <p>(iv) Does not include marketing to patients of items or services or engaging in patient recruitment activities.</p> <p>(8) The VBE, a VBE participant in the value-based arrangement acting on the VBE's behalf, or the VBE's accountable body or responsible person monitors and assesses, and reports such monitoring and assessment to</p>	<p>(iii) Are monitored, periodically assessed, and prospectively revised as necessary to ensure that the measure and its benchmark continue to advance the coordination and management of care of the target patient population;</p> <p>(iv) Relate to the remuneration exchanged under the value-based arrangement; and</p> <p>(v) Are not based solely on patient satisfaction or patient convenience.</p> <p>(5) The offeror of the remuneration does not take into account the volume or value of, or condition the remuneration on:</p> <p>(i) Referrals of patients who are not part of the target patient population; or</p> <p>(ii) Business not covered under the value-based arrangement.</p> <p>(6) The recipient pays at least 15 percent of the offeror's cost for the remuneration, using any reasonable accounting methodology, or the fair market value of the in-kind remuneration. If it is a one-time cost, the recipient makes such</p>	

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
		<p>the VBE’s accountable body or responsible person as applicable, no less frequently than annually or at least once during the term of the value-based arrangement for arrangements with terms of less than 1 year:</p> <p>(i) The coordination and management of care for the target population in the value-based arrangement;</p> <p>(ii) Any deficiencies in the delivery of quality care under the value-based arrangement; and</p> <p>(iii) Progress toward achieving the evidence-based, valid outcome measure(s) in the value-based arrangement.</p> <p>(9) The parties terminate the arrangement within 60 days if the VBE’s accountable body or responsible person determines that the value-based arrangement:</p> <p>(i) Is unlikely to further the coordination and management of care for the target patient population;</p> <p>(ii) Has resulted in material deficiencies in quality of care; or</p> <p>(iii) Is unlikely to achieve the evidence-based, valid outcome measure(s).</p>	<p>contribution in advance of receiving the in-kind remuneration. If it is an ongoing cost, the recipient makes such contribution at reasonable, regular intervals.</p> <p>(7) The value-based arrangement does not:</p> <p>(i) Limit the VBE participant’s ability to make decisions in the best interests of its patients;</p> <p>(ii) Direct or restrict referrals to a particular provider, practitioner, or supplier if:</p> <p>(A) A patient expresses a preference for a different practitioner, provider, or supplier;</p> <p>(B) The patient’s payor determines the provider, practitioner, or supplier; or</p> <p>(C) Such direction or restriction is contrary to applicable law under titles XVIII and XIX of the Act; or</p> <p>(iii) Induce parties to furnish medically unnecessary items or services, or reduce or limit medically necessary items or services furnished to any patient.</p> <p>(8) The exchange of remuneration by a limited technology participant and</p>	

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
		<p>(10) The offeror does not, and should not, know that the remuneration is likely to be diverted, resold, or used by the recipient for an unlawful purpose.</p> <p>(11) The VBE or VBE participant makes available to the Secretary, upon request, all materials and records sufficient to establish compliance with the conditions of this paragraph (ee).</p> <p>(12) For purposes of this paragraph (ee), the following definitions apply:</p> <p>(i) <i>Coordination and management of care (or coordinating and managing care)</i> means, for purposes of the anti-kickback statute safe harbors at § 1001.952, the deliberate organization of patient care activities and sharing of information between two or more VBE participants or VBE participants and patients, tailored to improving the health outcomes of the target patient population, in order to achieve safer and more effective care for the target patient population.</p>	<p>another VBE participant or the VBE must not be conditioned on any recipient’s exclusive use or minimum purchase of any item or service manufactured, distributed, or sold by the limited technology participant.</p> <p>(9) The VBE, a VBE participant in the value-based arrangement acting on the VBE’s behalf, or the VBE’s accountable body or responsible person reasonably monitors and assesses the following and reports the monitoring and assessment of the following to the VBE’s accountable body or responsible person, as applicable, no less frequently than annually or at least once during the term of the value-based arrangement for arrangements with terms of less than 1 year:</p> <p>(i) The coordination and management of care for the target patient population in the value-based arrangement;</p> <p>(ii) Any deficiencies in the delivery of quality care under the value-based arrangement;</p> <p>and</p>	

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
		<p>(ii) <i>Target patient population</i> means an identified patient population selected by the VBE or its VBE participants using legitimate and verifiable criteria that:</p> <p>(A) Are set out in writing in advance of the commencement of the value-based arrangement; and</p> <p>(B) Further the value-based enterprise’s value-based purpose(s).</p> <p>(iii) <i>Value-based activity</i></p> <p>(A) Means any of the following activities, provided that the activity is reasonably designed to achieve at least one value-based purpose of the value-based enterprise:</p> <p>(1) the provision of an item or service;</p> <p>(2) the taking of an action; or</p> <p>(3) the refraining from taking an action.</p> <p>(B) Does not include the making of a referral.</p> <p>(iv) <i>Value-based arrangement</i> means an arrangement for the provision of at least one value-based activity for a target patient population between or among:</p>	<p>(iii) Progress toward achieving the legitimate outcome or process measure(s) in the value-based arrangement.</p> <p>(10) If the VBE’s accountable body or responsible person determines, based on the monitoring and assessment conducted pursuant to paragraph (ee)(9) of this section, that the value-based arrangement has resulted in material deficiencies in quality of care or is unlikely to further the coordination and management of care for the target patient population, the parties must within 60 days either:</p> <p>(i) Terminate the arrangement; or</p> <p>(ii) Develop and implement a corrective action plan designed to remedy the deficiencies within 120 days, and if the corrective action plan fails to remedy the deficiencies within 120 days, terminate the value-based arrangement.</p> <p>(11) The offeror does not and should not know that the remuneration is likely to be diverted, resold, or used by the</p>	

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
		<p>(A) The value-based enterprise and one or more of its VBE participants; or</p> <p>(B) VBE participants in the same value-based enterprise.</p> <p>(v) <i>Value-based enterprise</i> or VBE means two or more VBE participants:</p> <p>(A) Collaborating to achieve at least one value-based purpose;</p> <p>(B) Each of which is a party to a value-based arrangement with the other or at least one other VBE participant in the value-based enterprise;</p> <p>(C) That have an accountable body or person responsible for financial and operational oversight of the value-based enterprise; and</p> <p>(D) That have a governing document that describes the value-based enterprise and how the VBE participants intend to achieve its value-based purpose(s).</p> <p>(vi) <i>Value-based enterprise participant</i> or <i>VBE participant</i> means an individual or entity that engages in at least one value-based activity as part of a value-based enterprise. VBE participant does not include a pharmaceutical manufacturer; a</p>	<p>recipient for an unlawful purpose.</p> <p>(12) For a period of at least 6 years, the VBE or VBE participant makes available to the Secretary, upon request, all materials and records sufficient to establish compliance with the conditions of this paragraph (ee).</p> <p>(13) The remuneration is not exchanged by:</p> <p>(i) A pharmaceutical manufacturer, distributor, or wholesaler;</p> <p>(ii) A pharmacy benefit manager;</p> <p>(iii) A laboratory company;</p> <p>(iv) A pharmacy that primarily compounds drugs or primarily dispenses compounded drugs;</p> <p>(v) Except to the extent the entity is a limited technology participant, a manufacturer of a device or medical supply;</p> <p>(vi) Except to the extent the entity or individual is a limited technology participant, an entity or individual that sells or rents durable medical equipment, prosthetics, orthotics, or supplies covered by a Federal health care program</p>	

