

§ 403.822

(9) *Reconsideration determination.* A reconsideration determination is a new determination that—

(i) Is based on a review of the contract determination, the evidence and findings upon which it was based, and any other written evidence submitted before notice of the reconsidered determination is mailed, including facts relating to the status of the endorsed sponsor subsequent to the contract determination; and

(ii) Affirms, reverses, or modifies the initial contract determination.

(10) *Notice of reconsidered determination.* As soon as practicable after the close of the hearing, the hearing officer issues a written reconsideration determination that contains the following:

(i) Findings with respect to the applicant's qualifications to enter into or an endorsed sponsor's qualifications to remain under a contract with CMS under section 1860D-31 of the Act;

(ii) A statement of the specific reasons for the reconsidered determination.

(11) *Effect of reconsidered determination.* A reconsidered determination is final and binding on the parties and is not subject to judicial review.

(g) *Compliance with HIPAA.* Failure of an endorsed sponsor to comply with HIPAA and/or the standards, implementation specifications, and requirements in 45 CFR parts 160, 162, and 164, as established in §403.812, shall be a violation of HIPAA and may be enforced under sections 1176 and 1177 of the Act.

§ 403.822 Reimbursement of transitional assistance and associated sponsor requirements.

(a) A Transitional Assistance Account is created within the Federal Supplementary Medical Insurance Trust Fund and kept separate from all other funds within that fund.

(b) The Managing Trustee of the Transitional Assistance Account shall pay on a monthly basis from the Account the amounts certified by CMS as necessary to make payments for transitional assistance as allowed in §403.808.

(c) Endorsed sponsors must routinely account to CMS for the transitional assistance provided to the transitional

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assistance enrollees for finalized (not pending, or denied) claims up to the allowed balance provided by CMS to the sponsor.

(d) Payment transactions will be audited by the Secretary or his agent.

(e) Federal funding in excess of the amount of the balance included in CMS's system is not permitted.

Subpart I—Transparency Reports and Reporting of Physician Ownership or Investment Interests

SOURCE: 78 FR 9521, Feb. 8, 2013, unless otherwise noted.

§ 403.900 Purpose and scope.

The regulations in this subpart implement section 1128G of the Act. These regulations apply to applicable manufacturers and applicable group purchasing organizations and describe the requirements and procedures for applicable manufacturers to report payments or other transfers of value provided to covered recipients, as well as for applicable manufacturers and applicable group purchasing organizations to report ownership or investment interests held by physicians or immediate family members of physicians in such entities.

§ 403.902 Definitions.

For purposes of this subpart, the following definitions apply:

Applicable group purchasing organization means an entity that:

- (1) Operates in the United States; and
- (2) Purchases, arranges for or negotiates the purchase of a covered drug, device, biological, or medical supply for a group of individuals or entities, but not solely for use by the entity itself.

Applicable manufacturer means an entity that is operating in the United States and that falls within one of the following categories:

- (1) An entity that is engaged in the production, preparation, propagation, compounding, or conversion of a covered drug, device, biological, or medical supply, but not if such covered drug, device, biological or medical supply is solely for use by or within the

entity itself or by the entity's own patients. This definition does not include distributors or wholesalers (including, but not limited to, repackagers, relabelers, and kit assemblers) that do not hold title to any covered drug, device, biological or medical supply.

(2) An entity under common ownership with an entity in paragraph (1) of this definition, which provides assistance or support to such entity with respect to the production, preparation, propagation, compounding, conversion, marketing, promotion, sale, or distribution of a covered drug, device, biological or medical supply.

Assistance and support means providing a service or services that are necessary or integral to the production, preparation, propagation, compounding, conversion, marketing, promotion, sale, or distribution of a covered drug, device, biological or medical supply.

Certified nurse midwife means a registered nurse who has successfully completed a program of study and clinical experience meeting guidelines prescribed by the Secretary, or has been certified by an organization recognized by the Secretary.

Certified registered nurse anesthetist means a certified registered nurse anesthetist licensed by the State who meets such education, training, and other requirements relating to anesthesia services and related care as the Secretary may prescribe. In prescribing such requirements the Secretary may use the same requirements as those established by a national organization for the certification of nurse anesthetists. Such term also includes, as prescribed by the Secretary, anesthesiologist assistant.

Charitable contribution includes, but is not limited to, any payment or transfer of value made to an organization with tax-exempt status under the Internal Revenue Code of 1986, which is not provided in exchange for any goods, items or services.

Charity care means services provided by a covered recipient specifically for a patient who is unable to pay for such services or for whom payment would be a significant hardship, where the covered recipient neither receives, nor ex-

pects to receive, payment because of the patient's inability to pay.

Clinical investigation means any experiment involving one or more human subjects, or materials derived from human subjects, in which a drug, device, biological or medical supply is administered, dispensed or used.

Clinical nurse specialist means, an individual who—

(1) Is a registered nurse and is licensed to practice nursing in the State in which the clinical nurse specialist services are performed; and

(2) Holds a master's degree in a defined clinical area of nursing from an accredited educational institution.

Common ownership refers to circumstances where the same individual, individuals, entity, or entities directly or indirectly own 5 percent or more total ownership of two entities. This includes, but is not limited to, parent corporations, direct and indirect subsidiaries, and brother or sister corporations.

Covered drug, device, biological, or medical supply means any drug, device, biological, or medical supply for which payment is available under Title XVIII of the Act or under a State plan under Title XIX or XXI of the Act (or a waiver of such plan), either separately (such as through a fee schedule or formulary) or as part of a bundled payment (for example, under the hospital inpatient prospective payment system or the hospital outpatient prospective payment system) and which is of the type that in the case of a—

(1) Drug or biological, by law, requires a prescription to be dispensed; or

(2) Device (including a medical supply that is a device), by law, requires premarket approval by or premarket notification to the FDA.

