

rate of an EACH that it treats as a sole community hospital if, during a cost reporting period, the hospital experiences an increase in its Medicare inpatient operating costs per discharge that is directly attributable to activities related to its membership in a rural health network.

(2) *Request and documentation.* In order for a hospital to qualify for an increase in its hospital-specific rate, it must meet the following criteria:

(i) The hospital must submit its request to its intermediary no later than 180 days after the date on the intermediary's notice of program reimbursement.

(ii) The request must include documentation specifically identifying the increased costs resulting from the hospital's participation in a rural health network and show that the increased costs during the cost reporting period will result in increased costs in subsequent cost reporting periods that are not already accounted for under the prospective payment system payment.

(iii) The hospital must show that the cost increases are incremental costs that would not have been incurred in the absence of the hospital's membership in a rural health network.

(iv) The hospital must show that the cost increases do not include amounts for start-up and one-time, nonrecurring costs attributable to its membership in a rural health network.

(3) *Intermediary recommendation.* The intermediary forwards the following material to CMS within 60 days of receipt from the hospital:

(i) The hospital's documentation and the intermediary's verification of that documentation.

(ii) The intermediary's analysis and recommendation of the request.

(iii) The hospital's Medicare cost report for the year in which the increase in costs occurred and the prior year.

(4) *CMS determination.* CMS determines, within 120 days of receiving all necessary information from the intermediary, whether an increase in the hospital-specific rate is warranted and, if it is, the amount of the increase. CMS grants an adjustment only if a hospital's Medicare inpatient operating costs per discharge exceed the hospital's hospital-specific rate. The ad-

justed hospital-specific rate cannot exceed the hospital's Medicare inpatient operating costs per discharge for the cost reporting period.

(d) *Termination of EACH designation.* If CMS determines that a hospital no longer complies with the terms, conditions, and limitations that were applicable at the time CMS designated the hospital as an EACH, CMS will terminate the EACH designation of the hospital, effective with discharges occurring on or after 30 days after the date of the determination.

(e) *Review of CMS determination.* A determination by CMS that a hospital's EACH designation should be terminated, is subject to review under part 405, subpart R of this chapter, including the time limits for filing requests for hearings as specified in §§ 405.1811(a) and 405.1841(a)(1) and (b) of this chapter.

[58 FR 30669, May 26, 1993, as amended at 59 FR 45398, Sept. 1, 1994; 60 FR 45848, Sept. 1, 1995; 61 FR 21972, May 13, 1996; 62 FR 46030, Aug. 29, 1997; 70 FR 47486, Aug. 12, 2005]

## Subpart H—Payments to Hospitals Under the Prospective Payment Systems

### §412.110 Total Medicare payment.

Under the prospective payment systems, Medicare's total payment for inpatient hospital services furnished to a Medicare beneficiary by a hospital will equal the sum of the payments listed in §§ 412.112 through 412.115, reduced by the amounts specified in § 412.120.

[50 FR 12741, Mar. 29, 1985, as amended at 57 FR 39824, Sept. 1, 1992]

### §412.112 Payments determined on a per case basis.

A hospital is paid the following amounts on a per case basis:

(a) The appropriate prospective payment rate for inpatient operating costs for each discharge as determined in accordance with subparts D, E, and G of this part.

(b) Effective for cost reporting periods beginning on or after October 1, 1991, the appropriate prospective payment rate for capital-related costs for each discharge as determined in accordance with subpart M of this part.

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(c) The appropriate outlier payment amounts determined under subpart F of this part.

(d) Additional payments for new medical services and technologies determined under subpart F of this part.

[56 FR 43448, Aug. 30, 1991, as amended at 57 FR 39824, Sept. 1, 1992; 68 FR 45470, Aug. 1, 2003]

### § 412.113 Other payments.

(a) *Capital-related costs*—(1) *Payment*. Subject to the reductions described in paragraph (a)(2) of this section, payment for capital-related costs (as described in § 413.130 of this chapter) for cost reporting periods beginning before October 1, 1991 is determined on a reasonable cost basis.

