services for reasons other than to reflect annual coding changes:

(i) Items or services that are directly related to the LEJR procedure or the quality or safety of LEJR care would be included in the episode.

(ii) Items or services for chronic conditions that may be affected by the LEJR procedure or post-surgical care would be related and included in the episode.

(iii) Items and services for chronic conditions that are generally not affected by the LEJR procedure or post-surgical care would be excluded from the episode.

(iv) Items and services for acute clinical conditions not arising from existing, episode-related chronic clinical conditions or complications of LEJR surgery would be excluded from the episode.

(v) PBPM payments under CMS models determined to be primarily used for care coordination or care management services for clinical conditions in excluded categories of diagnoses, as described in §510.200(d), would be excluded from the episode.

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

(i) Potential revisions to the exclusion to allow for public comment; and

(ii) An updated exclusions list after consideration of public comment.

§510.205 Beneficiary inclusion criteria.

(a) Episodes tested in the CJR model include only those in which care is furnished to beneficiaries who meet all of the following criteria upon admission to the anchor hospitalization:

(1) Are enrolled in Medicare Parts A and Part B.

(2) Eligibility for Medicare is not on the basis of end stage renal disease, as described in §406.13 of this chapter.

(3) Are not enrolled in any managed care plan (for example, Medicare Advantage, health care prepayment plans, or cost-based health maintenance organizations).

(4) Are not covered under a United Mine Workers of America health care plan.

(5) Have Medicare as their primary payer.

(b) If at any time during the episode a beneficiary no longer meets all of the criteria in this section, the episode is canceled in accordance with §510.210(b).

§510.210 Determination of the episode.

(a) *General.* The episode begins with the admission of a Medicare beneficiary described in §510.205 to a participant hospital for an anchor hospitalization and ends on the 90th day after the date of discharge, with the day of discharge itself being counted as the first day in the 90-day post-discharge period.

(b) *Cancellation of an episode.* The episode is canceled and is not included in the determination of NPRA as specified in §510.305 if the beneficiary does any of the following during the episode:

(1) Ceases to meet any criterion listed in §510.205.

(2) Is readmitted to any participant hospital for another anchor hospitalization.

(3) Initiates an LEJR episode under BPCI.

(4) Dies.

Subpart D—Pricing and Payment

§510.300 Determination of episode target prices.

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

(1) MS–DRG assigned at discharge for anchor hospitalization and presence of hip fracture diagnosis for anchor hospitalization—

(i) MS–DRG 469 with hip fracture;

(ii) MS–DRG 469 without hip fracture;

(iii) MS–DRG 470 with hip fracture; or

(iv) MS–DRG 470 without hip fracture.

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

(3) *Episodes that straddle performance years or payment updates.* The episode

target price that applies to the type of episode as of the date of admission for the anchor hospitalization is the episode 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.

(b) *Episode target price.* (1) CMS calculates episode 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 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 performance year 5.

(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 years 4 and 5.

(3) *Exception for low-volume hospitals.* Episode target prices for participant hospitals with fewer than 20 CJR episodes in total across the 3 historical years of data used to calculate the episode 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 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 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 target prices.* CMS communicates episode target prices to participant hospitals before the performance period in which they apply.

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

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

(2) *Discount factors for repayment amounts.* The applicable discount factor for repayment amounts are—

(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.

(3) *Discount factors affected by the quality incentive payment and composite performance years.* 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 a different effective discount factor used for calculating reconciliation payments and repayment amounts.

(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.

[80 FR 73540, Nov. 24, 2015, as amended at 81 FR 11451, Mar. 4, 2016]

§ 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