

(3) Any TIN associated with the QP that, during the APM Incentive Payment base period, is associated with an APM Entity participating in an Advanced APM through which the eligible clinician had achieved QP status;

(4) Any TIN associated with the QP that, during the APM Incentive Payment base period, participated in an APM Entity in an Advanced APM;

(5) Any TIN associated with the QP that, during the APM Incentive Payment base period, participated with an APM Entity in any track of the APM through which the eligible clinician achieved QP status;

(6) Any TIN associated with the QP that, during the APM Incentive Payment base period, participated with an APM Entity in an APM other than an Advanced APM;

(7) Any TIN associated with the QP that submitted a claim for covered professional services furnished by the QP during the APM Incentive Payment base period, even if such TIN has no relationship to any APM Entity or APM; then

(8) If we have not identified any TIN associated with the QP to which we can make the APM Incentive Payment, we will attempt to contact the QP via a public notice to request their Medicare payment information. The QPs identified in the public notice, or any other eligible clinicians who believe that they are entitled to an APM Incentive Payment must then notify CMS of their claim as directed in the public notice by September 1 of the payment year, or 60 days after CMS announces that initial payments for the year have been made, whichever is later. After that time, any claims by a QP to an APM Incentive Payment will be forfeited for such payment year.

(d) *Timing of the APM Incentive Payment.* APM Incentive Payments made under this section are made as soon as practicable following the calculation and validation of the APM Incentive Payment amount, but in any event no later than 1 year after the incentive payment base period.

(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 rebasing 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.

[81 FR 77537, Nov. 4, 2016, as amended at 85 FR 85035, Dec. 28, 2020; 86 FR 65681, Nov. 19, 2021; 87 FR 70230, Nov. 18, 2022]

**§ 414.1455 Limitation on review.**

(a) There is no right to administrative or judicial review under sections 1869, 1878, or otherwise, of the Act of the following:

(1) The determination that an eligible clinician is a QP or Partial QP under § 414.1425.

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

(b)(1) An eligible clinician or APM Entity may request targeted review of a QP or Partial QP determination only if they believe in good faith that, due to a CMS clerical error, an eligible clinician was omitted from a Participation List.

(2) If CMS determines that there was such a clerical error, if the QP determination for the eligible clinician would have been made at the APM Entity level under § 414.1425(b)(1), CMS will assign to the eligible clinician the most favorable QP status that was determined at the APM Entity level on any snapshot dates for the relevant QP Performance Period on which the eligible clinician participated in the APM Entity.

(3) The process for targeted review is as follows:

(i) An eligible clinician or APM Entity may submit a request for targeted review.

(ii) All requests for targeted review must be submitted during the targeted review request submission period, which is a 60-day period that begins with the publication of MIPS performance feedback as described at

§414.1385(a)(2). The targeted review request submission period may be extended as specified by CMS.

(iii) All requests for targeted review must be submitted in accordance with the form and manner specified by CMS.

(iv) A request for targeted review may be denied if the request is duplicative of another request for a targeted review; the request is not submitted during the targeted review request submission period; or the request is outside the scope of targeted review specified in this section. If the targeted review request is denied, CMS will make no changes to the QP status of the eligible clinician for whom targeted review was requested.

(v) CMS will respond to each timely submitted request for targeted review.

(vi) A request for targeted review may include additional information in support of the request at the time it is submitted. CMS may also request additional information from the requestor. If CMS requests additional information relating to the eligible clinician or the APM Entity group that is the subject of a request for targeted review, responsive information must be provided and received by CMS within 30 days of the request. If CMS does not receive a timely response to a request for additional information, CMS may make a final decision on the targeted review request based on the information available.

(vii) If targeted review requests reveal a pattern of CMS error with impacts that extend beyond the scope of eligible clinicians or APM Entities that submitted such targeted review requests, CMS may adjust the QP status of other affected eligible clinicians as provided in paragraph (b)(2) of this section.

(viii) Decisions on a targeted review request are final, and not subject to any further administrative or judicial review in accordance with paragraph (a) of this section.

[85 FR 85035, Dec. 28, 2020]

**§414.1460 Monitoring and program integrity.**

(a) *Vetting eligible clinicians.* 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 participated during the QP Performance Period. A determination under this provision is not binding for other purposes.

(b) *Rescinding QP Determinations.* CMS may rescind a QP determination if:

(1) Any of the information CMS relied on in making the QP determination was inaccurate or misleading.

(2) The QP is terminated from an Advanced APM or Other Payer Advanced APM during the QP Performance Period or Incentive Payment Base Period; or

(3) The QP is found to be in violation of the terms of the relevant Advanced APM or any relevant Federal, State, or tribal statute or regulation during the QP Performance Period or Incentive Payment Base Period.

(c) *Information submitted for All-Payer Combination Option.* Information submitted by payers, APM Entities, or eligible clinicians for purposes of the All-Payer Combination Option may be subject to audit by CMS.

(d) *Reducing, denying, and recouping of APM Incentive Payments.* (1) CMS may reduce or deny an APM Incentive Payment to an eligible clinician.

(i) Who CMS determines is not in compliance with all Medicare conditions of participation and the terms of the relevant Advanced APM in which they participate during the QP Performance Period or Incentive Payment Base Period;

(ii) Who is terminated by an APM or Advanced APM during the QP Performance Period or Incentive Payment Base Period; or

(iii) Whose APM Entity is terminated by an APM or Advanced APM for non-compliance with any Medicare condition of participation or the terms of the relevant Advanced APM in which they participate during the QP Performance Period or Incentive Payment Base Period.

(2) CMS may reopen, revise, and recoup an APM Incentive Payment that was made in error in accordance with procedures similar to those set forth at §§405.980 through §405.986 and §§405.370 through 405.379 of this chapter or as established under the relevant APM.