Covered recipient means— (1) Any physician, physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, or certified nurse-midwife who is not a bona fide employee of the applicable manufacturer that is reporting the payment; or

(2) A teaching hospital, which is any institution that received a payment under 1886(d)(5)(B), 1886(h), or 1886(s) of the Act during the last calendar year

for which such information is available.

Device identifier is the mandatory, fixed portion of a unique device identifier (UDI) that identifies the specific version or model of a device and the labeler of that device (as described at 21 CFR 801.3 in paragraph (1) of the definition of “Unique device identifier”).

Employee means an individual who is considered to be “employed by” or an “employee” of an entity if the individual would be considered to be an employee of the entity under the usual common law rules applicable in determining the employer-employee relationship (as applied for purposes of section 3121(d)(2) of the Internal Revenue Code of 1986).

Immediate family member means any of the following:

- (1) Spouse.
- (2) Natural or adoptive parent, child, or sibling.
- (3) Stepparent, stepchild, stepbrother, or stepsister.
- (4) Father-, mother-, daughter-, son-, brother-, or sister-in-law.
- (5) Grandparent or grandchild.
- (6) Spouse of a grandparent or grandchild.

Indirect payments or other transfers of value refer to payments or other transfers of value made by an applicable manufacturer (or an applicable group purchasing organization) to a covered recipient (or a physician owner or investor) through a third party, where the applicable manufacturer (or applicable group purchasing organization) requires, instructs, directs, or otherwise causes the third party to provide the payment or transfer of value, in whole or in part, to a covered recipient(s) (or a physician owner or investor).

Know, knowing, or knowingly—(1) Means that a person, with respect to information—

- (i) Has actual knowledge of the information;
- (ii) Acts in deliberate ignorance of the truth or falsity of the information; or
- (iii) Acts in reckless disregard of the truth or falsity of the information; and
- (2) Requires no proof of a specific intent to defraud.

Long term medical supply or device loan means the loan of supplies or a device for 91 days or longer.

Non-teaching hospital covered recipient means a person who is one or more of the following: Physician; physician assistant; nurse practitioner; clinical nurse specialist; certified registered nurse anesthetist; or certified nurse-midwife.

NPPES stands for the National Plan & Provider Enumeration System.

Nurse practitioner means a nurse practitioner who performs such services as such individual is legally authorized to perform (in the State in which the individual performs such services) in accordance with State law (or the State regulatory mechanism provided by State law), and who meets such training, education, and experience requirements (or any combination thereof) as the Secretary may prescribe in regulations.

Operating in the United States means that an entity—

- (1) Has a physical location within the United States or in a territory, possession, or commonwealth of the United States; or
- (2) Otherwise conducts activities within the United States or in a territory, possession, or commonwealth of the United States, either directly or through a legally-authorized agent.

Ownership or investment interest—(1) Includes, but is not limited to the following:

- (i) Stock, stock option(s) (other than those received as compensation, until they are exercised).
- (ii) Partnership share(s);
- (iii) Limited liability company membership(s).
- (iv) Loans, bonds, or other financial instruments that are secured with an entity’s property or revenue or a portion of that property or revenue.
- (2) May be direct or indirect and through debt, equity or other means.
- (3) *Exceptions.* The following are not ownership or investment interests for the purposes of this section:
 - (i) An ownership or investment interest in a publicly traded security or mutual fund, as described in section 1877(c) of the Act.

(ii) An interest in an applicable manufacturer or applicable group purchasing organization that arises from a retirement plan offered by the applicable manufacturer or applicable group purchasing organization to the physician (or a member of his or her immediate family) through the physician's (or immediate family member's) employment with that applicable manufacturer or applicable group purchasing organization.

(iii) Stock options and convertible securities received as compensation, until the stock options are exercised or the convertible securities are converted to equity.

(iv) An unsecured loan subordinated to a credit facility.

(v) An ownership or investment interest if an applicable manufacturer or applicable group purchasing organization did not know, as defined in this section, about such ownership or investment interest.

(vi) A titular ownership or investment interest that excludes the ability or right to receive the financial benefits of ownership or investment, including, but not limited to, the distribution of profits, dividends, proceeds of sale, or similar returns on investment; or

(vii) An interest in an entity that arises from an employee stock ownership plan (ESOP) that is qualified under section 401(a) of the Internal Revenue Code of 1986.

Payment or other transfer of value means a transfer of anything of value.

Physician has the same meaning given that term in section 1861(r) of the Act.

Physician assistant means a physician assistant who performs such services as such individual is legally authorized to perform (in the State in which the individual performs such services) in accordance with State law (or the State regulatory mechanism provided by State law), and who meets such training, education, and experience requirements (or any combination thereof) as the Secretary may prescribe in regulations.

Physician-owned distributorship, for the purposes of determining the existence of a reportable ownership or investment interest under this subpart, means an entity that:

(1) Meets the definition of an applicable manufacturer or applicable group purchasing organization as defined in this section, and

(2) Meets at least one of the following two conditions:

(i) Has a minimum of 5 percent direct or indirect ownership or investment interest in the applicable manufacturer or applicable group purchasing organization held by a physician or a physician's immediate family member, or

(ii) A physician or a physician's immediate family member receives compensation from the applicable manufacturer or group purchasing organization in the form of a commission, return on investment, profit sharing, profit distribution, or other remuneration directly or indirectly derived from the sale or distribution of devices by the applicable manufacturer or group purchasing organization in which the physician or physician's immediate family member has ownership.

(3) This physician owned distributor definition does not apply for purposes of any other laws or regulations, including, but not limited to, section 1877 of the Act, the regulations at 42 CFR part 411, subpart J, section 1128B of the Act, or the regulations at 42 CFR 1001.952.

Related to a covered drug, device, biological, or medical supply means that a payment or other transfer of value is made in reference to or in connection with one or more covered drugs, devices, biologicals, or medical supplies.