(2) *Reduction to capital-related payments*. (i) Except for sole community hospitals as defined in § 412.92, the amount of capital-related payments for cost-reporting periods beginning before October 1, 1991 (including a return on equity capital as provided under § 413.157 of this chapter) is reduced by—

(A) Three and one-half percent for payments attributable to portions of cost reporting periods occurring during Federal FY 1987;

(B) Seven percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) occurring during fiscal year 1988 and before January 1, 1988;

(C) Twelve percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) in fiscal year 1988 occurring on or after January 1, 1988;

(D) Fifteen percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) occurring during fiscal year 1989 and beginning on or after January 1, 1990 and ending on or before September 30, 1991; and

(E) Ten percent for payments attributable to portions of cost-reporting periods occurring on or after October 1, 1991 and before the beginning of the hospital's first cost-reporting period beginning on or after October 1, 1991.

(ii) If a hospital's cost reporting period encompasses more than one Federal fiscal year, the reductions to capital-related payments are determined on a prorated monthly basis.

(3) For cost-reporting periods beginning on or after October 1, 1991, a hospital with a hospital-specific rate above the Federal capital rate is paid a hold-harmless payment for old capital determined in accordance with subpart M of this part.

(b) *Direct medical education costs*. (1) Payment for the direct medical education costs of interns and residents in approved programs for cost reporting periods beginning prior to July 1, 1985, and for approved education activities of nurses and paramedical health professionals is made as described in § 413.85 of this chapter.

(2) For cost reporting periods beginning on or after July 1, 1985, payment for the direct medical education costs of interns and residents in approved programs is made as described in §§ 413.75 through 413.83 of this subchapter.

(3) Except as provided in § 413.75(c) of this subchapter, for cost reporting periods during the prospective payment transition period, the costs of medical education must be determined in a manner that is consistent with the treatment of these costs for purposes of determining the hospital-specific portion of the payment rate as provided in subpart E of this part.

(c) *Anesthesia services furnished by hospital or CAH employed nonphysician anesthesiologists or obtained under arrangements*. (1) For cost reporting periods beginning on or after October 1, 1984 through any part of a cost reporting period occurring before January 1, 1989, payment is determined on a reasonable cost basis for anesthesia services provided in the hospital or CAH by qualified nonphysician anesthesiologists (certified registered nurse anesthesiologists and anesthesiologist's assistants) employed by the hospital or CAH or obtained under arrangements.

(2)(i) For cost reporting periods, or any part of a cost reporting period, beginning on or after January 1, 1989, through any part of a cost reporting period occurring before January 1, 1990, payment is determined on a reasonable cost basis for anesthesia services provided in a hospital or CAH by qualified nonphysician anesthesiologists employed by the hospital or CAH or obtained under arrangement, if the hospital or CAH

demonstrates to its intermediary prior to April 1, 1989 that it meets the following criteria:

(A) The hospital or CAH is located in a rural area as defined in §412.62(f) and is not deemed to be located in an urban area under the provisions of §412.64(b)(3). Effective December 2, 2010, the hospital or CAH is either located in a rural area as defined at §412.62(f) and is not deemed to be located in an urban area under the provisions of §412.64(b)(3) or the hospital or CAH has reclassified as rural under the provisions at §412.103.

(B) The hospital or CAH must have employed or contracted with a qualified nonphysician anesthetist, as defined in §410.69 of this chapter, as of January 1, 1988 to perform anesthesia services in that hospital or CAH. The hospital or CAH may employ or contract with more than one anesthetist; however, the total number of hours of service furnished by the anesthetists may not exceed 2,080 hours per year.

