

share savings with the Medicare program, 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 described in § 512.230 for an anchor hospitalization.

(b) *Hospital exclusions.* (1) A hospital is excluded from participating in EPMs for EPM anchor MS-DRGs that are included 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 treatment (SHFFT).* Discharge under a SHFFT MS-DRG (MS-DRGs 480 to 482).

(d) *Identifying AMI historical episodes and EPM episodes with AMI ICD-CM diagnosis codes.* CMS develops a list of AMI ICD-9-CM and ICD-10-CM diagnosis 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 discharged under PCI MS-DRGs (MS-DRGs 246 to 251). The list of ICD-9-CM and ICD-10-CM diagnosis codes representing AMI is posted on the CMS Web site.

(1) On an annual basis, or more frequently as needed, CMS updates the list of ICD-10-CM diagnosis codes representing AMI to reflect coding changes or other issues brought to CMS' attention.

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

(3) CMS posts the following to the CMS Web site:

(i) Potential AMI ICD-10-CM diagnosis 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 episodes with PCI MS-DRGs and inpatient claims that contain intracardiac ICD-9-CM procedure codes. CMS excludes historical AMI model episodes discharged 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 procedure 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).

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(viii) 37.90 (Insertion of left atrial appendage device).

§ 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, dis-

tribution 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