Research includes a systematic investigation designed to develop or contribute to generalizable knowledge relating broadly to public health, including behavioral and social-sciences research. This term encompasses basic and applied research and product development.

Short term medical supply or device loan means the loan of a covered device or a device under development, or the provision of a limited quantity of medical supplies for a short-term trial period, not to exceed a loan period of 90 cumulative days per calendar year or a quantity of 90 cumulative days of average daily use per calendar year, to permit evaluation of the device or medical supply by the covered recipient.

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Third party means another individual or entity, regardless of whether such individual or entity is operating in the United States.

Unique device identifier means an identifier that adequately identifies a device through its distribution and use by meeting the requirements of 21 CFR 801.40 and 830.3.

[78 FR 9521, Feb. 8, 2013, as amended at 79 FR 68000, Nov. 13, 2014; 84 FR 63185, Nov. 15, 2019; 85 FR 10, Jan 2, 2020; 86 FR 65659, Nov. 19, 2021]

§ 403.904 Reports of payments or other transfers of value to covered recipients.

(a) *General rule.* (1) Direct and indirect payments or other transfers of value provided by an applicable manufacturer to a covered recipient during the preceding calendar year, and direct and indirect payments or other transfers of value provided to a third party at the request of or designated by the applicable manufacturer on behalf of a covered recipient during the preceding calendar year, must be reported by the applicable manufacturer to CMS on an annual basis.

(2) For CY 2013, only payments or other transfers of value made on or after August 1, 2013 must be reported to CMS.

(3) An applicable manufacturer or applicable group purchasing organization that has reported payments or transfers of value under the scope of this section may not remove, delete, or alter any record(s) unless an error is discovered in the information that had been furnished, or the record is otherwise believed to meet exceptions for reporting.

(b) *Limitations.* Certain limitations on reporting apply in the following circumstances:

(1) Applicable manufacturers for whom total (gross) revenues from covered drugs, devices, biologicals, or medical supplies constituted less than 10 percent of total (gross) revenue during the fiscal year preceding the reporting year are only required to report payments or other transfers of value that are related to one or more covered drugs, devices, biologicals or medical supplies.

(2) Applicable manufacturers under paragraph (2) of the definition in § 403.902 are only required to report payments or other transfers of value that are related to a covered drug, device, biological, or medical supply for which they provided assistance or support to an applicable manufacturer under paragraph (1) of the definition.

(3) Applicable manufacturers under either paragraph (1) or (2) of the definition in § 403.902 that have separate operating divisions that do not manufacture any covered drugs, devices, biologicals, or medical supplies (for example, animal health divisions) are only required to report payments to covered recipients related to the activities of these separate divisions if those payments or other transfers of value are related to a covered drug, device, biological, or medical supply. This includes reporting of payments or other transfers of value that are related to covered drugs, devices, biologicals, or medical supplies made by applicable manufacturers to covered recipients through these operating divisions.

(4) Applicable manufacturers that do not manufacture a covered drug, device, biological, or medical supply except when under a written agreement to manufacture the covered drug, device, biological, or medical supply for another entity, do not hold the FDA approval, licensure, or clearance for the covered drug, device, biological, or medical supply, and are not involved in the sale, marketing, or distribution of the product, are only required to report payments or other transfers of value that are related to one or more covered drugs, devices, biologicals, or medical supplies.

(c) *Required information to report.* A report must contain all of the following information for each payment or other transfer of value:

(1) *Name of the covered recipient.* For non-teaching hospital covered recipients, the name must be as listed in the National Plan & Provider Enumeration System (NPPES) (if applicable) and include first and last name, middle initial, and suffix (for all that apply).

(2) *Address of the covered recipient.* Primary business address of the covered recipient, including all the following:

- (i) Street address.
- (ii) Suite or office number (if applicable).
- (iii) City.
- (iv) State.
- (v) ZIP code.

(3) *Identifiers for non-teaching hospital covered recipients.* In the case of a covered recipient the following identifiers:

- (i) The specialty.
- (ii) National Provider Identifier (if applicable and as listed in the NPPES). If a National Provider Identifier cannot be identified for a non-teaching hospital covered recipient, the field may be left blank, indicating that the applicable manufacturer could not find one.
- (iii) State professional license number(s) (for at least one State where the non-teaching hospital covered recipient maintains a license), and the State(s) in which the license is held.

(4) *Amount of payment or other transfer of value.* A payment or other transfer of value made to a group of covered recipients should be distributed appropriately among the individual covered recipients who requested the payment, on whose behalf the payment was made, or who are intended to benefit from the payment or other transfer of value.

(5) *Date of payment or transfer of value.* The date of each payment or other transfer of value.

(i) For payments or other transfers of value made over multiple dates (rather than as a lump sum), applicable manufacturers may choose whether to report each payment or other transfer of value as separate line item using the dates the payments or other transfers of value were each made, or as a single line item for the total payment or other transfer of value using the first payment date as the reported date.

(ii) For small payments or other transfers of value reported as a single line item, applicable manufacturers must report the date that the first bundled small payment or other transfer of value was provided to the covered recipient.

(6) *Form of payment or transfer of value.* The form of each payment or

other transfer of value, as described in paragraph (d) of this section.

(7) *Nature of payment or transfer of value.* The nature of each payment or other transfer of value, as described in paragraph (e) of this section.

(8) *Related covered drug, device, biological or medical supply.* Report the marketed or brand name of the related covered drugs, devices, biologicals, or medical supplies, and therapeutic area or product category unless the payment or other transfer of value is not related to a particular covered drug, device, biological or medical supply.

(i) For drugs and biologicals—

(A) If the marketed name has not yet been selected, applicable manufacturers must indicate the name registered on *clinicaltrials.gov*.