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
		<p>manufacturer, distributor, or supplier of durable medical equipment, prosthetics, orthotics, or supplies; or a laboratory.</p> <p>(vii) <i>Value-based purpose</i> means:                      (A) Coordinating and managing the care of a target patient population;                      (B) Improving the quality of care for a target patient population;                      (C) Appropriately reducing the costs to, or growth in expenditures of, payors without reducing the quality of care for a target patient population; or                      (D) Transitioning from healthcare delivery and payment mechanisms based on the volume of items and services provided to mechanisms based on the quality of care and control of costs of care for a target patient population.</p>	<p>(other than a pharmacy or a physician, provider, or other entity that primarily furnishes services); or                      (vii) A medical device distributor or wholesaler that is not otherwise a manufacturer of a device or medical supplies.</p> <p>(14) For purposes of this paragraph (ee), the following definitions apply:                      (i) <i>Coordination and management of care (or coordinating and managing care)</i> means the deliberate organization of patient care activities and sharing of information between two or more VBE participants, one or more VBE participants and the VBE, or one or more VBE participants and patients, that is designed to achieve safer, more effective, or more efficient care to improve the health outcomes of the target patient population.</p> <p>(ii) <i>Digital health technology</i> means hardware, software, or services that electronically capture, transmit, aggregate, or analyze data and that are used for the purpose of coordinating</p>	

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
			<p>and managing care; such term includes any internet or other connectivity service that is necessary and used to enable the operation of the item or service for that purpose.</p> <p><i>(iii) Limited technology participant</i> means a VBE participant that exchanges digital health technology with another VBE participant or a VBE and that is:</p> <p>(A) A manufacturer of a device or medical supply, but not including a manufacturer of a device or medical supply that was obligated under 42 CFR 403.906 to report one or more ownership or investment interests held by a physician or an immediate family member during the preceding calendar year, or that reasonably anticipates that it will be obligated to report one or more ownership or investment interests held by a physician or an immediate family member during the present calendar year (for purposes of this paragraph, the terms “ownership or investment interest,” “physician,” and “immediate family member”</p>	

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
			<p>have the same meaning as set forth in 42 CFR 403.902); or (B) An entity or individual that sells or rents durable medical equipment, prosthetics, orthotics, or supplies covered by a Federal health care program (other than a pharmacy or a physician, provider, or other entity that primarily furnishes services).</p> <p><i>(iv) Manufacturer of a device or medical supply</i> means an entity that meets the definition of applicable manufacturer in 42 CFR 403.902 because it is engaged in the production, preparation, propagation, compounding, or conversion of a device or medical supply that meets the definition of covered drug, device, biological, or medical supply in 42 CFR 403.902, but not including entities under common ownership with such entity.</p> <p><i>(v) Target patient population</i> means an identified patient population selected by the VBE or its VBE participants using legitimate and verifiable criteria that:</p> <p>(A) Are set out in writing in advance of the commencement</p>	

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
			<p>of the value-based arrangement; and</p> <p>(B) Further the value-based enterprise's value-based purpose(s).</p> <p>(vi) <i>Value-based activity</i>. (A) Means any of the following activities, provided that the activity is reasonably designed to achieve at least one value-based purpose of the value-based enterprise: (1) The provision of an item or service; (2) The taking of an action; or (3) The refraining from taking an action; and (B) Does not include the making of a referral.</p> <p>(vii) <i>Value-based arrangement</i> means an arrangement for the provision of at least one value-based activity for a target patient population to which the only parties are: (A) The value-based enterprise and one or more of its VBE participants; or (B) VBE participants in the same value-based enterprise.</p> <p>(viii) <i>Value-based enterprise</i> or VBE means two or more VBE participants:</p>	

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
			<p>(A) Collaborating to achieve at least one value-based purpose;</p> <p>(B) Each of which is a party to a value-based arrangement with the other or at least one other VBE participant in the value-based enterprise;</p> <p>(C) That have an accountable body or person responsible for financial and operational oversight of the value-based enterprise; and</p> <p>(D) That have a governing document that describes the value-based enterprise and how the VBE participants intend to achieve its value-based purpose(s).</p> <p><i>(ix) Value-based enterprise participant</i> or VBE participant means an individual or entity that engages in at least one value-based activity as part of a value-based enterprise, other than a patient acting in their capacity as a patient.</p> <p><i>(x) Value-based purpose</i> means:</p> <p>(A) Coordinating and managing the care of a target patient population;</p> <p>(B) Improving the quality of care for a target patient population;</p>	

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
			(C) Appropriately reducing the costs to or growth in expenditures of payors without reducing the quality of care for a target patient population; or (D) Transitioning from health care delivery and payment mechanisms based on the volume of items and services provided to mechanisms based on the quality of care and control of costs of care for a target patient population.	
<p><b>§ 1001.952 (ff) Exceptions – Value-based arrangements with substantial downside financial risk</b></p>	<p>N/A</p>	<p>As used in section 1128B of the Act, “remuneration” does not include the exchange of payments or anything of value between a VBE and a VBE participant pursuant to a value-based arrangement if all of the standards in paragraphs (ff)(1) through (8) are met:</p> <p>(1) The VBE (directly or through a VBE participant acting on the VBE’s behalf) has assumed (or is contractually obligated to assume in the next 6 months) substantial downside financial risk (as defined in this paragraph (ff)) from a payor for providing or arranging for the provision of items and services for a target patient population.</p>	<p>As used in section 1128B of the Act, “remuneration” does not include the exchange of payments or anything of value between a VBE and a VBE participant pursuant to a value-based arrangement if all of the following standards in paragraphs (ff)(1) through (8) of this section are met:</p> <p>(1) The remuneration is not exchanged by:</p> <ul style="list-style-type: none"> <li>(i) A pharmaceutical manufacturer, distributor, or wholesaler;</li> <li>(ii) A pharmacy benefit manager;</li> <li>(iii) A laboratory company;</li> <li>(iv) A pharmacy that primarily compounds drugs or primarily dispenses compounded drugs;</li> </ul>	<p>The final rule introduces protection for certain value-based arrangements where the participant in the value-based enterprise assumes substantial downside financial risk. It also defines “substantial downside financial risk.”</p> <p>The final rule modifies and clarifies many of the safe harbor requirements from the proposed rule. For safe harbor protection, a VBE must assume substantial downside financial risk from a payor under one of three methodologies, and a VBE participant must assume a meaningful share of the VBE’s total risk. In the final rule, meaningful share has been reduced to 5%, from the proposed 8%.</p> <p>The safe harbor, as finalized, protects both monetary and in-kind</p>

