share savings with the Medicare pro-
gram, if it meets the requirements for
doing so, and is also liable for sharing
losses incurred under the program or
model, if it meets the criteria under
which sharing losses occurs.

Subpart B—Episode Payment
Model Participants

§ 512.100 EPM episodes being tested.

(a) Initiation of an episode. An episode
is initiated when an EPM participant
admits a Medicare beneficiary de-
scribed in § 512.230 for an anchor hos-
pitalization.

(b) Hospital exclusions. (1) A hospital
is excluded from participating in EPMs
for EPM anchor MS–DRGs that are in-
cluded in BPCI episodes in which the
hospital currently participates.

(2) These exclusions cease to apply as
of the date that the hospital no longer
meets the conditions specified in this
paragraph (b) or September 30, 2018,
whichever date is sooner.

(c) Types of EPM episodes. An EPM
episode is initiated by a beneficiary’s
admission to an EPM participant for
an anchor hospitalization that is paid
under an EPM anchor MS–DRG and, in
the case of the AMI model, with an
AMI ICD–10–CM diagnosis code if the
admission is under a PCI MS–DRG. The
EPM anchor MS–DRGs and ICD–10–CM
diagnosis codes for the EPM episodes
are as follows:

(1) Acute myocardial infarction (AMI).
   (i) Discharge under an AMI MS–DRG
       (MS–DRGs 280 to 282); or
   (ii) Discharge under a PCI MS–DRG
       (MS–DRGs 246 to 251) with an ICD–10–
       CM diagnosis code of AMI on the claim
       for the anchor hospitalization in the
       principal or secondary diagnosis code
       position.

(2) Coronary artery bypass graft
       (CABG). Discharge under a CABG MS–
       DRG (MS–DRGs 231 to 236).

(3) Surgical hip/femur fracture treat-
       ment (SHFFT). Discharge under a
       SHFFT MS–DRG (MS–DRGs 480 to 482).

(d) Identifying AMI historical episodes
    and EPM episodes with AMI ICD–CM di-
    agnosis codes. CMS develops a list of
    AMI ICD–9–CM and ICD–10–CM diag-
    nosis codes that identify the initiation
    of historical episodes or initiate AMI
    model episodes when reported in the
    principal or secondary diagnosis code
    position on the inpatient hospital
    claim for a historical hospitalization
    or the anchor hospitalization dis-
    charged under PCI MS–DRGs (MS–
    DRGs 246 to 251). The list of ICD–9–CM
    and ICD–10–CM diagnosis codes rep-
    resenting AMI is posted on the CMS
    Web site.

   (1) On an annual basis, or more fre-
       quently as needed, CMS updates the
       list of ICD–10–CM diagnosis codes rep-
       resenting AMI to reflect coding
       changes or other issues brought to
       CMS’ attention.

   (2) CMS applies the following stand-
       ard when revising the list of ICD–10–CM
diagnosis codes representing AMI: The
       ICD–10–CM diagnosis code is suffi-
       ciently specific that it represents an
       AMI.

   (3) CMS posts the following to the
       CMS Web site:
       (i) Potential AMI ICD–10–CM diag-
           nosis codes for public comment; and
       (ii) A final AMI ICD–10–CM diagnosis
code list after consideration of public
       comment.

   (4) CMS excludes AMI historical epi-
       sodes with PCI MS–DRGs and inpatient
       claims that contain intracardiac ICD–
       9–CM procedure codes. CMS excludes
       historical AMI model episodes dis-
       charged under PCI MS–DRGs with an
       AMI ICD–9–CM diagnosis code in the
       principal or secondary diagnosis code
       position on the inpatient hospital
       claim from the AMI historical episodes
       that set episode benchmark prices if
       there is an intracardiac ICD–9–CM pro-
       cedure code in any procedure code field
       on the inpatient hospital claim. The
       intracardiac ICD–9–CM procedure codes
       are as follows:
       (i) 35.52 (Repair of atrial septal defect
           with prosthesis, closed technique).
       (ii) 35.96 (Percutaneous balloon
           valvuloplasty).
       (iii) 35.97 (Percutaneous mitral valve
           repair with implant).
       (iv) 37.26 (Catheter based invasive
           electrophysiologic testing).
       (v) 37.27 (Cardiac mapping).
       (vi) 37.34 (Excision or destruction of
           other lesion or tissue of heart, endovascular approach).
       (vii) 37.36 (Excision, destruction, or
           exclusion of left atrial appendage).
§ 512.105 Geographic areas.

(a) The SHFFT model must be implemented in the same geographic areas as the CJR model as described under §510.105 of the chapter.

(b) The geographic areas for inclusion in the CABG and AMI models will be obtained using a random sampling of certain MSAs in the United States. All counties within each of the selected MSAs are selected for inclusion in the AMI and CABG models. CMS excludes MSAs that met the following criteria between January 1, 2014 and December 31, 2014 from the possibility of being selected geographic areas. MSAs are excluded if they—

1. Had fewer than 75 AMI episodes;
2. Had fewer than 75 AMI episodes that were not attributable to BPCI Model 2 or 4, AMI, CABG or PCI episodes;
3. Had more than 50 percent of otherwise qualifying (BPCI or non BPCI) episodes attributable to a BPCI Model 2 or 4 AMI, CABG or PCI episodes; or
4. Are in Maryland, Vermont, or another state where CMS is implementing a state-wide all-payer model. In such situations all MSAs in the state may be excluded even if hospitals are otherwise being paid in accordance with the IPPS and would otherwise qualify as an eligible EPM participant.

(c) In all geographic areas where the AMI, CABG, or SHFFT models are being implemented, the accountable financial entity must be an acute care IPPS hospital.

§ 512.110 Access to records and retention.

EPM participants, EPM collaborators, collaboration agents, downstream collaboration agents, and any other individuals or entities performing EPM activities must:

(a) Allow the Government, including CMS, OIG, HHS, and the Comptroller General or their designees, scheduled and unscheduled access to all books, contracts, records, documents, and other evidence (including data related to utilization and payments, quality of care criteria, billings, lists of EPM collaborators, sharing arrangements, distribution arrangements, downstream distribution arrangements, and the documentation required under §§512.500(d) and 512.525(d)) sufficient to enable the audit, evaluation, inspection, or investigation of the following:

1. The individual’s or entity’s compliance with EPM requirements and, if applicable, the individual’s or entity’s compliance with CR incentive payment model requirements.
2. The calculation, distribution, receipt, or recoupment of gainsharing payments, alignment payments, distribution payments, and downstream distribution payments.
3. The obligation to repay any reconciliation payments or CR incentive payments, if applicable, owed to CMS.
4. The quality of the services furnished to an EPM beneficiary during an EPM episode.
5. The sufficiency of EPM beneficiary notifications.
6. The accuracy of the EPM participant’s submissions under CEHRT use requirements.

(b) Maintain all such books, contracts, records, documents, and other evidence for a period of 10 years from the last day of the EPM participant’s participation in the EPM or from the date of completion of any audit, evaluation, inspection, or investigation, whichever is later, unless—

1. CMS determines a particular record or group of records should be retained for a longer period and notifies the EPM participant at least 30 calendar days before the disposition date; or
2. There has been a dispute or allegation of fraud or similar fault against the EPM participant, EPM collaborator, collaboration agent, downstream collaboration agent, or any other individual or entity performing EPM activities in which case the records must be maintained for 6 years from the date of any resulting final resolution of the dispute or allegation of fraud or similar fault.

§ 512.120 EPM participant CEHRT track requirements.

(a) EPM CEHRT use. For performance year 2 if the EPM participant elects downside risk and for performance