(B) Any regularly used identifiers must be reported, including, but not limited to, national drug codes.

(ii) For devices, if the device has a unique device identifier (UDI), then the device identifier (DI) portions of it must be reported, as applicable.

(iii) Applicable manufacturers may report the marketed name and therapeutic area or product category for payments or other transfers of value related to a non-covered drug, device, biological, or medical supply.

(iv) Applicable manufacturers must indicate if the related drug, device, biological, or medical supply is covered or non-covered.

(v) Applicable manufacturers must indicate if the payment or other transfer of value is not related to any covered or non-covered drug, device, biological or medical supply.

(9) *Eligibility for delayed publication.* Applicable manufacturers must indicate whether a payment or other transfer of value is eligible for delayed publication, as described in § 403.910.

(10) *Payments to third parties.* (i) If the payment or other transfer of value was provided to a third party at the request of or designated on behalf of a covered recipient, the payment or transfer of value must be reported in the name of that covered recipient.

(ii) If the payment or other transfer of value was provided to a third party at the request of or designated on behalf of a covered recipient, the name of the entity that received the payment

or other transfer of value (if made to an entity) or indicate “individual” (if made to an individual). If a covered recipient performed a service, but neither accepted the offered payment or other transfer of value nor requested that it be made to a third party, the applicable manufacturer is not required to report the offered payment or other transfer of value unless the applicable manufacturer nonetheless provided it to a third party and designated such payment or other transfer of value as having been provided on behalf of the covered recipient.

(11) *Payments or transfers of value to physician owners or investors.* Must indicate whether the payment or other transfer of value was provided to a physician or the immediate family of the physician who holds an ownership or investment interest (as defined § 403.902) in the applicable manufacturer.

(12) *Additional information or context for payment or transfer of value.* May provide a statement with additional context for the payment or other transfer of value.

(d) *Reporting the form of payment or other transfer of value.* An applicable manufacturer must report each payment or transfer of value, or separable part of that payment or transfer of value, as taking one of the following forms of payment that best describes the form of the payment or other transfer of value, or separable part of that payment or other transfer of value.

- (1) Cash or cash equivalent.
- (2) In-kind items or services.
- (3) Stock.
- (4) Stock option.
- (5) Any other ownership interest.
- (6) Dividend, profit or other return on investment.

(e) *Reporting the nature of the payment or other transfer of value.* (1) *General rule.* The categories describing the nature of a payment or other transfer of value are mutually exclusive for the purposes of reporting under subpart I of this part.

(2) *Rules for categorizing natures of payment.* An applicable manufacturer must categorize each payment or other transfer of value, or separable part of that payment or transfer of value, with

one of the categories listed in paragraphs (e)(2)(i) through (xviii) of this section, using the designation that best describes the nature of the payment or other transfer of value, or separable part of that payment or other transfer of value. If a payment or other transfer of value could reasonably be considered as falling within more than one category, the applicable manufacturer should select one category that it deems to most accurately describe the nature of the payment or transfer of value.

- (i) Consulting fee.
- (ii) Compensation for services other than consulting, including serving as faculty or as a speaker at an event other than a continuing education program.
- (iii) Honoraria.
- (iv) Gift.
- (v) Entertainment.
- (vi) Food and beverage.
- (vii) Travel and lodging (including the specified destinations).
- (viii) Education.
- (ix) Research.
- (x) Charitable contribution.
- (xi) Debt forgiveness.
- (xii) Royalty or license.
- (xiii) Current or prospective ownership or investment interest.
- (xiv) Compensation for serving as faculty or as a speaker for a medical education program.
- (xv) Long term medical supply or device loan.
- (xvi) Grant.
- (xvii) Space rental or facility fees (teaching hospital only).
- (xviii) Acquisitions.

(f) *Special rules for research payments.* All payments or other transfers of value made in connection with an activity that meets the definition of research in this section and that are subject to a written agreement, a research protocol, or both, must be reported under these special rules.

(1) Research-related payments or other transfers of value to covered recipients, including research-related payments or other transfers of value made indirectly to a covered recipient through a third party, must be reported to CMS separately from other payments or transfers of value, and must include the following information

(in lieu of the information required by § 403.904(c)):

(i) Name of the research institution, individual or entity receiving the payment or other transfer of value.

(A) If paid to a non-teaching hospital covered recipient, all of the following must be provided:

(1) The non-teaching hospital covered recipient's name as listed in the NPPES (if applicable).

(2) National Provider Identifier.

(3) State professional license number(s) (for at least one State where the non-teaching hospital covered recipient maintains a license) and State(s) in which the license is held.

(4) Specialty.

(5) Primary business address of the non-teaching hospital covered recipient(s).

(B) If paid to a teaching hospital covered recipient, list the name and primary business address of teaching hospital.

(C) If paid to a non-covered recipient (such as a non-teaching hospital or clinic), list the name and primary business address of the entity.

(ii) Total amount of the research payment, including all research-related costs for activities outlined in a written agreement, research protocol, or both.

(iii) Name of the research study.

(iv) Name(s) of any related covered drugs, devices, biologicals, or medical supplies (subject to the requirements specified in paragraph (c)(8) of this section); for drugs and biologicals, the relevant National Drug Code(s), if any; and for devices and medical supplies, the relevant device identifier, if any, and the therapeutic area or product category if a marketed name is not available.

(v) Information about each non-teaching hospital covered recipient principal investigator (if applicable) set forth in paragraph (f)(1)(i)(A) of this section.

(vi) Contextual information for research (optional).

(vii) ClinicalTrials.gov identifier (optional).

(2) For pre-clinical studies (before any human studies have begun), only report the following information:

(i) Research entity name (as required in paragraph (f)(1)(i) of this section).

(ii) Total amount of payment (as required in paragraph (f)(1)(ii) of this section).

(ii) Principal investigator(s) (as required in paragraph (f)(1)(v) of this section).