(C) The hospital or CAH must provide data for its entire patient population to demonstrate that, during calendar year 1987, its volume of surgical procedures (inpatient and outpatient) requiring anesthesia services did not exceed 250 procedures. For purposes of this section, a *surgical procedure requiring anesthesia services* means a surgical procedure in which the anesthesia is administered and monitored by a qualified nonphysician anesthetist, a physician other than the primary surgeon, or an intern or resident.

(D) Each qualified nonphysician anesthetist employed by or under contract with the hospital or CAH has agreed in writing not to bill on a reasonable charge basis for his or her patient care to Medicare beneficiaries in that hospital or CAH.

(ii) To maintain its eligibility for reasonable cost payment under paragraph (c)(2)(i) of this section in calendar years after 1989, a qualified hospital or CAH must demonstrate prior to January 1 of each respective year that for the prior year its volume of surgical procedures requiring anesthesia service did not exceed 500 procedures; or, effective October 1, 2002, did not exceed 800 procedures.

(iii) A hospital or CAH that did not qualify for reasonable cost payment for nonphysician anesthetist services furnished in calendar year 1989 can qualify in subsequent years if it meets the criteria in paragraphs (c)(2)(i)(A), (B), and (D) of this section, and demonstrates to its intermediary prior to the start of the calendar year that it met these criteria. The hospital or CAH must provide data for its entire patient population to demonstrate that, during calendar year 1987 and the year immediately preceding its election of reasonable cost payment, its volume of surgical procedures (inpatient and outpatient) requiring anesthesia services did not exceed 500 procedures, or, effective October 1, 2002, did not exceed 800 procedures.

(iv) For administrative purposes for the calendar years after 1990, the volume of surgical procedures for the immediately preceding year is the sum of the surgical procedures for the nine month period ending September 30, annualized for the twelve month period.

(d) *Organ acquisition.* Payment for organ acquisition costs as specified in part 413, subpart L, incurred by hospitals with approved transplant programs is made on a reasonable cost basis.

(e) *Allogeneic hematopoietic stem cell acquisition.* For cost reporting periods beginning on or after October 1, 2020, in the case of a subsection (d) hospital that furnishes an allogeneic hematopoietic stem cell transplant to an individual, payment to such hospital for hematopoietic stem cell acquisition costs is made on a reasonable cost basis.

(1) An allogeneic hematopoietic stem cell transplant is the intravenous infusion of hematopoietic cells derived from bone marrow, peripheral blood stem cells, or cord blood, but not including embryonic stem cells, of a donor to an individual that are or may be used to restore hematopoietic function in such individual having an inherited or acquired deficiency or defect.

(2) Allogeneic hematopoietic stem cell acquisition costs recognized under

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this paragraph (e) are costs of acquiring hematopoietic stem cells from a donor. These costs are as follows:

(i) Registry fees from a national donor registry described in 42 U.S.C. 274k, if applicable, for stem cells from an unrelated donor.

(ii) Tissue typing of donor and recipient.

(iii) Donor evaluation.

(iv) Physician pre-admission/pre-procedure donor evaluation services.

(v) Costs associated with the collection procedure (for example, general routine and special care services, procedure/operating room and other ancillary services, apheresis services), and transportation costs of stem cells if the recipient hospital incurred or paid such costs.

(vi) Post-operative/post-procedure evaluation of donor.

(vii) Preparation and processing of stem cells derived from bone marrow, peripheral blood stem cells, or cord blood (but not including embryonic stem cells).

(3) A subsection (d) hospital that furnishes inpatient allogeneic hematopoietic stem cell transplants is required to hold all allogeneic hematopoietic stem cell acquisition charges and bill them to Medicare using the appropriate revenue code, when the transplant occurs.

(4) A subsection (d) hospital must maintain an itemized statement that identifies, for all costs defined in paragraph (e)(2) of this section, the services furnished in collecting hematopoietic stem cells including all invoices or statements for purchased services for all donors and their service charges. Records must be for the person receiving the services (donor or recipient; for all donor sources, the hospital must identify the prospective recipient), and the recipient's Medicare beneficiary identification number.