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
		<p>(2) Under the value-based arrangement, the VBE participant meaningfully shares in the VBE’s substantial downside financial risk for providing or arranging for the provision of items and services for the target patient population. For purposes of this paragraph (ff), a VBE participant meaningfully shares in the VBE’s substantial downside financial risk if the value-based arrangement provides that the VBE participant is subject to risk under one of the following three methodologies:</p> <p>(i) A risk-sharing payment pursuant to which the VBE participant is at risk for 8 percent of the amount for which the VBE is at risk under its agreement with the applicable payor;</p> <p>(ii) A partial or full capitation payment or similar payment methodology, excluding the Medicare inpatient prospective payment system or other like payment methodology; or</p> <p>(iii) In the case of a VBE participant that is a physician, a payment that meets the requirements of the regulatory exception for value-based arrangements with meaningful</p>	<p>(v) A manufacturer of a device or medical supply;</p> <p>(vi) An entity or individual that sells or rents durable medical equipment, prosthetics, orthotics, or supplies covered by a Federal health care program (other than a pharmacy or a physician, provider, or other entity that primarily furnishes services); or</p> <p>(vii) A medical device distributor or wholesaler that is not otherwise a manufacturer of a device or medical supplies.</p> <p>(2) The VBE (directly or through a VBE participant, other than a payor, acting on the VBE’s behalf) has assumed through a written contract or a value-based arrangement (or has entered into a written contract or a value-based arrangement to assume in the next 6 months) substantial downside financial risk from a payor for a period of at least 1 year.</p> <p>(3) The VBE participant (unless the VBE participant is the payor from which the VBE is assuming risk) is at risk for a meaningful share of the VBE’s substantial downside financial</p>	<p>remuneration exchanged pursuant to value-based arrangements between VBEs and VBE participants.</p> <p>Other safe harbor conditions addressed in the final rule include: ineligible entities; a 6-month “phase-in” period; requirements that certain remuneration be used to engage in value-based activities and directly connect to certain value-based purposes; writing and record retention requirements; protections for patient choice and clinical decision-making; protections against medically unnecessary services; limits on marketing or patient recruitment; and limits on remuneration that takes into account business or patients outside the value-based arrangement.</p> <p>The final rule does not include the proposed limit on outside funding of protected remuneration.</p>

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
		<p>downside financial risk at § 411.357(aa)(2) of this title.</p> <p>(3) The remuneration provided by, or shared among, the VBE and VBE participant:</p> <p>(i) Is used primarily to engage in value-based activities that are directly connected to the items and services for which the VBE is at substantial downside financial risk and that are set forth in writing pursuant to paragraph (ff)(4) of this section;</p> <p>(ii) Is directly connected to one or more of the VBE’s value-based purposes, at least one of which must be the coordination and management of care for the target patient population;</p> <p>(iii) Does not induce VBE participants to reduce or limit medically necessary items or services furnished to any patient;</p> <p>(iv) Does not include the offer or receipt of an ownership or investment interest in an entity or any distributions related to such ownership or investment interest; and</p> <p>(v) Is not funded by, and does not otherwise result from the contributions of, any individual or entity outside of the VBE.</p>	<p>risk for providing or arranging for the provision of items and services for the target patient population.</p> <p>(4) The remuneration provided by, or shared among, the VBE and VBE participant:</p> <p>(i) Is directly connected to one or more of the VBE’s value-based purposes, at least one of which must be a value-based purpose defined in §1001.952(ee)(14)(x)(A), (B), or (C);</p> <p>(ii) Unless exchanged pursuant to risk methodologies defined in paragraph (ff)(9)(i) or (ii) of this section, is used predominantly to engage in value-based activities that are directly connected to the items and services for which the VBE has assumed (or has entered into a written contract or value based arrangement to assume in the next 6 months) substantial downside financial risk;</p> <p>(iii) Does not include the offer or receipt of an ownership or investment interest in an entity or any distributions related to such ownership or investment interest; and</p> <p>(iv) Is not exchanged or used for the purpose of marketing</p>	

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
		<p>(4) In advance of, or contemporaneous with, the commencement of the value-based arrangement or any material change to the value-based arrangement, the VBE and VBE participant set forth in a signed writing the terms of the value-based arrangement. The writing states all material terms of the value-based arrangement, including: a description of the nature and extent of the VBE’s substantial downside financial risk for the target patient population; a description of the manner in which the recipient meaningfully shares in the VBE’s substantial downside financial risk; the value-based activities; the target patient population; and the type and the offeror’s cost of the remuneration.</p> <p>(5) The VBE or VBE participant offering the remuneration does not take into account the volume or value of, or condition the remuneration on:</p> <p>(i) Referrals of patients who are not part of the target patient population; or</p> <p>(ii) Business not covered under the value-based arrangement.</p>	<p>items or services furnished by the VBE or a VBE participant to patients or for patient recruitment activities.</p> <p>(5) The value-based arrangement is set forth in writing, is signed by the parties in advance of, or contemporaneous with, the commencement of the value-based arrangement and any material change to the value-based arrangement, and specifies all material terms including:</p> <p>(i) Terms evidencing that the VBE is at substantial downside financial risk or will assume such risk in the next 6 months for the target patient population;</p> <p>(ii) A description of the manner in which the VBE participant (unless the VBE participant is the payor from which the VBE is assuming risk) has a meaningful share of the VBE’s substantial downside financial risk; and</p> <p>(iii) The value-based activities, the target patient population, and the type of remuneration exchanged.</p> <p>(6) The VBE or VBE participant offering the remuneration does not take into account the volume or value of, or condition the remuneration on:</p>	

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
		<p>(6) The value-based arrangement does not:</p> <p>(i) Place any limitation on VBE participants’ ability to make decisions in the best interest of their patients;</p> <p>(ii) Direct or restrict referrals to a particular provider, practitioner, or supplier if:</p> <p>(A) A patient expresses a preference for a different practitioner, provider, or supplier;</p> <p>(B) The patient’s payor determines the provider, practitioner, or supplier; or (C) Such direction or restriction is contrary to applicable law or regulations under titles XVIII and XIX of the Act; or</p> <p>(iii) Include marketing to patients of items or services or engaging in patient recruitment activities.</p> <p>(7) The VBE or VBE participant makes available to the Secretary, upon request, all materials and records sufficient to establish compliance with the conditions of this paragraph (ff).</p> <p>(8) For purposes of this paragraph (ff), the following definitions apply:</p>	<p>(i) Referrals of patients who are not part of the target patient population; or</p> <p>(ii) Business not covered under the value-based arrangement.</p> <p>(7) The value-based arrangement does not:</p> <p>(i) Limit the VBE participant’s ability to make decisions in the best interests of its patients;</p> <p>(ii) Direct or restrict referrals to a particular provider, practitioner, or supplier if:</p> <p>(A) A patient expresses a preference for a different practitioner, provider, or supplier;</p> <p>(B) The patient’s payor determines the provider, practitioner, or supplier; or</p> <p>(C) Such direction or restriction is contrary to applicable law under titles XVIII and XIX of the Act; or</p> <p>(iii) Induce parties to reduce or limit medically necessary items or services furnished to any patient.</p> <p>(8) For a period of at least 6 years, the VBE or VBE participant makes available to the Secretary, upon request, all materials and records sufficient to establish compliance with</p>	