(g) *Special rules for reporting food and beverage.* (1) When allocating the cost of food and beverage among covered recipients in a group setting where the cost of each individual covered recipient's meal is not separately identifiable, such as a platter provided to physicians in a group practice setting, applicable manufacturers must calculate the value per person by dividing the entire cost of the food or beverage by the total number of individuals who partook in the meal (including both covered recipients and non-covered recipients, such as office staff). The per person value of the meal must be reported as a payment or other transfer of value only for covered recipients who actually partook in the food or beverage.

(2) Applicable manufacturers are not required to report or track buffet meals, snacks, soft drinks, or coffee made generally available to all participants of a large-scale conference or similar large-scale event.

(h) *Exclusions from reporting.* The following are excluded from the reporting requirements specified in this section:

(1) Indirect payments or other transfers of value (as defined in § 403.902), where the applicable manufacturer is unaware of the identity of the covered recipient. An applicable manufacturer is unaware of the identity of a covered recipient if the applicable manufacturer does not know (as defined in § 403.902) the identity of the covered recipient during the reporting year or by the end of the second quarter of the following reporting year.

(2)(i) For CY 2013, payments or other transfers of value less than \$10, unless the aggregate amount transferred to, requested by, or designated on behalf of the covered recipient exceeds \$100 in a calendar year.

(ii) For CY 2014 and subsequent calendar years, to determine if transfers of value are excluded under this section, the dollar amounts specified in paragraph (h)(2)(i) of this section must

be increased by the same percentage as the percentage increase in the consumer price index for all urban consumers (all items; U.S. city average) for the 12-month period ending with June of the previous year. CMS will publish the values for the next reporting year 90 days before the beginning of the reporting year.

(iii) Payments or other transfers of value of less than \$10 in CY 2013 (or less than the amount described in paragraph (h)(2)(i) of this section for CY 2014 and subsequent calendar years) provided at large-scale conferences and similar large-scale events, as well as events open to the public, do not need to be reported nor included for purposes of the \$100 aggregate threshold in CY 2013 (or the aggregate threshold calculated in accordance paragraph (h)(2)(i) of this section for CY 2014 and subsequent calendar years), even if the aggregate total for a covered recipient exceeds the aggregate threshold for the calendar year.

(iv) When reporting payments or other transfers of value under the \$10 threshold for CY 2013 (or under the amount described in paragraph (i)(2)(ii) of this section for CY 2014 and subsequent calendar years) for covered recipients that exceed the aggregate threshold for the reporting year, applicable manufacturers may (but are not required to) report all small payments to a particular covered recipient that fall within the same nature of payment category as a single payment or other transfer of value.

(3) Product samples, including coupons and vouchers that can be used by a patient to obtain samples, which are not intended to be sold and are intended for patient use.

(4) Educational materials and items that directly benefit patients or are intended to be used by or with patients, including the value of an applicable manufacturer's services to educate patients regarding a covered drug, device, biological, or medical supply.

(5) Short term medical supply or device loan.

(6) Items or services provided under a contractual warranty (including service or maintenance agreements), whether or not the warranty period has expired, including the replacement of a

covered device, where the terms of the warranty are set forth in the purchase or lease agreement for the covered device.

(7) A transfer of anything of value to a non-teaching hospital covered recipient when the covered recipient is a patient, research subject or participant in data collection for research, and not acting in the professional capacity of a covered recipient.

(8) Discounts, including rebates.

(9) In-kind items used for the provision of charity care.

(10) A dividend or other profit distribution from, or ownership or investment interest in, a publicly traded security or mutual fund.

(11) In the case of an applicable manufacturer who offers a self-insured plan or directly reimburses for healthcare expenses, payments for the provision of health care to employees and their families.

(12) In the case of a covered recipient who is a licensed non-medical professional, a transfer of anything of value to the covered recipient if the transfer is payment solely for the non-medical professional services of the licensed non-medical professional.

(13) In the case of a non-teaching hospital covered recipient, a transfer of anything of value to the covered recipient if the transfer is payment solely for the services of the covered recipient with respect to an administrative proceeding, legal defense, prosecution, or settlement or judgment of a civil or criminal action and arbitration.

(14) A payment or transfer of value to a covered recipient if the payment or transfer of value is made solely in the context of a personal, non-business-related relationship.

[78 FR 9521, Feb. 8, 2013, as amended at 79 FR 68000, Nov. 13, 2014; 84 FR 63186, Nov. 15, 2019; 86 FR 65659, Nov. 19, 2021]

§ 403.906 Reports of physician ownership and investment interests.

(a) *General rule.* (1) Each applicable manufacturer and applicable group purchasing organization must report to CMS on an annual basis all ownership and investment interests in the applicable manufacturer or applicable group purchasing organization that were held by a physician or an immediate family

member of a physician during the preceding calendar year.

(2) For CY 2013, only ownership or investment interests held on or after August 1, 2013 must be reported to CMS.

(b) *Identifying information.* Reports on physician ownership and investment interests must include the following identifying information:

(1) Name of the physician (as listed in the National Plan & Provider Enumeration System (if applicable), including first and last name, middle initial, and suffix (for all that apply), and an indication of whether the ownership or investment interest was held by the physician or an immediate family member of the physician.

(2) Primary business address of the physician, including the following:

- (i) Street address.
- (ii) Suite or office number (if applicable).
- (iii) City.
- (iv) State.
- (v) ZIP code.

(3) The following information for the physician (regardless of whether the ownership or investment interest is held by an immediate family member of the physician):

- (i) The specialty.
- (ii) National Provider Identifier (if applicable and as listed in NPPES).
- (iii) State professional license number(s) (for at least one State where the physician maintains a license), and the State(s) in which the license is held.

(4) Dollar amount invested by each physician or immediate family member of the physician.