(f) Additional resource costs of domestic National Institute for Occupational Safety and Health approved surgical N95 respirators. (1) For cost reporting periods beginning on or after January 1, 2023, a payment adjustment to a hospital for the additional resource costs of domestic National Institute for Occupational Safety and Health approved surgical N95 res-

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pirators is made as described in paragraph (f)(2) of this section.

(2) The payment adjustment is based on the estimated difference in the reasonable cost incurred by the hospital for domestic National Institute for Occupational Safety and Health approved surgical N95 respirators purchased during the cost reporting period as compared to other National Institute for Occupational Safety and Health approved surgical N95 respirators purchased during the cost reporting period.

[50 FR 12741, Mar. 29, 1985]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 412.113, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at [www.govinfo.gov](http://www.govinfo.gov).

### § 412.115 Additional payments.

(a) *Bad debts*. An additional payment is made to each hospital in accordance with § 413.89 of this chapter for bad debts attributable to deductible and co-insurance amounts related to covered services received by beneficiaries.

(b) *Administration of blood clotting factor*. For discharges occurring on or after June 19, 1990, and before October 1, 1994, and for discharges occurring on or after October 1, 1997, an additional payment is made to a hospital for each unit of blood clotting factor furnished to a Medicare inpatient who is a hemophiliac. For discharges occurring on or after October 1, 2005, the additional payment is made based on the average sales price methodology specified in subpart K, part 414 of this chapter and the furnishing fee specified in § 410.63 of this subchapter.

(c) *QIO reimbursement for cost of sending requested patient records to the QIO*. An additional payment is made to a hospital in accordance with § 476.78 of this chapter for the costs of sending requested patient records to the QIO in electronic format, by facsimile, or by photocopying and mailing.

[50 FR 12741, Mar. 29, 1985, as amended at 51 FR 34793, Sept. 30, 1986; 55 FR 15175, Apr. 20, 1990; 56 FR 43448, Aug. 30, 1991; 57 FR 39825, Sept. 1, 1992; 57 FR 47787, Oct. 20, 1992; 58 FR 46339, Sept. 1, 1993; 62 FR 46030, Aug. 29, 1997; 68 FR 67960, Dec. 5, 2003; 70 FR 47486, Aug. 12, 2005; 85 FR 59022, Sept. 18, 2020]

**§412.116 Method of payment.**

(a) *General rules.* (1) Unless the provisions of paragraphs (b) and (c) of this section apply, hospitals are paid for hospital inpatient operating costs and capital-related costs for each discharge based on the submission of a discharge bill.

(2) Payments for inpatient hospital services furnished by an excluded psychiatric unit of a hospital (or by an excluded rehabilitation unit of a hospital for cost reporting periods beginning before January 1, 2002) are made as described in §§413.64(a), (c), (d), and (e) of this chapter.

(3) For cost reporting periods beginning on or after January 1, 2005, payments for inpatient hospital services furnished by an inpatient psychiatric facility that meets the conditions of §412.404 are made as described in §412.432.

(4) For cost reporting periods beginning on or after January 1, 2002, payments for inpatient hospital services furnished by a rehabilitation hospital or a rehabilitation unit that meets the conditions of §412.604 are made as described in §412.632.

(5) For cost reporting periods beginning on or after October 1, 2002, payments for inpatient hospital services furnished by a long-term care hospital that meets the conditions for payment of §§412.505 through 412.511 are made as described in §412.521.

(b) *Periodic interim payments—(1) Criteria for receiving periodic interim payments.* Effective with claims received on or after July 1, 1987, a hospital that meets the criteria in §413.64(h) of this chapter may request in writing to receive periodic interim payments as described in this paragraph. A hospital that is receiving periodic interim payments also receives payment on this basis for inpatient hospital services furnished by its excluded psychiatric or rehabilitation unit.

