

(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.

(e) *Maintenance of records.* (1) A payer 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 as necessary to enable the audit of an Other Payer Advanced APM determination. Such information and supporting documentation must be maintained for a period of 6 years after submission.

(2) An APM Entity or eligible clinician that submits information to CMS under §414.1445 for assessment under the All-Payer Combination Option or §414.1440 for QP determinations must maintain such books, contracts, records, documents, and other evidence as necessary to enable the audit of an Other Payer Advanced APM determination, QP determinations, and the accuracy of APM Incentive Payments for a period of 6 years from the end of the

QP Performance Period or from the date of completion of any audit, evaluation, or inspection, whichever is later.

(3) A payer, APM Entity or eligible clinician that submits information to CMS under §§414.1440 or 414.1445 must provide such information and supporting documentation to CMS upon request.

(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.

[81 FR 77537, Nov. 4, 2016, as amended at 82 FR 53965, Nov. 16, 2017]

#### **§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.