(5) Value and terms of each ownership or investment interest.

(6) Direct and indirect payments or other transfers of value provided to a physician holding an ownership or investment interest, and direct and indirect payments or other transfers of value provided to a third party at the request of or designated by the applicable manufacturer or applicable group purchasing organization on behalf of a physician owner or investor, must be reported by the applicable manufacturer or applicable group purchasing organization in accordance with the requirements for reporting payments or other transfers of value in § 403.904(c) through (h). The terms “applicable

manufacturer and applicable group purchasing organization” must be substituted for “applicable manufacturer,” and “physician owner or investor” must be substituted for “covered recipient” in each place they appear.

[78 FR 9521, Feb. 8, 2013, as amended at 79 FR 68001, Nov. 13, 2014]

§ 403.908 Procedures for electronic submission of reports.

(a) *File format.* Reports required under this subpart must be electronically submitted to CMS by March 31, 2014, and by the 90th day of each subsequent calendar year.

(b) *General rules.* (1) If an applicable manufacturer made no reportable payments or transfers of value in the previous calendar year, nor had any reportable ownership or investment interests held by a physician or a physician’s immediate family member (as defined in § 403.902) during the previous calendar year, the applicable manufacturer is not required to file a report.

(2) If an applicable group purchasing organization had no reportable ownership or investment interests held by a physician or physician’s immediate family member during the previous calendar year, the applicable group purchasing organization is not required to file a report.

(c) *Registration.* (1) Applicable manufacturers that have reportable payments or other transfers of value, ownership or investment interests, or both, are required to report under this subpart and must register with CMS within 90 days of the end of the calendar year for which a report is required.

(2) Applicable group purchasing organizations that have reportable ownership or investment interests are required to report under this subpart and must register with CMS within 90 days of the end of the calendar year for which a report is required.

(3) During registration, applicable manufacturers and applicable group purchasing organizations must name two points of contact with appropriate contact information. These points of contact must be updated for 2 years following record submission.

(4) An applicable manufacturer or applicable group purchasing organization that meets the definition of physician-

owned distributorship as defined in § 403.902 must identify its status as a physician-owned distributorship when registering or recertifying.

(d) *Other rules.* (1) *Consolidated reports.* (i) An applicable manufacturer under paragraph (1) of the definition that is under common ownership with separate entities that are also applicable manufacturers under paragraph (1) of the definition may, but is not required to, file a consolidated report of all the payments or other transfers of value to covered recipients, and physician ownership or investment interests, for all of the entities.

(ii) An applicable manufacturer under paragraph (1) of the definition of applicable manufacturer and an entity (or entities) under common ownership with the applicable manufacturer under paragraph (2) of the definition of applicable manufacturer may, but are not required to, file a consolidated report of all the payments or other transfers of value to covered recipients, and physician ownership or investment interests.

(iii) If multiple applicable manufacturers (under paragraph (1) or (2) of the definition or both paragraphs of the definition) submit a consolidated report, the report must provide the names of each applicable manufacturer and entity (or entities) under common ownership that the report covers, and the report must identify the specific entity that provided each payment.

(iv) A single payment or other transfer of value reported in a consolidated report must only be reported once by one applicable manufacturer.

(v) The applicable manufacturer submitting a consolidated report on behalf of itself and other applicable manufacturers under common ownership, as permitted under this paragraph, is liable for civil monetary penalties imposed on each of the applicable manufacturers whose reportable payments or other transfers of value were included in the consolidated report, up to the annual maximum amount specified in § 403.912(c) for each individual applicable manufacturer included in the report.

(2) *Joint ventures.* If a payment or other transfer of value is provided in accordance with a joint venture or

other cooperative agreement between two or more applicable manufacturers, the payment or other transfer of value must be reported—

(i) In the name of the applicable manufacturer that actually furnished the payment or other transfer of value to the covered recipient, unless the terms of a written agreement between the applicable manufacturers specifically require otherwise, so long as the agreement requires that all payments or other transfers of value in accordance with the arrangement are reported by one of the applicable manufacturers; and

(ii) Only once by one applicable manufacturer.

(e) *Attestation.* Each report, including any subsequent corrections to a filed report, must include an attestation by the Chief Executive Officer, Chief Financial Officer, Chief Compliance Officer, or other Officer of the applicable manufacturer or applicable group purchasing organization that the information reported is timely, accurate, and complete to the best of his or her knowledge and belief. For applicable manufacturers choosing to submit a consolidated report in accordance with paragraph (d)(1) of this section, the applicable manufacturer submitting the consolidated report must attest on behalf of itself, in addition to each of the other applicable manufacturers included in the consolidated report.

(f) *Assumptions document.* Applicable manufacturers and applicable group purchasing organizations may submit an assumptions document, explaining the reasonable assumptions made and methodologies used when reporting payments or other transfers of value, or ownership or investment interests. The assumptions documents will not be made available to covered recipients, physician owners or investors, or the public.

(g) *45-day review period for review and error correction.* (1) *General rule.* Applicable manufacturers, applicable group purchasing organizations, covered recipients, and physician owners or investors must have an opportunity to review and submit corrections to the information submitted for a period of not less than 45-days before CMS makes the information available to the

public. In no case may this 45-day period for review and submission of corrections prevent the information from being made available to the public.

(2) *Notification.* CMS notifies the applicable manufacturers, applicable group purchasing organizations, covered recipients, and physician owners or investors when the reported information is ready for review.

(i) Applicable manufacturers and applicable group purchasing organizations are notified through the points of contact they identified during registration.

(ii) Covered recipients—

(A) Are notified using an online posting and notifications on CMS's listserves.

(B) May also register with CMS to receive notification about the review processes.

(iii) The 45-day review period begins on the date specified in the online notification.

(3) *Process.* (i) An applicable manufacturer, applicable group purchasing organization, covered recipient or a physician owner or investor may log into a secure Web site to view only the information reported specifically about itself.