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
		<p>(i) <i>Substantial downside financial risk</i> means risk, for the entire term of the value-based arrangement, in the form of:</p> <p>(A) Shared savings with a repayment obligation to the payor of at least 40 percent of any shared losses, where loss is determined based upon a comparison of costs to historical expenditures, or to the extent such data is unavailable, evidence-based, comparable expenditures;</p> <p>(B) A repayment obligation to the payor under an episodic or bundled payment arrangement of at least 20 percent of any total loss, where loss is determined based upon a comparison of costs to historical expenditures, or to the extent such data is unavailable, evidence-based, comparable expenditures;</p> <p>(C) A prospectively paid population-based payment for a defined subset of the total cost of care of a target patient population, where such payment is determined based upon a review of historical expenditures, or to the extent such data is unavailable, evidence-based, comparable expenditures; or</p>	<p>the conditions of this paragraph (ff).</p> <p>(9) For purposes of this paragraph (ff), the following definitions apply:</p> <p>(i) Substantial downside financial risk means:</p> <p>(A) Financial risk equal to at least 30 percent of any loss, where losses and savings are calculated by comparing current expenditures for all items and services that are covered by the applicable payor and furnished to the target patient population to a bona fide benchmark designed to approximate the expected total cost of such care;</p> <p>(B) Financial risk equal to at least 20 percent of any loss, where:</p> <p>(1) Losses and savings are calculated by comparing current expenditures for all items and services furnished to the target patient population pursuant to a defined clinical episode of care that are covered by the applicable payor to a bona fide benchmark designed to approximate the expected total cost of such care for the defined clinical episode of care; and</p>	

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
		<p>(D) A partial capitated payment from the payor for a set of items and services for the target patient population, where such capitated payment reflects a discount equal to at least 60 percent of the total expected fee-for-service payments based on historical expenditures, or to the extent such data is unavailable, evidence-based, comparable expenditures of the VBE participants to the value-based arrangement.</p> <p>(ii) <i>Coordination and management of care, target patient population, value-based activity, value-based arrangement, value-based enterprise, value-based purpose, and VBE participant shall have the meaning set forth in paragraph (ee).</i></p>	<p>(2) The parties design the clinical episode of care to cover items and services collectively furnished in more than one care setting; or</p> <p>(C) The VBE receives from the payor a prospective, per-patient payment that is:</p> <p>(1) Designed to produce material savings; and</p> <p>(2) Paid on a monthly, quarterly, or annual basis for a predefined set of items and services furnished to the target patient population, designed to approximate the expected total cost of expenditures for the predefined set of items and services.</p> <p>(ii) Meaningful share means the VBE participant:</p> <p>(A) Assumes two-sided risk for at least 5 percent of the losses and savings, as applicable, realized by the VBE pursuant to its assumption of substantial downside financial risk; or</p> <p>(B) Receives from the VBE a prospective, per-patient payment on a monthly, quarterly, or annual basis for a predefined set of items and services furnished to the target patient population, designed to approximate the expected total</p>	

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
			<p>cost of expenditures for the predefined set of items and services, and does not claim payment in any form from the payor for the predefined items and services.</p> <p>(iii) Manufacturer of a device or medical supply, target patient population, value-based activity, value-based arrangement, value-based enterprise, value-based purpose, and VBE participant shall have the meaning set forth in paragraph (ee) of this section.</p>	
<p><b>§ 1001.952 (gg) Exceptions – Value-based arrangements with full financial risk</b></p>	<p><i>N/A</i></p>	<p>As used in section 1128B of the Act, “remuneration” does not include the exchange of payments or anything of value between the VBE and a VBE participant pursuant to a value-based arrangement if all of the standards in paragraphs (gg)(1) through (8) are met:</p> <p>(1) The VBE (directly or through a VBE participant acting on behalf of the VBE) has assumed (or is contractually obligated to assume in the next 6 months) full financial risk from a payor and has a signed writing with the payor that specifies the target patient population and contains terms evidencing that the VBE is at full financial risk for that</p>	<p>As used in section 1128B of the Act, “remuneration” does not include the exchange of payments or anything of value between the VBE and a VBE participant pursuant to a value-based arrangement if all of the standards in paragraphs (gg)(1) through (9) of this section are met:</p> <p>(1) The remuneration is not exchanged by:                      (i) A pharmaceutical manufacturer, distributor, or wholesaler;                      (ii) A pharmacy benefit manager;                      (iii) A laboratory company;                      (iv) A pharmacy that primarily compounds drugs or primarily</p>	<p>The final rule introduces protection of certain value-based arrangements where the participant in the value-based enterprise assumes full financial risk for the applicable items and services.</p> <p>It includes the definition of “full financial risk” that differs from the proposed definition, in that it require the VBE to be at risk on a prospective basis for the cost of all items and services covered by the applicable payor for each patient in the target patient population for a term of at least 1 year. The final rule also defines “prospective basis.”</p> <p>The final rule modifies several of the proposed safeguards in paragraphs</p>

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
		<p>population for a period of at least 1 year.</p> <p>(2) The value-based arrangement is set out in a writing signed by the parties that specifies the material terms of the value-based arrangement, including the value-based activities to be undertaken by the parties, and is for a period of at least 1 year.</p> <p>(3) The VBE participant does not claim payment in any form directly or indirectly from a payor for items or services covered under the value-based arrangement.</p> <p>(4) The remuneration exchanged between the VBE and a VBE participant:</p> <p>(i) Is used primarily to engage in the value-based activities set forth in writing pursuant to paragraph (gg)(2) of this section;</p> <p>(ii) Is directly connected to one or more of the VBE’s value-based purposes, at least one of which must be the coordination and management of care for the target patient population;</p> <p>(iii) Does not induce the VBE or VBE participants to reduce or limit medically necessary items</p>	<p>dispenses compounded drugs;</p> <p>(v) A manufacturer of a device or medical supply;</p> <p>(vi) An entity or individual that sells or rents durable medical equipment, prosthetics, orthotics, or supplies covered by a Federal health care program (other than a pharmacy or a physician, provider, or other entity that primarily furnishes services); or</p> <p>(vii) A medical device distributor or wholesaler that is not otherwise a manufacturer of a device or medical supplies.</p> <p>(2) The VBE (directly or through a VBE participant, other than a payor, acting on behalf of the VBE) has assumed through a written contract or a value-based arrangement (or has entered into a written contract or a value-based arrangement to assume in the next 1 year) full financial risk from a payor.</p> <p>(3) The value-based arrangement is set forth in writing, is signed by the parties, and specifies all material terms, including the value-based activities and the term.</p>	<p>(gg)(2-8), and adds a list of ineligible entities at paragraph (gg)(1).</p>