(i) *Failure of intermediary to make prompt payment.* Beginning with claims received in April 1987, the hospital's fiscal intermediary does not meet the requirements of section 1816(c)(2) of the Act, which provides for prompt payment of claims under Medicare Part A, for three consecutive calendar months. The hospital may continue to receive

periodic interim payments until the intermediary meets the requirements of section 1816 (c)(2) of the Act for three consecutive calendar months. For purposes of this paragraph, a hospital that is receiving periodic interim payments as of June 30, 1987 and meets the requirements of §413.64(h) of this chapter may continue to receive payment on this basis until the hospital's intermediary meets the requirements of section 1816(c)(2) of the Act for three consecutive calendar months beginning with April 1987.

(ii) *Hospitals that serve a disproportionate share of low-income patients.* The hospital is receiving periodic interim payments as of June 30, 1987 and has a disproportionate share payment adjustment factor of at least 5.1 percent as determined under §412.106(c) for purposes of establishing the average standardized amounts for discharges occurring on or after October 1, 1986 and before October 1, 1987. The hospital's request must be made by a date prior to July 1, 1987, specified by the intermediary.

(iii) *Small rural hospitals.* The hospital is receiving periodic interim payments as of June 30, 1987, makes its request by a date prior to July 1, 1987, specified by the intermediary, and, on July 1, 1987, the hospital—

(A) Is located in a rural area as defined in §412.62(f); and

(B) Has 100 or fewer beds available for use.

(2) *Frequency of payment.* The intermediary estimates a hospital's prospective payments as described in paragraph (b)(3) of this section and makes biweekly payments equal to  $\frac{1}{26}$  of the total estimated amount of payment for the year. Each payment is made two weeks after the end of a biweekly period of service, as described in §413.64(h)(5) of this chapter. These payments are subject to final settlement.

(3) *Amount of payment.* (i) The biweekly interim payment amount is based on the total estimated Medicare discharges for the reporting period multiplied by the hospital's estimated average prospective payment amount as described in paragraph (b)(3)(ii) of this paragraph. These interim payments are reviewed at least twice during the reporting period and adjusted if

necessary. Fewer reviews may be necessary if a hospital receives interim payments for less than a full reporting period.

(ii) For purposes of determining periodic interim payments under this paragraph, a hospital's estimated average prospective payment amount is computed as follows:

(A) If a hospital has no payment experience under the prospective payment system for operating costs, the intermediary computes the hospital's estimated average prospective payment amount for operating costs by multiplying its payment rates as determined under §412.70(c), but without adjustment by a DRG weighting factor, by the hospital's case-mix index, and subtracting from this amount estimated deductibles and coinsurance.

(B) Effective for cost-reporting periods beginning on or after October 1, 1991, the intermediary computes a hospital's estimated average prospective payment amount for capital-related costs by multiplying its prospective payment rate as determined under §412.340 or §412.344(a), as applicable, and under §412.308 for cost reporting periods beginning on or after October 1, 2001 but without adjustment by a DRG weighting factor, by the hospital's case-mix index. The intermediary may take into account estimated additional payments per discharge under §412.348. If the hospital is paid under §412.344(a)(1), the intermediary includes an estimated payment for old capital costs per discharge.

(C) If a hospital has payment experience under the prospective payment system for operating costs, and, for cost reporting periods beginning on or after October 1, 1991, for inpatient capital-related costs, the intermediary computes a hospital's estimated average prospective payment amount for operating costs and capital-related costs based on that payment experience, adjusted for projected changes, and subtracts from this amount estimated deductibles and coinsurance.

(4) *Termination of periodic interim payments*—(i) *Request by the hospital*. A hospital receiving periodic interim payments may convert to payments on a per discharge basis at any time.

(ii) *Removal by the intermediary*. An intermediary terminates periodic interim payments if—

(A) A hospital no longer meets the requirements of §413.64(h);

(B) A hospital is receiving payment under the criterion in paragraph (b)(1)(i) of this section and the intermediary meets the prompt payment requirements of section 1816(c)(2) of the Act for three consecutive calendar months; or

(C) A hospital that is receiving payment under the criterion set forth in paragraph (b)(1)(iii) of this section no longer meets the criterion.

