(*4*) 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.

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

§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

days after the date of receipt of the notification.

(6) The provisions at § 425.804(b), (c), and (e) of this chapter are applicable to reviews conducted in accordance with the reconsideration review process for CJR.

(7) The CMS reconsideration official issues a written determination within 30 days of the review. The determination is final and binding.

(c) *Exception to the process.* If the participant hospital contests a matter that does not involve an issue contained in, or a calculation which contributes to, a CJR reconciliation report, a notice of calculation error is not required. An example of such a matter is termination of the participant hospital from the model. In those instances, if CMS does not receive a request for reconsideration from the participant hospital within 10 calendar days of the notice of the initial determination, the initial determination is deemed final and CMS proceeds with action indicated in the initial determination.

(d) *Limitations on review.* In accordance with section 1115A(d)(2) of the Act, there is no administrative or judicial review under sections 1869 or 1878 of the Act or otherwise for the following:

(1) The selection of models for testing or expansion under section 1115A of the Act.

(2) The selection of organizations, sites, or participants to test those models selected.

(3) The elements, parameters, scope, and duration of such models for testing or dissemination.

(4) Determinations regarding budget neutrality under section 1115A(b)(3) of Act.

(5) The termination or modification of the design and implementation of a model under section 1115A(b)(3)(B) of Act.

(6) Decisions about expansion of the duration and scope of a model under section 1115A(c) of the Act, including the determination that a model is not expected to meet criteria described in paragraph (d)(1) or (2) of this section.

§ 510.315 Composite quality scores for determining reconciliation payment eligibility and quality incentive payments.

(a) *General.* A participant hospital's eligibility for a reconciliation payment under § 510.305(g), and the determination of quality incentive payments under paragraph (f) of this section, for a performance year depend on the hospital's composite quality score (including any quality performance points and quality improvement points earned) for that performance year.

(b) *Composite quality score.* CMS calculates a composite quality score for each participant hospital for each performance year, which equals the sum of the following:

(1) The hospital's quality performance points for the hospital-level risk-standardized complication rate following elective primary total hip arthroplasty and/or total knee arthroplasty measure (NQF #1550) described in § 510.400(a)(1). This measure is weighted at 50 percent of the composite quality score.

(2) The hospital's quality performance points for the Hospital Consumer Assessment of Healthcare Providers and Systems Survey measure (NQF #0166) described in § 510.400(a)(2). This measure is weighted at 40 percent of the composite quality score.

(3) Any additional quality improvement points the hospital may earn as a result of demonstrating improvement on either or both of the quality measures in paragraphs (b)(1) and (2) of this section, as described in paragraph (d) of this section.

(4) If applicable, 2 additional points for successful THA/TKA voluntary data submission of patient-reported outcomes and limited risk variable data, as described in § 510.400(b). Successful submission is weighted at 10 percent of the composite quality score.

(c) *Quality performance points.* CMS computes quality performance points for each quality measure based on the participant hospital's performance percentile relative to the national distribution of all hospitals' performance on that measure.

(1) For the hospital-level risk-standardized complication rate following elective primary total hip arthroplasty