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
		<p>or services furnished to any patient;</p> <p>(iv) Does not include the offer or receipt of an ownership or investment interest in an entity or any distributions related to such ownership or investment interest; and</p> <p>(v) Is not funded by, and does not otherwise result from the contributions of, any individual or entity outside of the VBE.</p> <p>(5) The VBE or VBE participant does not take into account the volume or value of, or condition the remuneration on:</p> <p>(i) Referrals of patients who are not part of the target patient population; or</p> <p>(ii) Business not covered under the value-based arrangement.</p> <p>(6) The VBE provides or arranges for:</p> <p>(i) An operational utilization review program; and</p> <p>(ii) A quality assurance program that protects against underutilization and specifies patient goals, including measurable outcomes, where appropriate.</p>	<p>(4) The VBE participant (unless the VBE participant is a payor) does not claim payment in any form from the payor for items or services covered under the contract or value-based arrangement between the VBE and the payor described in paragraph (2).</p> <p>(5) The remuneration provided by, or shared among, the VBE and VBE participant:</p> <p>(i) Is directly connected to one or more of the VBE’s value-based purposes;</p> <p>(ii) Does not include the offer or receipt of an ownership or investment interest in an entity or any distributions related to such ownership or investment interest; and</p> <p>(iii) Is not exchanged or used for the purpose of marketing items or services furnished by the VBE or a VBE participant to patients or for patient recruitment activities.</p> <p>(6) The value-based arrangement does not induce parties to reduce or limit medically necessary items or services furnished to any patient.</p>	

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
		<p>(7) The value-based arrangement does not include marketing to patients of items or services or engaging in patient recruitment activities.</p> <p>(8) The VBE or VBE participant makes available to the Secretary, upon request, all materials and records sufficient to establish compliance with the conditions of this paragraph (gg).</p> <p>(9) For purposes of this paragraph (gg), the following definitions apply:                      (i) <i>Full financial risk</i> means the VBE is financially responsible for the cost of all items and services covered by the applicable payor for each patient in the target patient population and is prospectively paid by the applicable payor; (ii) <i>Items and services</i> shall have the meaning set forth in § 1001.952(t)(2)(iv); and                      (iii) <i>Coordination and management of care, target patient population, value-based activity, value-based arrangement, value-based enterprise, value-based purpose, and VBE participant</i> shall have the meaning set forth in paragraph (ee).</p>	<p>(7) The VBE or VBE participant offering the remuneration does not take into account the volume or value of, or condition the remuneration on:                      (i) Referrals of patients who are not part of the target patient population; or                      (ii) Business not covered under the value-based arrangement.</p> <p>(8) The VBE provides or arranges for a quality assurance program for services furnished to the target patient population that:                      (i) Protects against underutilization; and                      (ii) Assesses the quality of care furnished to the target patient population.</p> <p>(9) For a period of at least 6 years, the VBE or VBE participant makes available to the Secretary, upon request, all materials and records sufficient to establish compliance with the conditions of this paragraph (gg).</p> <p>(10) For purposes of this paragraph (gg), the following definitions apply:</p>	

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
			<p>(i) <i>Full financial risk</i> means the VBE is financially responsible on a prospective basis for the cost of all items and services covered by the applicable payor for each patient in the target patient population for a term of at least 1 year.</p> <p>(ii) <i>Prospective basis</i> means that the VBE has assumed financial responsibility for the cost of all items and services covered by the applicable payor prior to the provision of items and services to patients in the target patient population.</p> <p>(iii) <i>Items and services</i> means health care items, devices, supplies, and services.</p> <p>(iv) <i>Manufacturer of a device or medical supply, target patient population, value-based activity, value-based arrangement, value-based enterprise, value-based purpose, and VBE participant</i> shall have the meaning set forth in paragraph (ee) of this section.</p>	
<p><b>§ 1001.952 (hh) Exceptions – Arrangements for patient engagement and support to improve quality,</b></p>	<p><i>N/A</i></p>	<p>As used in section 1128B of the Act, “remuneration” does not include a patient engagement tool or support furnished by a VBE participant to a patient in a target patient population if all of the conditions in paragraphs</p>	<p>As used in section 1128B of the Act, “remuneration” does not include a patient engagement tool or support furnished by a VBE participant to a patient in the target patient population of a value-based arrangement to which the VBE participant is a</p>	<p>The final rule introduces protection for certain patient engagement tools or support provided to certain patients by a participant in a value-based enterprise.</p> <p>The final rule adds a list of entities ineligible for protection, and</p>

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
<p><b>health outcomes, and efficiency</b></p>		<p>(hh)(1) through (6) of this section are met:</p> <p>(1) The patient engagement tool or support is furnished directly to the patient by a VBE participant.</p> <p>(2) No individual or entity outside of the applicable VBE funds or otherwise contributes to the provision of the patient engagement tool or support.</p> <p>(3) The patient engagement tool or support:</p> <p>(i) Is an in-kind preventive item, good, or service, or an in-kind item, good, or service such as health-related technology, patient health-related monitoring tools and services, or supports and services designed to identify and address a patient’s social determinants of health;</p> <p>(ii) That has a direct connection to the coordination and management of care of the target patient population;</p> <p>(iii) Does not include any gift card, cash, or cash equivalent;</p> <p>(iv) Does not include any in-kind item, good, or service used for patient recruitment or marketing of items or services to patients;</p>	<p>party if all of the conditions in paragraphs (hh)(1) through (9) of this section are met:</p> <p>(1) The VBE participant is not:</p> <p>(i) A pharmaceutical manufacturer, distributor, or wholesaler;</p> <p>(ii) A pharmacy benefit manager;</p> <p>(iii) A laboratory company;</p> <p>(iv) A pharmacy that primarily dispenses compounded drugs;</p> <p>(v) A manufacturer of a device or medical supply, unless the patient engagement tool or support is digital health technology;</p> <p>(vi) An entity or individual that sells or rents durable medical equipment, prosthetics, orthotics, or supplies covered by a Federal health care program (other than a pharmacy, a manufacturer of a device or medical supply, or a physician, provider, or other entity that primarily furnishes services);</p> <p>(vii) A medical device distributor or wholesaler that is not otherwise a manufacturer of a device or medical supply;</p> <p>or</p>	<p>modifies certain other elements of the proposed rule. The final rule removes illustrative categories of health-related technologies, patient health-related monitoring tools and services, and supports and services designed to identify and address a patient’s social determinants of health. The final rule is agnostic as to the types of in-kind tools and supports the safe harbor can protect.</p> <p>The final rules adds several new conditions to the safe harbor. It also removes several proposed conditions.</p>