(ii) Covered recipients and physician owners or investors are able to review data submitted about them for the previous reporting year.

(iii) If the applicable manufacturer, applicable group purchasing organization, covered recipient, or physician owner or investor agrees with the information reported, the applicable manufacturer, applicable group purchasing organization, covered recipient, or physician owner or investor may electronically certify that the information reported is accurate.

(iv) If a covered recipient or physician owner or investor disagrees with the information reported, the covered recipient or physician owner or investor can initiate a dispute, which is sent to the appropriate applicable manufacturer or applicable group purchasing organization to be resolved between the parties.

(v) Covered recipients and physician owners or investors may initiate disputes at any time after the 45-day period begins, but before the end of the

calendar year, but any changes resulting from disputes initiated outside the 45-day period, may not be made until the next time the data is refreshed.

(4) *Data disputes.* (i) In order to be corrected prior to the publication of the data, applicable manufacturers and applicable group purchasing organizations must notify CMS of resolved disputes and changes to the information submitted by no later than 15 days after the end of the 45-day period (that is, 60 days after the 45-day review period begins).

(ii) Disputes which are not resolved by 15 days after the end of the review and correction period, may still be resolved, but any changes resulting from the disputes may be made until the next time the data is refreshed.

(iii) If the dispute is not resolved by 15 days after the end of the 45-day review and correction period, CMS publicly reports and aggregates the applicable manufacturer's or applicable group purchasing organization's version of the payment or other transfer of value, or ownership or investment interest data, but marks the payment or other transfer of value or ownership or investment interest as disputed.

(h) *Errors or omissions.* (1) If an applicable manufacturer or applicable group purchasing organization discovers an error or omission in its annual report, it must submit corrected information to CMS immediately upon confirmation of the error or omission.

(2) Upon receipt, CMS notifies the affected covered recipient or physician owner or investor that the additional information has been submitted and is available for review. CMS updates the Web site at least once annually with corrected information.

[78 FR 9521, Feb. 8, 2013, as amended at 84 FR 63187, Nov. 15, 2019; 86 FR 65659, Nov. 19, 2021]

§ 403.910 Delayed publication for payments made under product research or development agreements and clinical investigations.

(a) *General rule.* Certain research payments or other transfers of value made to a covered recipient by an applicable manufacturer under a product research or development agreement may be delayed from publication on the Web site.

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Publication of a payment or other transfer of value is delayed when made in connection with the following instances:

(1) Research on or development of a new drug, device, biological, or medical supply, or a new application of an existing drug, device, biological, or medical supply.

(2) Clinical investigations regarding a new drug, device, biological, or medical supply.

(b) *Research or development agreement.* The research or development agreement must include a written agreement, a research protocol, or both between the applicable manufacturer and covered recipient.

(c) *Date of publication.* Payments or other transfers of value eligible for delayed publication must be reported to CMS (in the manner required in § 403.904(f)) on the first reporting date following the year in which they occur, but CMS does not publicly post the payment until the first annual publication date after the earlier of the following:

(1) The date of the approval, licensure or clearance of the covered drug, device, biological, or medical supply by FDA.

(2) Four calendar years after the date the payment or other transfer of value was made.

(d) *Notification of delayed publication.* (1) An applicable manufacturer must indicate on its research report to CMS whether a payment or other transfer of value is eligible for a delay in publication. The absence of this indication in the report will result in CMS posting all payments publicly in the first year of public reporting.

(2) An applicable manufacturer must continue to indicate annually in its report that FDA approval, licensure, or clearance of the new drug, device, biological or medical supply to which the payment or other transfer of value is related, is pending.

(3) An applicable manufacturer must notify CMS during subsequent annual submissions, if the new drug, device, biological or medical supply, to which the payment is related (or the new application of the existing drug, device, biological, or medical supply), is approved by the FDA.

(4) Failure to notify CMS when FDA approval occurs may be considered failure to report, and the applicable manufacturer may be subject to civil monetary penalties.

(5) If, after 4 years from the date of a payment first appearing in a report to CMS, there is an indication in a report that the payment is subject to delayed reporting, it is reported regardless of the indication.

(e) *Confidentiality.* Information submitted and eligible for delayed publication is considered confidential and will not be subject to disclosure under 5 U.S.C. 552, or any similar Federal, State, or local law, until on or after the date on which the information made available to the public as required in this section.

§ 403.912 Penalties for failure to report.

(a) *Failure to report.* (1) Any applicable manufacturer or applicable group purchasing organization that fails to timely, accurately or completely report the information required in accordance with the rules established under this subpart is subject to a civil monetary penalty of not less than \$1,000, but not more than \$10,000, as adjusted annually under 45 CFR part 102 for each payment or other transfer of value or ownership or investment interest not reported timely, accurately, or completely.

(2) The total amount of civil monetary penalties imposed on each applicable manufacturer or applicable group purchasing organization (regardless of whether the applicable manufacturer was a part of a consolidated report) with respect to failures to report in an annual submission of information will not exceed \$150,000 as adjusted annually under 45 CFR part 102.

(b) *Knowing failure to report.* (1) Any applicable manufacturer or applicable group purchasing organization that knowingly fails to timely, accurately or completely report the information required in accordance with the rules established under this subpart is subject to a civil monetary penalty of not less than \$10,000, but not more than \$100,000, as adjusted annually under 45 CFR part 102 for each payment or other

transfer of value or ownership or investment interest not reported timely, accurately, or completely.

(2) The total amount of civil monetary penalties imposed on each applicable manufacturer or group purchasing organization (regardless of whether the applicable manufacturer was a part of a consolidated report) with respect to knowing failures to report in an annual submission of information will not exceed \$1,000,000 as adjusted annually under 45 CFR part 102.

