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the performance period in which they apply.

(8) Inclusion of reconciliation payments and repayments. For performance years 3, 4, and 5 only, reconciliation payments and repayment amounts under §510.305(f)(2) and (f)(3) and from LEJR episodes included in the BPCI initiative are included in historical episode payments.

(c) Discount factor. A participant hospital’s episode quality-adjusted target prices incorporate discount factors to reflect Medicare’s portion of reduced expenditures from the CJR model as described in this section.

(1) Discount factors affected by the quality incentive payments and the composite quality score. In all performance years, the discount factor may be affected by the quality incentive payment and composite quality score as provided in §510.315 to create the effective discount factor or applicable discount factor used for calculating reconciliation payments and repayment amounts. The quality-adjusted target prices incorporate the effective or applicable discount factor at reconciliation.

(2) Discount factor for reconciliation payments. The discount factor for reconciliation payments in all performance years is 3.0 percent.

(3) Discount factors for repayment amounts. The discount factor for repayment amounts is—

(i) Not applicable in performance year 1, as the requirement for hospital repayment under the CJR model is waived in performance year 1;

(ii) In performance years 2 and 3, 2.0 percent; and

(iii) In performance years 4 and 5, 3.0 percent.

(d) Data sharing. (1) CMS makes available to participant hospitals, through the most appropriate means, data that CMS determines may be useful to participant hospitals to do the following:

(i) Determine appropriate ways to increase the coordination of care.

(ii) Improve quality.

(iii) Enhance efficiencies in the delivery of care.

(iv) Otherwise achieve the goals of the CJR model described in this section.

(2) Beneficiary-identifiable data. (i) CMS makes beneficiary-identifiable data available to a participant hospital in accordance with applicable privacy laws and only in response to the hospital’s request for such data for a beneficiary who has been furnished a billable service by the participant hospital corresponding to the episode definitions for CJR.

(ii) The minimum data necessary to achieve the goals of the CJR model, as determined by CMS, may be provided under this section for a participant hospital’s baseline period and no less frequently than on a quarterly basis throughout the hospital’s participation in the CJR model.


EDITORIAL NOTE: At 82 FR 613, Jan. 3, 2017, §510.300 was amended in part by redesignating paragraph (a)(5) as paragraph (a)(6); however, there was no paragraph (a)(5).
(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 quality-adjusted 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 quality-adjusted target price 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 quality-adjusted 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) Applies the following prior to determination of the reconciliation payment or repayment amount:

(A) Limitation on loss. Except as provided in paragraph (e)(1)(v)(C) of this section, the total amount of the NPRA and subsequent reconciliation calculation for a performance year cannot exceed the following:

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

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

(3) 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 (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.

(B) Limitation on gain. The total amount of the NPRA and subsequent reconciliation calculation for a performance year cannot exceed the following:

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

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

(3) 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 (i) of this section, the subsequent reconciliation calculation reassesses the limitation on gain for a given performance year by applying the limitations on gain to the aggregate of the 2 reconciliation calculations.

(C) 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 due to the NPRA and subsequent reconciliation calculation cannot exceed 3 percent of the amount calculated in paragraph (e)(1)(iii) of this section. For performance years 3 through 5, the 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. (i) Subject to paragraph (f)(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 (i) of this section and the post-episode spending and ACO overlap calculations as described in paragraph (j) of this section are added to the current year’s NPRA in order to determine the reconciliation payment 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 5.00 and less than 6.9), good (defined as greater than or equal to 6.9 and less than or equal to 15.0), or excellent (defined as greater than 15.0), 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 5.00 and less than 6.9), good (defined as greater than or equal to 6.9 and less than or equal to 15.0), or excellent (defined as greater than 15.0), 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 post-episode spending amount and ACO overlap calculation for the previous performance year, as applicable. (7) The reconciliation payment or repayment amount.

(i) Subsequent reconciliation calculation. (1) 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

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any additional episode cancelations due to overlap between the CJR model and other CMS models and programs, or for other reasons as specified in §510.210(b).

(2) The subsequent calculation for performance years 1 through 4 occurs concurrently with the first reconciliation process for the following 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 aggregate calculation of the amounts described in paragraphs (e)(1)(iv) and (i)(1) of this section for that performance year (the initial reconciliation and the subsequent reconciliation calculation) to ensure such amount does not exceed the applicable stop-loss or stop-gain limits. Because there will be no additional performance year after performance year 5, the subsequent reconciliation calculation for performance year 5 will occur independently in 2022.

(j) Additional adjustments to the reconciliation payment or repayment amount. (1) In order to account for shared savings payments, CMS will reduce the reconciliation payment or increase the repayment amount for the subsequent performance year (for years 1 through 4) by the amount of the participant hospital’s discount percentage that is paid to the ACO in the prior performance year as shared savings. (This amount will be assessed independently for performance year 5 in 2022.) This adjustment is made only 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 programs:

(i) The Pioneer ACO model.

(ii) The Medicare Shared Savings Program (excluding Track 3 for CJR episodes that initiate on or after July 1, 2017).

(iii) The Comprehensive ESRD Care Initiative (excluding a track with downside risk for CJR episodes that initiate after July 1, 2017).

(iv) The Next Generation ACO model (excluding CJR episodes that initiate on or after July 1, 2017).

(2) Increases in post-episode spending. If the average post-episode Medicare Parts A and B payments for a participant hospital in the prior performance year is greater than 3 standard deviations above the regional average post-episode payments for the same performance year, then the spending amount exceeding 3 standard deviations above the regional average post-episode payments for the same performance year is subtracted from the net reconciliation or added to the repayment amount for the subsequent performance year for years 1 through 4, and assessed independently for year 5.

§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 calculations involving a matter related to payment, reconciliation amounts, repayment amounts, the use of quality measure results in determining the composite quality score, or the application of the composite quality score during reconciliation, the participant hospital is required to provide written notice of the calculation error, in a form and manner specified by CMS.

(1) Unless the participant hospital provides such notice, CMS deems final the CJR reconciliation report 45 calendar days after it is issued and proceeds with the payment or repayment processes as applicable.

(2) If CMS receives a notice of a calculation error within 45 calendar days of the issuance of the reconciliation report, 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) Only participant hospitals may use the dispute resolution process described in this part.

(4) Only participant hospitals may use the notice of calculation error 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