§ 510.305 Determination of the NPRA and reconciliation process.

(a) General. Providers and suppliers furnishing items and services included in the episode bill for such items and services in accordance with existing rules and as if this part were not in effect.

(b) Reconciliation. CMS uses a series of reconciliation processes, which CMS performs as described in paragraphs (d) and (f) of this section after the end of each performance year, to establish final payment amounts to participant hospitals for CJR episodes for a given performance year. Following the end of each performance year, CMS determines actual episode payments for each episode for the performance year (other than episodes that have been canceled in accordance with §510.210(b)) and determines the amount of a reconciliation payment or repayment amount.

(c) Data used. CMS uses the most recent claims data available to perform each reconciliation calculation.

(d) Annual reconciliation. (1) Beginning 2 months after the end of each performance year, CMS performs a reconciliation calculation to establish an NPRA for each participant hospital.

(2) CMS—

(i) Calculates the NPRA for each participant hospital in accordance with paragraph (e) of this section including the adjustments provided for in paragraph (e)(1)(iv) of this section; and

(ii) Assesses whether hospitals meet specified quality requirements under §510.315.

(e) Calculation of the NPRA. By comparing the episode target prices described in §510.300 and the participant hospital’s actual episode spending for
the performance year and applying the adjustments in paragraph (e)(1)(v) of this section, CMS establishes an NPRA for each participant hospital for each performance year.

(1) Initial calculation. In calculating the NPRA for each participant hospital for each performance year, CMS does the following:

(i) Determines actual episode payments for each episode included in the performance year (other than episodes that have been canceled in accordance with §510.210(b)) using claims data that is available 2 months after the end of the performance year. Actual episode payments are capped at the amount determined in accordance with §510.300(b)(5) for the performance year.

(ii) Multiplies each episode target price, after applying any reduction to the discount percentage as provided in §510.315(f) by the number of episodes included in the performance year (other than episodes that have been canceled in accordance with §510.210(b)) to which that episode target price applies.

(iii) Aggregates the amounts computed in paragraph (e)(1)(ii) of this section for all episodes included in the performance year (other than episodes that have been canceled in accordance with §510.210(b)).

(iv) Subtracts the amount determined under paragraph (e)(1)(i) of this section from the amount determined under paragraph (e)(1)(iii) of this section.

(v) Makes the following adjustments:

(A) Increases in post-episode spending. If the average post-episode Medicare Parts A and B spending for a participant hospital in any given performance year is greater than 3 standard deviations above the regional average post-episode spending for the same performance year, then the spending amount exceeding three standard deviations above the regional average post-episode spending for the same performance year is applied to the NPRA.

(B) Limitation on loss. Except as provided in paragraph (e)(1)(v)(D) of this section, the total amount any participant hospital is responsible for repaying to Medicare for a performance year cannot exceed the following:

(i) For performance year 2 only, 5 percent of the amount calculated in paragraph (e)(1)(iii) of this section for the performance year.

(ii) For performance year 3, 10 percent of the amount calculated in paragraph (e)(1)(iii) of this section for the performance year.

(iii) For performance years 4, and 5, 20 percent of the amount calculated in paragraph (e)(1)(iii) of this section for the performance year.

(4) As provided in paragraph (h)(6)(i) of this section, the subsequent reconciliation calculation reassesses the limitation on loss for a given performance year by applying the limitations on loss to the aggregate of the 2 reconciliation calculations.

(C) Limitation on gain. The total amount of any reconciliation payment made to a participant hospital for a performance year cannot exceed the following:

(i) For performance years 1 and 2, 5 percent of the amount calculated in paragraph (e)(1)(iii) of this section for the performance year.

(ii) For performance year 3, 10 percent of the amount calculated in paragraph (e)(1)(iii) of this section for the performance year.

(iii) For performance years 4, and 5, 20 percent of the amount calculated in paragraph (e)(1)(iii) of this section for the performance year.

(iv) As provided in paragraph (h)(6)(i) of this section, the subsequent reconciliation calculation reassesses the limitation on gain for a given performance year by applying the limitation on gain limits to the aggregate of the two reconciliation calculations.

(D) Financial loss limits for rural hospitals, SCHs, MDHs, and RRCs. If a participant hospital is a rural hospital, SCH, MDH or RRC, then for performance year 2, the total repayment amount for which the participant hospital is responsible cannot exceed 3 percent of the amount calculated in paragraph (e)(1)(iii) of this section. For performance years 3 through 5, the total repayment amount cannot exceed 5 percent of the amount calculated in paragraph (e)(1)(iii) of this section.

(f) Determination of reconciliation or repayment amount—(1) Determination of the reconciliation or repayment amount. The total amount any participant hospital is responsible for repaying to Medicare for a performance year cannot exceed the following:

(i) For performance year 2 only, 5 percent of the amount calculated in paragraph (e)(1)(iii) of this section, for performance year 1.
the reconciliation payment (if any) is equal to the NPRA.

(ii) Subject to paragraph (f)(1)(iii) of this section, for performance years 2 through 5, results from the subsequent reconciliation calculation for a prior year’s reconciliation, as described in paragraph (h)(6)(1) of this section, are applied to the current year’s NPRA in order to determine the reconciliation or repayment amount.

(iii) The reconciliation or repayment amount may be adjusted as provided in §510.410(b).

(2) Reconciliation payment. If the amount described in paragraph (f)(1) of this section is positive and the composite quality score described in §510.315 is acceptable (defined as greater than or equal to 4.00), good (defined as greater than or equal to 6.0 and less than or equal to 13.2), or excellent (defined as greater than 13.2), Medicare pays the participant hospital a reconciliation payment in an amount equal to the amount described in paragraph (f)(1) of this section.