(iii) *Limitation on reelection*. If a hospital that is receiving periodic interim payments under the criterion set forth in paragraph (b)(1)(ii) or (b)(1)(iii) of this section is removed from that method of payment at its own request, it may reelect to receive periodic interim payments only under the criterion set forth in paragraph (b)(1)(i) of this section. However, if the hospital is removed from that method of payment by its intermediary because it no longer meets the requirements of §413.64(h) of this chapter, that hospital may subsequently reelect to receive periodic interim payments if it qualifies under the provisions of paragraph (b)(1)(ii) or (b)(1)(iii) of this section, subject to the requirements in §413.64(h) of this chapter.

(c) *Special interim payments for certain costs*. For capital-related costs for cost-reporting periods beginning before October 1, 1991, and the direct costs of medical education, which are not included in prospective payments but are reimbursed as specified in §§413.130 and 413.85 of this chapter, respectively, interim payments are made subject to final cost settlement. Interim payments for capital-related items for cost-reporting periods beginning before October 1, 1991, and the estimated cost of approved medical education programs (applicable to inpatient costs payable under Medicare Part A and for kidney acquisition costs in hospitals with approved kidney transplant programs) are determined by estimating the reimbursable amount for the year based on the previous year's experience and on substantiated information for the current year and divided into 26

equal biweekly payments. Each payment is made 2 weeks after the end of a biweekly period of services, as described in §413.64(h)(5) of this subchapter. The interim payments are reviewed by the intermediary at least twice during the reporting period and adjusted if necessary.

(d) *Special interim payment for unusually long lengths of stay*—(1) *First interim payment.* A hospital that is not receiving periodic interim payments under paragraph (b) of this section may request an interim payment after a Medicare beneficiary has been in the hospital at least 60 days. Payment for the interim bill is determined as if the bill were a final discharge bill and includes any outlier payment determined as of the last day for which services have been billed.

(2) *Additional interim payments.* A hospital may request additional interim payments at intervals of at least 60 days after the date of the first interim bill submitted under paragraph (d)(1) of this section. Payment for these additional interim bills, as well as the final bill, is determined as if the bill were the final bill with appropriate adjustments made to the payment amount to reflect any previous interim payment made under the provisions of this paragraph (d).

(e) *Outlier payment and additional payments for new medical services and technologies.* Payments for outlier cases and additional payments for new medical services and technologies (described in subpart F of this part) are not made on an interim basis.

(f) *Accelerated payments*—(1) *General rule.* Upon request, an accelerated payment may be made to a hospital that is not receiving periodic interim payments under paragraph (b) of this section if the hospital is experiencing financial difficulties because of the following:

(i) There is a delay by the intermediary in making payment to the hospital.

(ii) Due to an exceptional situation, there is a temporary delay in the hospital's preparation and submittal of bills to the intermediary beyond its normal billing cycle.

(2) *Approval of payment.* A hospital's request for an accelerated payment

must be approved by the intermediary and CMS.

(3) *Amount of payment.* The amount of the accelerated payment is computed as a percentage of the net payment for unbilled or unpaid covered services.

(4) *Recovery of payment.* Recovery of the accelerated payment is made by recoupment as hospital bills are processed or by direct payment by the hospital.

[53 FR 1627, Jan. 21, 1988, as amended at 53 FR 38532, Sept. 30, 1988; 54 FR 36495, Sept. 1, 1989; 56 FR 43449, Aug. 30, 1991; 57 FR 3016, Jan. 27, 1992; 59 FR 36712, July 19, 1994; 59 FR 45400, Sept. 1, 1994; 66 FR 41387, Aug. 7, 2001; 67 FR 56049, Aug. 30, 2002; 68 FR 45470, Aug. 1, 2003; 69 FR 66977, Nov. 15, 2004; 71 FR 48140, Aug. 18, 2006; 86 FR 73512, Dec. 27, 2021]

#### §412.120 Reductions to total payments.

(a) *Deductible and coinsurance.* Subject to paragraph (a)(2) of this section, the total Medicare payments otherwise payable to a hospital are reduced by the applicable deductible and coinsurance amounts related to inpatient hospital services as determined in accordance with §§409.82, 409.83, and 409.87 of this chapter.