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
		<p>(v) Does not result in medically unnecessary or inappropriate items or services reimbursed in whole or in part by a Federal health care program;</p> <p>(vi) Is recommended by the patient’s licensed healthcare provider; and</p> <p>(vii) advances one or more of the following goals:                      (A) Adherence to a treatment regimen determined by the patient’s licensed healthcare provider.                      (B) Adherence to a drug regimen determined by the patient’s licensed healthcare provider.                      (C) Adherence to a follow-up care plan established by the patient’s licensed healthcare provider.                      (D) Management of a disease or condition as directed by the patient’s licensed healthcare provider.                      (E) Improvement in measurable evidence-based health outcomes for the patient or for the target patient population.                      (F) Ensuring patient safety.</p> <p>(4) The offeror does not, and should not, know that the remuneration is likely to be diverted, sold, or utilized by the</p>	<p>(viii) A manufacturer of a device or medical supply that was obligated under 42 CFR 403.906 to report one or more ownership or investment interests held by a physician or an immediate family member during the preceding calendar year, or that reasonably anticipates that it will be obligated to report one or more ownership or investment interests held by a physician or an immediate family member during the present calendar year, even if the patient engagement tool or support is digital health technology (for purposes of this paragraph, the terms “ownership or investment interest,” “physician,” and “immediate family member” have the same meaning as set forth in 42 CFR 403.902).</p> <p>(2) The patient engagement tool or support is furnished directly to the patient (or the patient’s caregiver, family member, or other individual acting on the patient’s behalf) by a VBE participant that is a party to the value-based arrangement or its eligible agent.</p>	

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
		<p>patient other than for the express purpose for which the patient engagement tool or support is provided.</p> <p>(5) The aggregate retail value of patient engagement tools and supports furnished to a patient by a VBE participant on an annual basis does not exceed \$500 unless such patient engagement tools and supports are furnished to patients based on a good faith, individualized determination of the patient’s financial need.</p> <p>(6) The VBE participant makes available to the Secretary, upon request, all materials and records sufficient to establish that the patient engagement tool or support was distributed in a manner that meets the conditions of this paragraph (hh).</p> <p>(7) For purposes of this paragraph (hh), <i>coordination and management of care, target patient population, value-based purpose, VBE, and VBE participant</i> shall have the meaning set forth in paragraph (ee).</p>	<p>(3) The patient engagement tool or support:</p> <p>(i) Is an in-kind item, good, or service;</p> <p>(ii) That has a direct connection to the coordination and management of care of the target patient population;</p> <p>(iii) Does not include any cash or cash equivalent;</p> <p>(iv) Does not result in medically unnecessary or inappropriate items or services reimbursed in whole or in part by a Federal health care program;</p> <p>(v) Is recommended by the patient’s licensed health care professional; and</p> <p>(vi) Advances one or more of the following goals:</p> <p>(A) Adherence to a treatment regimen determined by the patient’s licensed health care professional.</p> <p>(B) Adherence to a drug regimen determined by the patient’s licensed health care professional.</p> <p>(C) Adherence to a followup care plan established by the patient’s licensed health care professional.</p> <p>(D) Prevention or management of a disease or condition as</p>	

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
			<p>directed by the patient’s licensed health care professional.</p> <p>(E) Ensure patient safety.</p> <p>(4) The patient engagement tool or support is not funded or contributed by:                      (i) A VBE participant that is not a party to the applicable value-based arrangement; or                      (ii) An entity listed in paragraph (hh)(1) of this section.</p> <p>(5) The aggregate retail value of patient engagement tools and supports furnished to a patient by a VBE participant on an annual basis does not exceed \$500. The monetary cap set forth in this paragraph (hh)(5) is adjusted each calendar year to the nearest whole dollar by the increase in the Consumer Price Index - Urban All Items (CPI-U) for the 12-month period ending the preceding September 30. OIG will publish guidance after September 30 of each year reflecting the increase in the CPI-U for the 12-month period ending September 30 and the new monetary cap applicable for the following calendar year.</p>	

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
			<p>(6) The VBE participant or any eligible agent does not exchange or use the patient engagement tools or supports to market other reimbursable items or services or for patient recruitment purposes.</p> <p>(7) For a period of at least 6 years, the VBE participant makes available to the Secretary, upon request, all materials and records sufficient to establish that the patient engagement tool or support was distributed in a manner that meets the conditions of this paragraph (hh).</p> <p>(8) The availability of a tool or support is not determined in a manner that takes into account the type of insurance coverage of the patient.</p> <p>(9) For purposes of this paragraph (hh), the following definitions apply:                      (i) <i>Eligible agent</i> means any person or entity that is not identified in paragraphs (hh)(1)(i) through (viii) of this section as ineligible to furnish protected tools and supports under this paragraph.                      (ii) <i>Coordination and management of care, target</i></p>	

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
			<i>patient population, value-based arrangement, VBE, VBE participant, manufacturer of a device or medical supply, and digital health technology</i> shall have the meaning set forth in paragraph (ee) of this section.	
<p><b>§ 1001.952 (ii) Exceptions – CMS-sponsored model arrangements and CMS-sponsored model patient incentives</b></p>	<p>N/A</p>	<p>(1) As used in section 1128B of the Act, “remuneration” does not include an exchange of anything of value between or among CMS-sponsored model parties under a CMS-sponsored model arrangement in a model for which CMS has determined that this safe harbor is available if all of the following conditions are met:</p> <p>(i) The CMS-sponsored model parties reasonably determine that the CMS-sponsored model arrangement will advance one or more goals of the CMS-sponsored model;</p> <p>(ii) The exchange of value does not induce CMS-sponsored model parties or other providers or suppliers to furnish medically unnecessary items or services or reduce or limit medically necessary items or services furnished to any patient</p>	<p>(1) As used in section 1128B of the Act, “remuneration” does not include an exchange of anything of value between or among CMS-sponsored model parties under a CMS-sponsored model arrangement for which CMS has determined that this safe harbor is available if all of the following conditions are met:</p> <p>(i) The CMS-sponsored model parties reasonably determine that the CMS-sponsored model arrangement will advance one or more goals of the CMS-sponsored model;</p> <p>(ii) The exchange of value does not induce CMS-sponsored model parties or other providers or suppliers to furnish medically unnecessary items or services, or reduce or limit medically necessary items or services furnished to any patient;</p> <p>(iii) The CMS-sponsored model parties do not offer, pay, solicit,</p>	<p>The final rule creates a new safe harbor to protect remuneration among parties to arrangements under a model (or other initiative) being tested or expanded by CMS (the Innovation Center and the Medicare Shared Savings Program). It protects incentives and supports provided by CMS model participants and their agents under a CMS-sponsored model to patients covered by the model.</p> <p>The final rule makes slight modifications to the conditions for safe harbor protection found in proposed rule.</p>

