(E) *Year 5.* Submit electronic health record data on over 90 percent of eligible AMI anchor hospitalizations between July 1, 2020 and June 30, 2021.

§512.412 Quality measures and reporting for CABG model.

(a) *Required measures.* (1) Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft (CABG) Surgery (NQF #2558) (MORT–30–CABG).

(2) HCAHPS Survey (NQF #0166).

(b) [Reserved]

§512.413 Quality measures and reporting for SHFFT model.

(a) *Required measures.* (1) Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty (NQF #1550) (Hip/Knee Complications).

(2) HCAHPS Survey (NQF #0166).

(b) *Voluntary measure.* (1) Patient-reported outcomes and limited risk variable data following elective primary THA/TKA.

(2) To be eligible to receive the additional points added to the SHFFT model composite quality score for successful voluntary data submission of patient-reported outcomes and limited risk variable data, as described in §512.315(d)(1)(iv), SHFFT model participants must submit the THA/TKA patient-reported outcome and limited risk variable data requested by CMS related to the pre- and post-operative periods for elective primary total hip and/or total knee arthroplasty procedures. The data must be submitted within 60 days of the end of the most recent performance period and be accompanied by the patient-reported outcomes and limited risk variable data (eleven elements finalized) as outlined in §512.315(d)(1)(iv).

(i) For each eligible procedure all eleven risk variable data elements are required to be submitted. The eleven risk variables are as follows:

(A) Date of birth.

(B) Race.

(C) Ethnicity.

(D) Date of admission to anchor hospitalization.

(E) Date of eligible THA/TKA procedure.

(F) Medicare Health Insurance Claim Number.

(G) Body mass index.

(H) Use of chronic (≥ 90 days) narcotics.

(I) Total painful joint count.

(J) Quantified spinal pain.

(K) Single Item Health Literacy Screening (SILS2) questionnaire.

(ii) Participants must also submit the amount of requested THA/TKA patient-reported outcomes data required for each year of the SHFFT model in order to be considered successful in submitting voluntary data.

(A) The amount of requested THA/TKA patient-reported outcomes data to submit, in order to be considered successful increases each subsequent year of the SHFFT model over the 5 years of the model.

(B) A phase-in approach that determines the amount of requested THA/TKA patient-reported outcomes data to submit over the 5 years of the SHFFT model is applied so that in year 1 successful submission of data would mean CMS received all requested THA/TKA patient-reported outcomes and limited risk variable data on both of the following:

(1) Greater than or equal to 60 percent of eligible procedures or greater than or equal to 75 percent eligible patients during the data collection period.

(2) Submission of requested THA/TKA PRO and limited risk variable data is completed within 60 days of the most recent performance period.

(iii) For years 1 through 5 of the model an increasing amount of data is requested by CMS for each performance period as follows:

(A) *Year 1 (2017).* Submit pre-operative data on primary elective THA/TKA procedures for ≥ 60 percent or ≥ 75 procedures performed between September 1, 2016 through June 30, 2017, unless CMS requests a more limited data set, in which case, submit all requested data elements.

(B) *Year 2 (2018).* Submit—

(1) Post-operative data on primary elective THA/TKA procedures for ≥ 60 percent or ≥ 75 procedures performed between September 1, 2016 and June 30, 2017; and

(2) Pre-operative data on primary elective THA/TKA procedures for ≥ 70 percent or ≥ 100 procedures performed between July 1, 2017 and June 30, 2018, unless CMS requests a more limited data set, in which case, submit all requested data elements.

(C) *Year 3 (2019).* Submit—

(1) Post-operative data on primary elective THA/TKA procedures for ≥ 70 percent or ≥ 100 procedures performed between July 1, 2017 and June 30, 2018; and

(2) Pre-operative data on primary elective THA/TKA procedures for ≥ 80 percent or ≥ 200 procedures performed between July 1, 2018 and June 30, 2019, unless CMS requests a more limited data set, in which case, submit all requested data elements.

(D) *Year 4 (2020).* Submit—

(1) Post-operative data on primary elective THA/TKA procedures for ≥ 80 percent or ≥ 200 procedures performed between July 1, 2018 and June 30, 2019; and

(2) Pre-operative data on primary elective THA/TKA procedures for ≥ 80 percent or ≥ 200 procedures performed between July 1, 2019 and June 30, 2020, unless CMS requests a more limited data set, in which case, submit all requested data elements.

(E) *Year 5 (2021).* Submit—

(1) Post-operative data on primary elective THA/TKA procedures for ≥ 80 percent or ≥ 200 procedures performed between July 1, 2019 and June 30, 2020; and

(2) Pre-operative data on primary elective THA/TKA procedures for ≥ 80 percent or ≥ 200 procedures performed between July 1, 2020 and June 30, 2021, unless CMS requests a more limited data set, in which case, submit all requested data elements.

§ 512.450 Beneficiary choice and beneficiary notification.

(a) *Beneficiary choice.* The EPMs do not restrict Medicare beneficiaries' ability to choose any Medicare enrolled provider or supplier, or any physician or practitioner who has opted out of Medicare.

(1) As part of discharge planning and referral, EPM participants must provide a complete list of HHAs, SNFs, IRFs, or LTCHs that are participating in the Medicare program, and that serve the geographic area (as defined by the HHA) in which the patient resides, or in the case of a SNF, IRF, or LTCH, in the geographic area requested by the patient.

(i) This list must be presented to EPM beneficiaries for whom home health care, SNF, IRF, or LTCH services are medically necessary.

(ii) EPM participants must specify on the list those post-acute care providers on the list with whom they have a sharing arrangement.

(iii) EPM participants may recommend preferred providers and suppliers, consistent with applicable statutes and regulations.

(iv) EPM participants may not limit beneficiary choice to any list of providers or suppliers in any manner other than that permitted under applicable statutes and regulations.

(v) EPM participants must take into account patient and family preferences when they are expressed.

(2) EPM participants may not charge any EPM collaborator a fee to be included on any list of preferred providers or suppliers, nor may the EPM participant accept such payments.

(b) *Required beneficiary notification—*(1) *EPM participant detailed notification.* Each EPM participant must provide written notification to any Medicare beneficiary that meets the criteria in § 512.240 of his or her inclusion in the EPM. The notification must be provided upon admission to the EPM participant if the admission that initiates the EPM episode is not scheduled with the EPM participant in advance. If the admission is scheduled in advance, then the EPM participant must provide notice as soon as the admission is scheduled. In circumstances where, due to the patient's condition, it is not feasible to provide notification at such times, the notification must be provided to the beneficiary or his or her representative as soon as is reasonably practicable but no later than discharge from the EPM participant accountable for the EPM episode. The EPM participant must be able to generate a list of all beneficiaries receiving such notification, including the date on which the