(c) *Total annual civil monetary penalties.* The amount of civil monetary penalties imposed on each applicable manufacturer or applicable group purchasing organization under paragraphs (a)(1) and (b)(1) of this section are—

(1) Aggregated separately;

(2) Subject to separate aggregate totals under paragraphs (a)(2) and (b)(2) of this section, with a maximum combined annual total of \$1,150,000 as adjusted annually under 45 CFR part 102.

(d) *Determinations regarding the amount of civil monetary penalties.* In determining the amount of the civil monetary penalty, factors to be considered include, but are not limited to, the following:

(1) The length of time the applicable manufacturer or applicable group purchasing organization failed to report, including the length of time the applicable manufacturer or applicable group purchasing organization knew of the payment or other transfer of value, or ownership or investment interest.

(2) Amount of the payment the applicable manufacturer or applicable group purchasing organization failed to report.

(3) Level of culpability.

(4) Nature and amount of information reported in error.

(5) Degree of diligence exercised in correcting information reported in error.

(e) *Record retention and audits.* (1) *Maintenance of records.* (i) Applicable manufacturers and applicable group purchasing organizations must maintain all books, contracts, records, documents, and other evidence sufficient to enable the audit, evaluation, and inspection of the applicable manufacturer's or applicable group purchasing organization's compliance with the re-

quirement to timely, accurately or completely submit information in accordance with the rules established under this subpart.

(ii) The items described in paragraph (e)(1)(i) of this section must be maintained for a period of at least 5 years from the date the payment or other transfer of value, or ownership or investment interest is published publicly on the Web site.

(2) *Audit.* HHS, CMS, OIG or their designees may audit, inspect, investigate and evaluate any books, contracts, records, documents, and other evidence of applicable manufacturers and applicable group purchasing organizations that pertain to their compliance with the requirement to timely, accurately or completely submit information in accordance with the rules established under this subpart.

(3) The requirements in this subpart are in addition to, and do not limit, any other applicable requirements that may obligate applicable manufacturers or applicable group purchasing organizations to retain and allow access to records.

(f) *Use of funds.* Funds collected by the Secretary as a result of the imposition of a civil monetary penalty under this section must be used to carry out the operation of this subpart.

(g) *Notice, hearings, appeals, and collection.* Civil monetary penalties imposed under this section are subject to the provisions set forth in subparts A and B of part 402 of this chapter, including those pertaining to notice, opportunity for a hearing, appeals procedures, and collection of penalties.

[78 FR 9521, Feb. 8, 2013, as amended at 81 FR 61561, Sept. 6, 2016; 82 FR 42749, Sept. 12, 2017]

§ 403.914 Preemption of State laws.

(a) *General rule.* In the case of a payment or other transfer of value provided by an applicable manufacturer to a covered recipient, this subpart preempts any statute or regulation of a State or political subdivision of a State that requires an applicable manufacturer to disclose or report, in any format, the type of information regarding the payment or other transfer of value required to be reported under this subpart.

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(b) *Information collected for public health purposes.* (1) Information required to be reported to a Federal, State, or local governmental agency for public health surveillance, investigation, or other public health purposes or health oversight purposes must still be reported to appropriate Federal, State, or local governmental agencies, regardless of whether the same information is required to be reported under this subpart.

(2) Governmental agencies include, but are not limited to, the following:

(i) Agencies that are charged with preventing or controlling disease, injury, disability.

(ii) Agencies that conduct oversight activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions, or other activities necessary for oversight of the health care system.

Subpart K—Access to Identifiable Data for the Center for Medicare and Medicaid Models

SOURCE: 79 FR 68001, Nov. 13, 2014, unless otherwise noted.

§ 403.1100 Purpose and scope.

The regulations in this subpart implement section 1115A of the Act. The intent of that section is to enable CMS to test innovative payment and service delivery models to reduce program expenditures while preserving and/or enhancing the quality of care furnished to individuals under titles XVIII, XIX, and XXI of the Act. The Secretary is also required to conduct an evaluation of each model tested.

§ 403.1105 Definitions.

For purposes of this subpart—

Applicable titles means Titles XVIII, XIX, or XXI of the Act.

§ 403.1110 Evaluation of models.

(a) *Evaluation.* The Secretary conducts an evaluation of each model tested under section 1115A of the Act. Such evaluation must include an analysis of the following:

(1) The quality of care furnished under the model, including the measurement of patient-level outcomes and

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patient-centeredness criteria determined appropriate by the Secretary.

(2) The changes in spending under the applicable titles by reason of the model.

(b) *Information.* Any State or other entity participating in the testing of a model under section 1115A of the Act must collect and report such information, including “protected health information” as that term is defined at 45 CFR 160.103, as the Secretary determines is necessary to monitor and evaluate such model. Such data must be produced to the Secretary at the time and in the form and manner specified by the Secretary.

Subpart L—Requirements for Direct-to-Consumer Television Advertisements of Drugs and Biological Products To Include the List Price of That Advertised Product

SOURCE: 84 FR 20757, May 10, 2019, unless otherwise noted.

§ 403.1200 Scope.

(a) *Covered pharmaceuticals.* Except as specified in paragraph (b) of this section, this subpart applies to advertisements for a prescription drug or biological product distributed in the United States for which payment is available, directly or indirectly, under titles XVIII or XIX of the Social Security Act.

(b) *Excepted pharmaceuticals.* An advertisement for any prescription drug or biological product that has a list price, as defined in § 403.1201, less than \$35 per month for a 30-day supply or typical course of treatment shall be exempt from the requirements of this subpart.

§ 403.1201 Definitions.

For the purposes of this subpart, the following definitions apply:

(a) *Biological product.* Biological product means any biological product, as that term is defined in Public Health Service Act (“PHS Act”) section 351(i), that is licensed by the Food and Drug Administration pursuant to section 351 and is subject to the requirements of