to the FFS–CR participant's request for such data for a beneficiary who has been furnished a billable service by the FFS–CR participant corresponding to the AMI care period or CABG care period definitions.

(2) The minimum data necessary to achieve the goals of the CR incentive payment test, as determined by CMS, may be provided under this section no less frequently than on a quarterly basis throughout the FFS–CR participant's participation in the CR incentive payment test.

§ 512.730 Compliance enforcement for FFS–CR participants.

(a) *General*. FFS–CR participants must comply with all of the requirements outlined in this subpart. Except as specifically noted in this subpart, the regulations under this subpart must not be construed to affect the payment, coverage, program integrity, or other requirements (such as those in parts 412 and 482 of this chapter) that apply to providers and suppliers under this chapter.

(b) *Failure to comply*. (1) CMS may take one or more of the remedial actions set forth in paragraph (b)(2) of this section if a FFS–CR participant does any of the following:

(i) Fails to comply with any requirements of this subpart or is identified as noncompliant through monitoring by HHS (including CMS and OIG) of the CR incentive payment model, including but not limited to the following:

(A) Avoiding potentially high-severity patients.

(B) Targeting potentially low-severity patients.

(C) Failing to provide medically appropriate services or systematically engaging in the over or under-delivery of appropriate care.

(D) Failing to provide beneficiaries with complete and accurate information.

(ii) Takes any action that threatens the health or safety of patients.

(iii) Avoids at risk Medicare beneficiaries, as this term is defined in § 425.20 of this chapter.

(iv) Avoids patients on the basis of payer status.

(v) Is subject to sanctions or final actions of an accrediting organization or Federal, state, or local government agency that could lead to the inability to comply with the requirements and provisions of this subpart.

(vi) Takes any action that CMS determines for program integrity reasons is not in the best interests of the CR incentive payment model, or fails to take any action that CMS determines for program integrity reasons should have been taken to further the best interests of the CR incentive payment model.

(viii) Is subject to action by HHS (including OIG and CMS) or the Department of Justice to redress an allegation of fraud or significant misconduct, including intervening in a False Claims Act qui tam matter, issuing a pre demand or demand letter under a civil sanction authority, or similar actions.

(ix) Is subject to action involving violations of the physician self-referral law, civil monetary penalties law, Federal anti-kickback statute, antitrust laws, or any other applicable Medicare laws, rules, or regulations that are relevant to the CR incentive payment model.

(2) Remedial actions include the following:

(i) Issuing a warning letter to the FFS–CR participant.

(ii) Requiring the FFS–CR participant to develop a corrective action plan, commonly referred to as a CAP.

(iii) Reducing or eliminating the FFS–CR participant's CR incentive payment.

(iv) Terminating the FFS–CR participant from the CR incentive payment model.

§ 512.735 Enforcement authority for FFS–CR participants.

(a) *OIG authority*. OIG authority is not limited or restricted by the provisions of the CR incentive payment model, including the authority to audit, evaluate, investigate, or inspect the FFS–CR participant, or any other person or entity or their records, data, or information, without limitation.

(b) *Other authorities*. None of the provisions of the CR incentive payment model limits or restricts the authority