(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 effective discount factors or applicable discount factors described in § 510.300(c):

(1) A 1.0 percentage point reduction to the effective discount factor or applicable discount factor for participant hospitals with good quality performance, defined as composite quality scores that are greater than or equal to 6.9 and less than or equal to 15.0.

(2) A 1.5 percentage point reduction to the effective discount factor or applicable discount factor for participant hospitals with excellent quality performance, defined as composite quality scores that are greater than 15.0.

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

§ 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 episode are included in the calculation of actual episode payments.

(b) *Proration of services.* Payments for services that straddle the episode are prorated using the following methodology:

(1) *Non-IPPS inpatient services and other inpatient services.* Non-IPPS inpatient services, and services furnished by other inpatient providers that extend beyond the end of the episode are prorated according to the percentage of the actual length of stay (in days) that falls within the episode.

(2) *Home health agency services.* Home health services paid under the prospective payment system in part 484, subpart E of this chapter are prorated according to the percentage of days, starting with the first billable service date (''start of care date'') and through and including the last billable service date, that occur during the episode. This methodology is applied in the same way if the home health services begin (the start of care date) prior to the start of the episode.

(3) *IPPS services.* IPPS claim amounts that extend beyond the end of the episode are prorated according to the geometric mean length of stay, using the following methodology:

(i) The first day of the IPPS stay is counted as 2 days.

(ii) If the actual length of stay that occurred during the episode is equal to or greater than the MS–DRG geometric mean, the normal MS–DRG payment is fully allocated to the episode.

(iii) If the actual length of stay that occurred during the episode is less than the geometric mean, the normal MS–DRG payment amount is allocated to the episode based on the number of inpatient days that fall within the episode.

(iv) If the full amount is not allocated to the episode, any remainder amount is allocated to the post-episode spending calculation (defined in § 510.2).