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
		<p>(iii) The CMS-sponsored model parties do not offer, pay, solicit, or receive remuneration in return for, or to induce or reward, any Federal health care program referrals or other Federal health care program business generated outside of the CMS-sponsored model;</p> <p>(iv) The CMS-sponsored model parties, in advance of, or contemporaneous with the commencement of, the CMS-sponsored model arrangement, set forth the terms of the CMS-sponsored model arrangement in a signed writing. The writing must specify, at a minimum, the activities to be undertaken by the CMS-sponsored model parties and the nature of the remuneration to be exchanged under the CMS-sponsored model arrangement;</p> <p>(v) The parties to the CMS-sponsored model arrangement make available to the Secretary, upon request, all materials and records sufficient to establish whether the remuneration was exchanged in a manner that meets the conditions of this safe harbor; and</p>	<p>or receive remuneration in return for, or to induce or reward, any Federal health care program referrals or other Federal health care program business generated outside of the CMS-sponsored model;</p> <p>(iv) The CMS-sponsored model parties in advance of or contemporaneous with the commencement of the CMS-sponsored model arrangement set forth the terms of the CMS-sponsored model arrangement in a signed writing. The writing must specify at a minimum the activities to be undertaken by the CMS-sponsored model parties and the nature of the remuneration to be exchanged under the CMS-sponsored model arrangement;</p> <p>(v) The parties to the CMS-sponsored model arrangement make available to the Secretary, upon request, all materials and records sufficient to establish whether the remuneration was exchanged in a manner that meets the conditions of this safe harbor; and</p> <p>(vi) The CMS-sponsored model parties satisfy such</p>	

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
		<p>(vi) The CMS-sponsored model parties satisfy such programmatic requirements as may be imposed by CMS in connection with the use of this safe harbor.</p> <p>(2) As used in section 1128B of the Act, “remuneration” does not include a CMS-sponsored model patient incentive under a model for which CMS has determined that this safe harbor is available, if all of the conditions of paragraph (ii)(2)(i) through (v) are met:</p> <p>(i) The CMS-sponsored model participant reasonably determines that the CMS-sponsored model patient incentive will advance one or more goals of the CMS-sponsored model;</p> <p>(ii) The CMS-sponsored model patient incentive has a direct connection to the patient’s healthcare;</p> <p>(iii) The CMS-sponsored model participant makes available to the Secretary, upon request, all materials and records sufficient to establish whether the CMS-sponsored model patient</p>	<p>programmatic requirements as may be imposed by CMS in connection with the use of this safe harbor.</p> <p>(2) As used in section 1128B of the Act, “remuneration” does not include a CMS-sponsored model patient incentive for which CMS has determined that this safe harbor is available if all of the following conditions are met:</p> <p>(i) The CMS-sponsored model participant reasonably determines that the CMS-sponsored model patient incentive will advance one or more goals of the CMS-sponsored model;</p> <p>(ii) The CMS-sponsored model patient incentive has a direct connection to the patient’s health care unless the participation documentation expressly specifies a different standard;</p> <p>(iii) The CMS-sponsored model patient incentive is furnished by a CMS-sponsored model participant (or by an agent of the CMS-sponsored model participant under the CMS-sponsored model participant’s direction and control), unless</p>	

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
		<p>incentive was distributed in a manner that meets the conditions of this paragraph; and</p> <p>(iv) The CMS-sponsored model participant satisfies such programmatic requirements as may be imposed by CMS in connection with the use of this safe harbor.</p> <p>(v) For purposes of this paragraph (ii)(2), a patient may retain any incentives received prior to the termination or expiration of the participation documentation of the CMS-sponsored model participant.</p> <p>(3) For purposes of this paragraph (ii), the following definitions apply:</p> <p>(i) <i>CMS-sponsored model</i> means:                      (A) A model being tested under section 1115A(b) of the Act or a model expanded under section 1115A(c) of the Act; or                      (B) The Medicare shared savings program under section 1899 of the Act;</p> <p>(ii) <i>CMS-sponsored model arrangement</i> means an arrangement between or among</p>	<p>otherwise specified by the participation documentation;</p> <p>(iv) The CMS-sponsored model participant makes available to the Secretary, upon request, all materials and records sufficient to establish whether the CMS-sponsored model patient incentive was distributed in a manner that meets the conditions of this safe harbor; and</p> <p>(v) The CMS-sponsored model patient incentive is furnished consistent with the CMS-sponsored model and satisfies such programmatic requirements as may be imposed by CMS in connection with the use of this safe harbor.</p> <p>(3) For purposes of this paragraph (ii), the following definitions apply:</p> <p>(i) <i>CMS-sponsored model</i> means:                      (A) A model being tested under section 1115A(b) of the Act or a model expanded under section 1115A(c) of the Act; or                      (B) The Medicare shared savings program under section 1899 of the Act.</p>	

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
		<p>CMS-sponsored model parties to engage in activities under the CMS-sponsored model and that is consistent with, and is not a type of arrangement prohibited by, the participation documentation;</p> <p>(iii) <i>CMS-sponsored model participant</i> means an individual or entity that is subject to, and is operating under, participation documentation with CMS to participate in a CMS-sponsored model;</p> <p>(iv) <i>CMS-sponsored model party</i> means: (A) A CMS-sponsored model participant; or (B) Other individual or entity who the participation documentation specifies may enter into a CMS-sponsored model arrangement;</p> <p>(v) <i>CMS-sponsored model patient incentive</i> means remuneration not of a type prohibited by the participation documentation and is furnished consistent with the CMS-sponsored model by a CMS-sponsored model participant (or by an agent of the CMS-sponsored model participant</p>	<p>(ii) <i>CMS-sponsored model arrangement</i> means a financial arrangement between or among CMS-sponsored model parties to engage in activities under the CMS-sponsored model that is consistent with, and is not a type of arrangement prohibited by, the participation documentation.</p> <p>(iii) <i>CMS-sponsored model participant</i> means an individual or entity that is subject to and is operating under participation documentation with CMS to participate in a CMS-sponsored model.</p> <p>(iv) <i>CMS-sponsored model party</i> means: (A) A CMS-sponsored model participant; or (B) Another individual or entity whom the participation documentation specifies may enter into a CMS-sponsored model arrangement.</p> <p>(v) <i>CMS-sponsored model patient incentive</i> means remuneration not of a type prohibited by the participation documentation that is furnished to a patient under the terms of a CMS-sponsored model.</p>	

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
		<p>under the CMS-sponsored model participant’s direction and control) directly to a patient under the CMS-sponsored model; and</p> <p>(vi) <i>Participation documentation</i> means the participation agreement, cooperative agreement, regulations, or model-specific addendum to an existing contract with CMS that:</p> <p>(A) Is currently in effect, and</p> <p>(B) Specifies the terms of a CMS-sponsored model.</p>	<p>(vi) <i>Participation documentation</i> means the participation agreement, legal instrument setting forth the terms and conditions of a grant or cooperative agreement, regulations, or model-specific addendum to an existing contract with CMS that specifies the terms of a CMS-sponsored model.</p>	
<b>§ 1001.952 (jj) Exceptions – Cybersecurity technology and related services</b>	N/A	<p>As used in section 1128B of the Act, “remuneration” does not include nonmonetary remuneration (consisting of certain types of cybersecurity technology and services), if all of the conditions in paragraphs (jj)(1) through (5) are met:</p> <p>(1) The technology and services are necessary and used predominantly to implement and maintain effective cybersecurity.</p> <p>(2) The donor does not:</p> <p>(i) Directly take into account the volume or value of referrals or other business generated between the parties when determining the eligibility of a potential recipient for the</p>	<p>As used in section 1128B of the Act, “remuneration” does not include nonmonetary remuneration (consisting of cybersecurity technology and services) that is necessary and used predominantly to implement, maintain, or reestablish effective cybersecurity if all of the conditions in paragraphs (jj)(1) through (4) of this section are met.</p> <p>(1) The donor does not:</p> <p>(i) Directly take into account the volume or value of referrals or other business generated between the parties when determining the eligibility of a potential recipient for the</p>	The final rule created a new safe harbor to protect certain cybersecurity donations and related services. It defines “cybersecurity” and “technology.”

