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 performance years 1 through 4 occurs concurrently with the first reconciliation process for the following 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 aggregate calculation of the amounts described in paragraphs (e)(1)(iv) and (i)(1) of this section for that performance year (the initial reconciliation and the subsequent reconciliation calculation) to ensure such amount does not exceed the applicable stop-loss or stop-gain limits. Because there will be no additional performance year after performance year 5, the subsequent reconciliation calculation for performance year 5 will occur independently in 2022.

(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 years 1 through 4) 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 5 in 2022.) 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) *Increases in post-episode spending.* If the average post-episode Medicare Parts A and B payments for a participant hospital in the prior performance year is greater than 3 standard deviations above the regional average post-episode payments for the same performance year, then the spending amount exceeding 3 standard deviations above the regional average post-episode payments for the same performance year is subtracted from the net reconciliation or added to the repayment amount for the subsequent performance year for years 1 through 4, and assessed independently for year 5.

[80 FR 73540, Nov. 24, 2015, as amended at 81 FR 11451, Mar. 4, 2016; 82 FR 613, Jan. 3, 2017]

§ 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 calculations involving a matter related to payment, reconciliation amounts, repayment amounts, the use of quality measure results in determining the composite quality score, or the application of the composite quality score during reconciliation, the participant hospital is required to provide written notice of the calculation error, in a form and manner specified by CMS.

(1) Unless the participant hospital provides such notice, CMS deems final the CJR reconciliation report 45 calendar days after it is issued and proceeds with the payment or repayment processes as applicable.

(2) If CMS receives a notice of a calculation error within 45 calendar days of the issuance of the reconciliation report, 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) Only participant hospitals may use the dispute resolution process described in this part.

(4) Only participant hospitals may use the notice of calculation error 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 that contributes to, a CJR reconciliation report, a notice of calculation error is not required. In these 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. This does not apply to the limitations on review in paragraph (e) of this section.

(d) *Notice of a participant hospital's termination from the CJR model.* If a participant hospital receives notification that it has been terminated from the CJR model, it must provide a written notice to CMS requesting review of the termination within 10 calendar days of the notice. CMS has 30 days to respond to the participant hospital's request for review. If the participant hospital fails to notify CMS, the termination is deemed final.

(e) *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 section 1115A(c)(1) or (2) of the Act.

[80 FR 73540, Nov. 24, 2015, as amended at 82 FR 615, Jan. 3, 2017]

§ 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