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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

and/or total knee arthroplasty measure (NQF #1550) described in §510.400(a)(1), CMS assigns the participant hospital measure value to a performance percentile and then quality performance points are assigned based on the following performance percentile scale:

(i) 10.00 points for ≥90th.
(ii) 9.25 points for ≥80th and <90th.
(iii) 8.50 points for ≥70th and <80th;
(iv) 7.75 points for ≥60th and <70th.
(v) 7.00 points for ≥50th and <60th.
(vi) 6.25 points for ≥40th and <50th.
(vii) 5.50 points for ≥30th and <40th.
(viii) [Reserved]
(ix) 0.0 points for <30th.

(2) For the Hospital Consumer Assessment of Healthcare Providers and Systems Survey measure (NQF #0166) described in §510.400(a)(2), CMS assigns the participant hospital measure value to a performance percentile and quality performance points are assigned based on the following performance percentile scale:

(i) 8.00 points for ≥90th.
(ii) 7.40 points for ≥80th and <90th.
(iii) 6.80 points for ≥70th and <80th.
(iv) 6.20 points for ≥60th and <70th.
(v) 5.60 points for ≥50th and <60th.
(vi) 5.00 points for ≥40th and <50th.
(vii) 4.40 points for ≥30th and <40th.
(viii) [Reserved]
(ix) 0.0 points for <30th.

(d) *Quality improvement points.* If a participant hospital's quality performance percentile on an individual measure described in §510.400(a) increases from the previous performance year by at least 3 deciles on the performance percentile scale, then the hospital is eligible to receive quality improvement points equal to 10 percent of the total available points for that individual measure.

(e) *Exception for hospitals without a measure value.* In the case of a participant hospital without a measure value that would allow CMS to assign quality performance points for that quality measure, CMS assigns the 50th percentile quality performance points to the hospital for the individual measure.

(1) A participant hospital will not have a measure value for the—

(i) 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) if the hospital does not meet the minimum 25 case count; or

(ii) Hospital Consumer Assessment of Healthcare Providers and Systems Survey measure (NQF #0166) described in §510.400(a)(2) if the hospital does not meet the minimum of 100 completed survey and does not have 4 consecutive quarters of HCAHPS data.

(ii) For either of the measures described in paragraphs (e)(1) or (2) of this section, if CMS identifies an error in the data used to calculate the measure and suppresses the measure value.

(f) *Quality incentive payments.* CMS provides incentive payments to participant hospitals that demonstrate good or excellent quality performance on the composite quality scores described in paragraph (b) of this section. These incentive payments are implemented in the form of the following reductions to the applicable discount factors described in §510.300(c):

(1) A 1.0 percentage point reduction to the applicable discount factor for participant hospitals with good quality performance, defined as composite quality scores that are greater than or equal to 6.0 and less than or equal to 13.2.

(2) A 1.5 percentage point reduction to the applicable discount factor for participant hospitals with excellent quality performance, defined as composite quality scores that are greater than 13.2.

§510.320 Treatment of incentive programs or add-on payments under existing Medicare payment systems.

The CJR model does not replace any existing Medicare incentive programs or add-on payments. The target price and NPRA for a participant hospital are independent of, and do not affect, any incentive programs or add-on payments under existing Medicare payment systems.

§510.325 Allocation of payments for services that straddle the episode.

(a) *General.* Services included in the episode that straddle the episode are prorated so that only the portion attributable to care furnished during the