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
		<p>technology or services, or the amount or nature of the technology or services to be donated; or</p> <p>(ii) Condition the donation of technology or services, or the amount or nature of the technology or services to be donated, on future referrals.</p> <p>(3) Neither the recipient nor the recipient’s practice (or any affiliated individual or entity) makes the receipt of technology or services, or the amount or nature of the technology or services, a condition of doing business with the donor.</p> <p>(4) The arrangement is set forth in a written agreement that:</p> <p>(i) Is signed by the parties;</p> <p>(ii) Describes the technology and services being provided and the amount of the recipient’s contribution, if any; and</p> <p>(5) The donor does not shift the costs of the technology or services to any Federal health care program.</p> <p>(6) For purposes of this paragraph (jj) the following definitions apply:</p>	<p>technology or services, or the amount or nature of the technology or services to be donated; or</p> <p>(ii) Condition the donation of technology or services, or the amount or nature of the technology or services to be donated, on future referrals.</p> <p>(2) Neither the recipient nor the recipient’s practice (or any affiliated individual or entity) makes the receipt of technology or services, or the amount or nature of the technology or services, a condition of doing business with the donor.</p> <p>(3) A general description of the technology and services being provided and the amount of the recipient’s contribution, if any, are set forth in writing and signed by the parties.</p> <p>(4) The donor does not shift the costs of the technology or services to any Federal health care program.</p> <p>(5) For purposes of this paragraph (jj) the following definitions apply:</p>	

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
		(i) <i>cybersecurity</i> means the process of protecting information by preventing, detecting, and responding to cyberattacks. (ii) <i>technology</i> means any software or other types of information technology, other than hardware.	(i) <i>Cybersecurity</i> means the process of protecting information by preventing, detecting, and responding to cyberattacks. (ii) <i>Technology</i> means any software or other types of information technology.	
<b>§ 1001.952 (kk) Exceptions – ACO Beneficiary Incentive Program</b>	N/A	As used in section 1128B of the Act, “remuneration” does not include an incentive payment made by an ACO to an assigned beneficiary under a beneficiary incentive program established under section 1899(m) of the Act, as amended by Congress from time to time, if the incentive payment is made in accordance with the requirements found in such subsection.	As used in section 1128B of the Act, “remuneration” does not include an incentive payment made by an ACO to an assigned beneficiary under a beneficiary incentive program established under section 1899(m) of the Act, as amended by Congress from time to time, if the incentive payment is made in accordance with the requirements found in such subsection.	The final rule excepts from the definition of “remuneration” incentive payments from ACOs to assigned beneficiaries under a beneficiary incentive program, if the payment is made in accordance with program requirements established in the law implementing the program.
<b>Definitions (proposed changes to the CMP regulations at 42 CFR § 1003.110)</b>				
<b>§ 1003.110 – Definitions; Remuneration</b>	The term “remuneration” does not include: ...	... (10) The provision of telehealth technologies by a provider of services or a renal dialysis facility (as such terms are defined for purposes of title XVIII of the Act) to an individual with end stage renal disease who is receiving home dialysis for which payment is being made under part B of such title, if—	... (10) The provision of telehealth technologies by a provider of services, physician, or a renal dialysis facility (as such terms are defined for purposes of title XVIII of the Act) to an individual with end-stage renal disease who is receiving home dialysis for which payment is being made under part B of such title, if:	The final rule adds an exception for the provision of certain telehealth technologies related to in-home dialysis services to the definition of “remuneration.” This definition applies to the beneficiary inducements CMP.  The final rule removes most of the proposed language text language that does not exist in the statutory exception at 1128A(i)(6)(J).

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
		<p>(i) The telehealth technologies are furnished to the individual by the provider of services or the renal dialysis facility that is currently providing the in-home dialysis, telehealth visits, or other end stage renal disease care to the patient;</p> <p>(ii) The telehealth technologies are not offered as part of any advertisement or solicitation;</p> <p>(iii) The telehealth technologies contribute substantially to the provision of telehealth services related to the individual’s end stage renal disease, is not of excessive value, and is not duplicative of technology that the beneficiary already owns if that technology is adequate for the telehealth purposes; and</p> <p>(iv) The provider of services or a renal dialysis facility does not bill Federal health care programs, other payors, or individuals for the telehealth technologies, claim the value of the telehealth technologies as a bad debt for payment purposes under a Federal health care program, or otherwise shift the burden of the value of the</p>	<p>(i) The telehealth technologies are furnished to the individual by the provider of services, physician, or the renal dialysis facility that is currently providing the in-home dialysis, telehealth services, or other end-stage renal disease care to the individual, or has been selected or contacted by the individual to schedule an appointment or provide services;</p> <p>(ii) The telehealth technologies are not offered as part of any advertisement or solicitation; and</p> <p>(iii) The telehealth technologies are provided for the purpose of furnishing telehealth services related to the individual’s end-stage renal disease.</p>	

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



Reference	Current Regulations prior to January 19, 2021	Proposed Regulations	Final Amended Regulations, effective January 19, 2021	Change / Comments
		telehealth technologies onto a Federal health care program, other payors, or individuals.		
<b>§ 1003.110 – Definitions; Telehealth Technologies</b>	<i>N/A</i>	Telehealth technologies, for purposes of the definition of the term “remuneration” as set forth in this section and the telehealth technologies exception to section 50302(c) of the Bipartisan Budget Act of 2018, which adds an exception as new section 1128A(i)(6)(J) of the Act, means multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner used in the diagnosis, intervention, or ongoing care management—paid for by Medicare Part B—between a patient and the remote healthcare provider. Telephones, facsimile machines, and electronic mail systems are not telehealth technologies.	<i>Telehealth technologies</i> , for purposes of paragraph (10) of the definition of the term “remuneration” as set forth in this section, means hardware, software, and services that support distant or remote communication between the patient and provider, physician, or renal dialysis facility for diagnosis, intervention, or ongoing care management.	The final rule creates a new definition of “telehealth technologies” for the purposes of the definition of “remuneration” in 42 CFR § 1003.110 and the telehealth technologies exception to section 50302(c) of the Budget Act of 2018.  Compared to the proposed rule, the final rule modifies the definition of “telehealth technologies” and includes physicians as a type of practitioner that can donate telehealth technologies to a patient.

**Anti-Kickback Statute and Civil Monetary Penalty Regulations  
Comparison Chart of the Current Regulations, Proposed Regulations, and Final Amended Regulations, effective  
January 19, 2021**



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