510.300 Determination of episode quality-adjusted target prices.

(a) General. CMS establishes episode quality-adjusted target prices for participant hospitals for each performance year or performance year subset of the model as specified in this section. Episode quality-adjusted target prices are established according to the following:

(1) MS-DRG and fracture status. MS-DRG assigned at discharge for anchor hospitalization and present of hip fracture diagnosis for anchor hospitalization -

(i)(A) MS-DRG 469 with hip fracture; or

(B) For episodes beginning on or after October 1, 2020, MS-DRG 521;

(ii) MS-DRG 469 without hip fracture;

(iii)(A) MS-DRG 470 with hip fracture; or

(B) For episodes beginning on or after October 1, 2020, MS-DRG 522; or

(iv) MS-DRG 470 without hip fracture.

(2) Applicable time period for performance year or performance year subset episode quality-adjusted target prices. Episode quality-adjusted target prices are updated to account for Medicare payment updates no less than 2 times per year, for updated quality-adjusted target prices effective October 1 and January 1, and at other intervals if necessary.

(3) Episodes that straddle performance years or performance year subsets or payment updates. The quality-adjusted target price that applies to the type of episode as of the date of admission for the anchor hospitalization is the quality-adjusted target price that applies to the episode.

(4) Identifying episodes with hip fracture. CMS develops a list of ICD-CM hip fracture diagnosis codes that, when reported in the principal diagnosis code files on the claim for the anchor hospitalization, represent a bone fracture for which a hip replacement procedure, either a partial hip arthroplasty or a total hip arthroplasty, could be the primary surgical treatment. The list of ICD-CM hip fracture diagnosis codes used to identify hip fracture episodes is posted on the CMS Web site.

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

(ii) CMS applies the following standards when revising the list of ICD-CM hip fracture diagnosis codes.

(A) The ICD-CM diagnosis code is sufficiently specific that it represents a bone fracture for which a physician could determine that a hip replacement procedure, either a PHA or a THA, could be the primary surgical treatment.

(B) The ICD-CM diagnosis code is the primary reason (that is, principal diagnosis code) for the anchor hospitalization.

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

(A) Potential ICD-CM hip fracture diagnosis codes for public comment; and

(B) A final ICD-CM hip fracture diagnosis code list after consideration of public comment.

(5) Quality performance. Quality-adjusted target prices reflect effective discount factors or applicable discount factors based on a hospital's composite quality score, as specified in §§ 510.300(c) and 510.315(f).

(b) Episode quality-adjusted target price. (1) CMS calculates quality-adjusted target prices based on a blend of each participant hospital's hospital-specific and regional episode expenditures. The region corresponds to the U.S. Census Division associated with the primary address of the CCN of the participant hospital and the regional component is based on all hospitals in said region, except as follows. In cases where an MSA selected for participation in CJR spans more than one U.S. Census Division, the entire MSA will be grouped into the U.S. Census Division where the largest city by population in the MSA is located for quality-adjusted target price and reconciliation calculations. The calendar years used for historical expenditure calculations are as follows:

(i) Episodes beginning in 2012 through 2014 for performance years 1 and 2.

(ii) Episodes beginning in 2014 through 2016 for performance years 3 and 4.

(iii) Episodes beginning in 2016 through 2018 for each of performance year subsets 5.1 and 5.2.

(2) Specifically, the blend consists of the following:

(i) Two-thirds of the participant hospital's own historical episode payments and one-third of the regional historical episode payments for performance years 1 and 2.

(ii) One-third of the hospital's own historical episode payments and two-thirds of the regional historical episode payments for performance year 3.

(iii) Regional historical episode payments for performance year 4 and each of performance year subsets 5.1 and 5.2.

(3) Exception for low-volume hospitals. Quality-adjusted target prices for participant hospitals with fewer than 20 CJR episodes in total across the 3 historical years of data used

to calculate the quality-adjusted target price are based on 100 percent regional historical episode payments.

(4) Exception for recently merged or split hospitals. Hospital-specific historical episode payments for participant hospitals that have undergone a merger, consolidation, spin off or other reorganization that results in a new hospital entity without 3 full years of historical claims data are determined using the historical episode payments attributed to their predecessor(s).

(5) Exception for high episode spending. Episode payments are capped at 2 standard deviations above the mean regional episode payment for both the hospital-specific and regional components of the quality-adjusted target price.

(6) Exclusion of incentive programs and add-on payments under existing Medicare payment systems. Certain incentive programs and add-on payments are excluded from historical episode payments by using, with certain modifications, the CMS Price (Payment) Standardization Detailed Methodology used for the Medicare spending per beneficiary measure in the Hospital Value-Based Purchasing Program.

(7) Communication of episode quality-adjusted target prices. CMS communicates episode quality-adjusted target prices to participant hospitals before the performance period in which they apply.

(8) Inclusion of reconciliation payments and repayments. For performance years 3, 4, and each of performance year subsets 5.1 and 5.2 only, reconciliation payments and repayment amounts under § 510.305(f)(2) and (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 and performance year subsets, 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 and performance year subsets 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 year 4 and each of performance year subsets 5.1 and 5.2, 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.