

(e) *Treatment of APM Incentive Payment amount in APMs.* (1) APM Incentive Payments made under this section are not included in determining actual expenditures under an APM.

(2) APM Incentive Payments made under this section are not included in calculations for the purposes of re-basing benchmarks in an APM.

(f) *Treatment of APM Incentive Payment for other Medicare incentive payments and payment adjustments.* APM Incentive Payments made under this section will not be included in determining the amount of incentive payment made to eligible clinicians under section 1833(m), (x), and (y) of the Act.

#### §414.1455 Limitation on review.

There is no administrative or judicial review under sections 1869, 1878, or otherwise, of the Act of the following:

(a) The determination that an eligible clinician is a QP or Partial QP under §414.1425 and the determination that an APM Entity is an Advanced APM Entity under §414.1410.

(b) The determination of the amount of the APM Incentive Payment under §414.1450, including any estimation as part of such determination.

#### §414.1460 Monitoring and program integrity.

(a) *Vetting eligible clinicians prior to payment of the APM Incentive Payment.* Prior to payment of the APM Incentive Payment, CMS determines if eligible clinicians were in compliance with all Medicare conditions of participation and the terms of the relevant Advanced APMs in which they participate during the QP Performance Period. For QPs not meeting these standards there may be a reduction or denial of the APM Incentive Payment. A determination under this provision is not binding for other purposes.

(b) *Termination by Advanced APMs.* CMS may reduce or deny an APM Incentive Payment to eligible clinicians who are terminated by APMs or whose Advanced APM Entities are terminated by APMs for non-compliance with all Medicare conditions of participation or the terms of the relevant Advanced APMs in which they participate during the QP Performance Periods.

(c) *Information submitted for All-Payer Combination Option.* Information submitted by eligible clinicians or Advanced APM Entities to meet the requirements of the All-Payer Combination Option may be subject to audit by CMS. Eligible clinicians and Advanced APM Entities must maintain copies of any supporting documentation related to All-Payer Combination Option for at least 10 years and must attest to the accuracy and completeness of the data submitted.

(d) *Recoupment of APM Incentive Payment.* For any QPs who are terminated from an Advanced APM or found to be in violation of any Federal, State, or tribal statute, regulation, or other binding guidance during the QP Performance Period or Incentive Payment Base Period or terminated after these periods as a result of a violation occurring during either period, CMS may rescind such eligible clinicians' QP determinations and, if necessary, recoup part or all of any such eligible clinicians' APM Incentive Payment or deduct such amount from future payments to such individuals. CMS may reopen and recoup any payments that were made in error in accordance with procedures similar to those set forth at 42 CFR 405.980 and 42 CFR 405.370 through 405.379 or established under the relevant APM. The APM Incentive Payment will be recouped if an audit reveals a lack of support for attested statements provided by eligible clinicians and Advanced APM Entities.

(e) *Maintenance of records.* An Advanced APM Entity or eligible clinician that submits information to CMS under §414.1445 for assessment under the All-Payer Combination Option must maintain such books contracts, records, documents, and other evidence for a period of 10 years from the final date of the QP Performance Period or from the date of completion of any audit, evaluation, or inspection, whichever is later, unless:

(1) CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies the Advanced APM Entity of eligible clinician at least 30 days before the formal disposition date; or

(2) There has been a termination, dispute, or allegation of fraud or similar

fault against the Advanced APM Entity or eligible clinician, in which case the Advanced APM Entity or eligible clinician must retain records for an additional 6 years from the date of any resulting final resolution of the termination, dispute, or allegation of fraud or similar fault.

(f) *OIG authority.* None of the provisions of this part limit or restrict OIG's authority to audit, evaluate, investigate, or inspect the Advanced APM Entity, its eligible clinicians, and other individuals or entities performing functions or services related to its APM activities.

**§ 414.1465 Physician-focused payment models.**

(a) *Definition.* A physician-focused payment model (PFPM) is an Alternative Payment Model:

- (1) In which Medicare is a payer;
- (2) In which eligible clinicians that are eligible professionals as defined in section 1848(k)(3)(B) of the Act are participants and play a core role in implementing the APM's payment methodology; and
- (3) Which targets the quality and costs of services that eligible professionals participating in the Alternative Payment Model provide, order, or can significantly influence.

(b) *Criteria.* In carrying out its review of physician-focused payment model proposals, the PTAC must assess whether the physician-focused payment model meets the following criteria for PFPMs sought by the Secretary. The Secretary seeks PFPMs that:

- (1) *Incentives: Pay for higher-value care.* (i) Value over volume: provide incentives to practitioners to deliver high-quality health care.
- (ii) *Flexibility:* provide the flexibility needed for practitioners to deliver high-quality health care.
- (iii) *Quality and Cost:* are anticipated to improve health care quality at no additional cost, maintain health care quality while decreasing cost, or both improve health care quality and decrease cost.
- (iv) *Payment methodology:* pay APM Entities with a payment methodology designed to achieve the goals of the PFPM Criteria. Addresses in detail

through this methodology how Medicare, and other payers if applicable, pay APM Entities, how the payment methodology differs from current payment methodologies, and why the PFPM cannot be tested under current payment methodologies.

(v) *Scope:* aim to broaden or expand the CMS APM portfolio by addressing an issue in payment policy in a new way or including APM Entities whose opportunities to participate in APMs have been limited.

(vi) *Ability to be evaluated:* have evaluable goals for quality of care, cost, and any other goals of the PFPM.

(2) *Care delivery improvements: Promote better care coordination, protect patient safety, and encourage patient engagement.* (i) *Integration and Care Coordination:* encourage greater integration and care coordination among practitioners and across settings where multiple practitioners or settings are relevant to delivering care to the population treated under the PFPM.

(ii) *Patient Choice:* encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients.

(iii) *Patient Safety:* aim to maintain or improve standards of patient safety.

(3) *Information Enhancements: Improving the availability of information to guide decision-making.* (i) *Health Information Technology:* encourage use of health information technology to inform care.

(ii) [Reserved]

**PART 415—SERVICES FURNISHED BY PHYSICIANS IN PROVIDERS, SUPERVISING PHYSICIANS IN TEACHING SETTINGS, AND RESIDENTS IN CERTAIN SETTINGS**

**Subpart A—General Provisions**

Sec.

415.1 Basis and scope.

**Subpart B—Fiscal Intermediary Payments to Providers for Physician Services**

415.50 Scope.

415.55 General payment rules.

415.60 Allocation of physician compensation costs.