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 1 through 4 to establish final payment amounts to participant hospitals for CJR episodes for a given performance year. Following the end of each performance year 1 through 4, 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. Within performance year 5, CMS separately performs the reconciliation processes described in paragraphs (d) and (f) of this section for performance year subsets 5.1 and 5.2 and following the end of each performance year subset 5.1 and 5.2, CMS separately determines the actual episode payment for each episode for the subset of 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 for each of performance year subsets 5.1 and 5.2.

(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 of performance years 1 through 4 and performance year subset 5.1 and 5 months after the end of performance year subset 5.2, CMS does all of the following:

(i) Performs a reconciliation calculation to establish an NPRA for each participant hospital.

(ii) For participant hospitals that experience a reorganization event in which one or more hospitals reorganize under the CCN of a participant hospital performs -

(A) Separate reconciliation calculations (during both initial and subsequent reconciliations for a performance year) for each predecessor participant hospital for episodes where anchor hospitalization admission occurred before the effective date of the reorganization event; and

(B) Reconciliation calculations (during both initial and subsequent reconciliations for a performance year) for each new or surviving participant hospital for episodes where the anchor hospitalization admission occurred on or after the effective date of the reorganization event.

(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 quality-adjusted target prices described in § 510.300 and the participant hospital's actual episode spending for each of performance years 1 through 4 and each of performance year subsets 5.1 and 5.2 and applying the adjustments in paragraph (e)(1)(v) of this section, CMS establishes an NPRA for each participant hospital for each such performance year or performance year subset.

(1) Initial calculation. In calculating the NPRA for each participant hospital for each of performance years 1 through 4 and each of performance year subsets 5.1 and 5.2, CMS does the following:

(i) Determines actual episode payments for each episode included in the performance year or performance year subset (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 or performance year subset. Actual episode payments are capped, as applicable, at the amount determined in accordance with § 510.300(b)(5) for the performance year or performance year subset at the amount determined in paragraph (k) of this section for episodes affected by extreme and uncontrollable circumstances, or at the quality adjusted target price determined for that episode under § 510.300 for an episode with actual episode payments that include a claim with a COVID-19 diagnosis code and initiate after the earlier of March 31, 2021 or the last day of the emergency period described in paragraph (k)(4) of this section.

(ii) Multiplies each episode quality-adjusted target price by the number of episodes included in the performance year or performance year subset (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 or performance year subset (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 or performance year subset 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 year 4 and each of performance year subsets 5.1 and 5.2, 20 percent of the amount calculated in paragraph (e)(1)(iii) of this section for the performance year or performance year subset.

(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.

(5) The post-episode spending and ACO overlap calculation amounts in paragraphs (j)(1) and (2) of this section are not subject to the limitation on loss.

(B) Limitation on gain. The total amount of the NPRA and subsequent reconciliation calculation for a performance year or performance year subset 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 year 4 and each of performance year subsets 5.1 and 5.2, 20 percent of the amount calculated in paragraph (e)(1)(iii) of this section for the performance year or performance year subset.

(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.

(5) The post-episode spending and ACO overlap calculation amounts in paragraphs (j)(1) and (j)(2) of this section are not subject to the limitation on gain.

(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 and 4 and for performance year subsets

5.1 and 5.2, 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 4 and for each of performance year subsets 5.1 and 5.2, 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 or performance year subset.

(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 or performance year subset, 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 or performance year subset. 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) As applicable, the NPRA and subsequent reconciliation calculation amount for the previous performance year or performance year subset.

(6) As applicable, the post-episode spending amount and ACO overlap calculation for the previous performance year or performance year subset.

(7) The reconciliation payment or repayment amount.

(i) Subsequent reconciliation calculation. (1) Fourteen months after the end of each of performance years 1 through 4 and performance year subset 5.1 and seventeen months after the end of performance year subset 5.2, CMS performs an additional calculation, using claims data available at that time, to account for final claims run-out and 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 each of performance years 1 through 4 and performance year subset 5.1 occurs concurrently with the first reconciliation process for the following performance year (or in the case of performance year subset 5.1, with the first reconciliation of performance year subset 5.2) . 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 or performance year subset (the initial reconciliation and the subsequent reconciliation calculation) to ensure such amount does not exceed the applicable stop-loss or stop-gain limits. The subsequent reconciliation calculation for performance year subset 5.2 will occur independently in 2023.

(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 performance years 1 through 4 and performance year subset 5.1) 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 subset 5.2 in 2023.) 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) If the average post-episode Medicare Parts A and B payments for a participant hospital in the prior performance year or performance year subset is greater than 3 standard deviations above the regional average post-episode payments for the same performance year or performance year subset, then the spending amount exceeding 3 standard deviations above the regional average post-episode payments for the same performance year or performance year subset is subtracted from the net reconciliation or added to the repayment amount for the subsequent performance year for years 1 through 4 and performance year subset 5.1, and assessed independently for performance year subset 5.2.

(k) Extreme and uncontrollable circumstances adjustment. (1) The episode spending adjustments specified in paragraph (k)(2) of this section apply for a participant hospital that has a CCN primary address that meets both of the following:

(i) Is located in an emergency area during an emergency period, as those terms are defined in section 1135(g) of the Act, for which the Secretary has issued a waiver under section 1135; and

(ii) Is located in a county, parish, or tribal government designated in a major disaster declaration under the Stafford Act.

(2)(i) For a non-fracture episode with a date of admission to the anchor hospitalization that is on or within 30 days before the date that the emergency period (as defined in section 1135(g) of the Act) begins, actual episode payments are capped at the target price determined for that episode under § 510.300.

(ii) For a fracture episode with a date of admission to the anchor hospitalization that is on or within 30 days before or after the date that the emergency period (as defined in section 1135(g) of the Act) begins, actual episode payments are capped at the target price determined for that episode under § 510.300.

(3) The following is an extreme and uncontrollable circumstances adjustment for 2019 Novel Coronavirus (previously referred to as 2019-nCoV, now as COVID-19):

(i) The episode spending adjustments specified in paragraph (k)(4) of this section apply for a participant hospital that has a CCN primary address that is located in an emergency area during an emergency period, as those terms are defined in section 1135(g) of the Act, for which the Secretary issued a waiver or modification of requirements under section 1135 of the Act on March 13, 2020.

(ii) [Reserved]

(4) For a fracture or non-fracture episode with a date of admission to the anchor hospitalization that is on or within 30 days before the date that the emergency period (as defined in section 1135(g) of the Act) begins or that occurs on or before March 31, 2021 or the last day of such emergency period, whichever is earlier, actual episode payments are capped at the quality adjusted target price determined for that episode under § 510.300.