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.

Subpart B—Fiscal Intermediary Payments to Providers for Physician Services