(3) Repayment amount. If the amount described in paragraph (f)(1) of this section is negative, the participant hospital pays to Medicare an amount equal to the amount described in paragraph (f)(1) of this section, in accordance with §405.371 of this chapter. CMS waives this requirement for performance year 1.

(g) Determination of eligibility for reconciliation based on quality. (1) CMS assesses each participant hospital’s performance on quality metrics, as described in §510.315, to determine whether the participant hospital is eligible to receive a reconciliation payment for a performance year.

(2) If the hospital’s composite quality score described in §510.315 is acceptable (defined as greater than or equal to 4.00), good (defined as greater than or equal to 6.0 and less than or equal to 13.2), or excellent (defined as greater than 13.2), and the hospital is determined to have a positive NPRA under §510.305(e), the hospital is eligible for a reconciliation payment.

(3) If the hospital’s composite quality score described in §510.315 is below acceptable, defined as less than 4.00 for a performance year, the hospital is not eligible for a reconciliation payment.

(4) If the hospital is found to be engaged in an inappropriate and systemic under delivery of care, the quality of the care provided must be considered to be seriously compromised and the hospital must be ineligible to receive or retain a reconciliation payment for any period in which such under delivery of care was found to occur.

(h) Reconciliation report. CMS issues each participant hospital a CJR reconciliation report for the performance year. Each CJR reconciliation report contains the following:

(1) Information on the participant hospital’s composite quality score described in §510.315.

(2) The total actual episode payments for the participant hospital.

(3) The NPRA.

(4) Whether the participant hospital is eligible for a reconciliation payment or must make a repayment to Medicare.

(5) The NPRA and subsequent reconciliation calculation amount for the previous performance year, as applicable.

(6) The reconciliation payment or repayment amount.

(1) Subsequent reconciliation calculation. (A) Fourteen months after the end of each performance year, CMS performs an additional calculation, using claims data available at that time, to account for final claims run-out and any additional overlap between the CJR model and other CMS models and programs as described in paragraph (h)(6)(1)(B) of this section.

(B) The subsequent reconciliation calculation accounts for cases in which a portion of the CJR discount percentage is paid out to an ACO as shared savings by reducing the reconciliation payment amount for a CJR hospital, if available, by the amount of the discount percentage paid out to the ACO as shared savings. This adjustment is only made when the participant hospital is a participant or provider/supplier in the ACO and the beneficiary in the CJR episode is assigned to one of the following ACO models or program:

(1) The Pioneer ACO model.

(2) The Medicare Shared Savings Program.

(3) The Next Generation ACO model.
(d) The Comprehensive ESRD Care Initiative.

(C) The additional calculation occurs concurrently with the reconciliation process for the most recent performance year. If the result of the subsequent calculation is different than zero, CMS applies the stop-loss and stop-gain limits in paragraph (e) of this section to the calculations in aggregate for that performance year (the initial reconciliation and the subsequent calculation) to ensure the amount does not exceed the stop-loss or stop-gain limits. CMS then applies the subsequent calculation amount to the NPRA for the most recent performance year in order to determine the reconciliation amount or repayment amount for the most recent performance year. Because hospitals will not have financial repayment responsibility for performance year 1, for the performance year 2 reconciliation report only, the subsequent calculation amount (for performance year 1) is applied to the performance year 1 NPRA to ensure that the combined amount is not less than 0. If the combined performance year 1 NPRA and subsequent calculation for performance year 1 is less than 0, the subsequent calculation amount would be capped at the value that would result in a net amount of 0 for the combined performance year 1 NPRA and subsequent calculation.

§510.310 Appeals process.

(a) Notice of calculation error (first level of appeal). Subject to the limitations on review in subpart d of this part, if a participant hospital wishes to dispute the calculation that involves a matter related to payment, reconciliation amounts, repayment amounts, or determinations associated with quality measures affecting payment, the hospital is required to provide written notice of the error, in a form and manner specified by CMS.

(1) Unless the participant hospital provides such notice, the CJR reconciliation report is deemed final 45 calendar days after it is issued.

(2) If CMS receives a timely notice of a calculation error, CMS responds in writing within 30 calendar days to either confirm that there was an error in the calculation or verify that the calculation is correct, although CMS reserves the right to an extension upon written notice to the participant hospital.

(3) If a participant hospital does not submit timely notice of a calculation error in accordance with the timelines and processes specified by CMS, then CMS deems final the CJR reconciliation report and proceeds with the payment or repayment processes, as applicable.

(4) Only participant hospitals may use the dispute resolution process described in this part.

(b) Dispute resolution process (second level of appeal). (1) If the participant hospital is dissatisfied with CMS’s response to the notice of a calculation error, the participant hospital may request a reconsideration review in a form and manner as specified by CMS.

(2) The reconsideration review request must provide a detailed explanation of the basis for the dispute and include supporting documentation for the participant hospital’s assertion that CMS or its representatives did not accurately calculate the NPRA, the reconciliation payment, or the repayment amount in accordance with §510.305.

(3) If CMS does not receive a request for reconsideration from the participant hospital within 10 calendar days of the issue date of CMS’s response to the participant hospital’s notice of calculation error, then CMS’s response to the calculation error is deemed final and CMS proceeds with reconciliation payment or repayment processes, as applicable, as described in §510.305.

(4) A CMS reconsideration official notifies the participant hospital in writing within 15 calendar days of receiving the participant hospital’s review request of the following:

(i) The date, time, and location of the review.

(ii) The issues in dispute.

(iii) The review procedures.

(iv) The procedures (including format and deadlines) for submission of evidence.

(5) The CMS reconsideration official takes all reasonable efforts to schedule the review to occur no later than 30...