(b) *Payment by workers' compensation, automobile medical, no-fault or liability insurance or an employer group health plan primary to Medicare.* If workers' compensation, automobile medical, no-fault, or liability insurance or an employer group health plan which is primary to Medicare pays in full or in part, the Medicare payment is determined in accordance with the following guidelines:

(1) If workers' compensation pays, in accordance with the applicable provisions of §§405.316 through 405.321 of this chapter.

(2) If automobile medical, no-fault, or liability insurance pays, in accordance with the applicable provisions of §§405.322 through 405.325 of this chapter.

(3) If an employer group health plan which is primary to Medicare pays for services to ESRD beneficiaries, in accordance with the applicable provisions of §§405.326 through 405.329 of this chapter.

(4) If an employer group health plan which is primary to Medicare pays for services to employees age 65–69 and

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their spouses age 65–69, in accordance with the applicable provisions of §§ 405.340 through 405.344 of this chapter.

[50 FR 12741, Mar. 29, 1985, as amended at 55 FR 36071, Sept. 4, 1990; 56 FR 573, Jan. 7, 1991; 57 FR 39825, Sept. 1, 1992]

### **§ 412.125 Effect of change of ownership on payments under the prospective payment systems.**

When a hospital's ownership changes, as described in § 489.18 of this chapter, the following rules apply:

(a) Payment for the operating and capital-related costs of inpatient hospital services for each patient, including outlier payments, as provided in § 412.112, and payments for hemophilia clotting factor costs under § 412.115(b), are made to the entity that is the legal owner on the date of discharge. Payments are not prorated between the buyer and seller.

(1) The owner on the date of discharge is entitled to submit a bill for all inpatient hospital services furnished to a beneficiary regardless of when the beneficiary's coverage began or ended during a stay, or of how long the stay lasted.

(2) Each bill submitted must include all information necessary for the intermediary to compute the payment amount, whether or not some of that information is attributable to a period during which a different party legally owned the hospital.

(b) Other payments under § 412.113 and payments for bad debts as described in § 412.115(a), are made to each owner or operator of the hospital (buyer and seller) in accordance with the principles of reasonable cost reimbursement.

[50 FR 12741, Mar. 29, 1985, as amended at 56 FR 43449, Aug. 30, 1991]

### **§ 412.130 Retroactive adjustments for incorrectly excluded hospitals and units.**

(a) *Hospitals for which adjustment is made.* The intermediary makes the payment adjustment described in paragraph (b) of this section for the following hospitals:

(1) A hospital that was excluded from the prospective payment systems specified in § 412.1(a)(1) or paid under the

prospective payment system specified in § 412.1(a)(3), as a new rehabilitation hospital for a cost reporting period beginning on or after October 1, 1991 based on a certification under § 412.29(c) regarding the inpatient population the hospital planned to treat during that cost reporting period, if the inpatient population actually treated in the hospital during that cost reporting period did not meet the requirements of § 412.29(b).

(2) A hospital that has a unit excluded from the prospective payment systems specified in § 412.1(a)(1) or paid under the prospective payment system specified in § 412.1(a)(3), as a new rehabilitation unit for a cost reporting period beginning on or after October 1, 1991, based on a certification under § 412.29(c) regarding the inpatient population the hospital planned to treat in that unit during the period, if the inpatient population actually treated in the unit during that cost reporting period did not meet the requirements of § 412.29(b).

(3) A hospital that added new beds to its existing rehabilitation unit for a cost reporting period beginning on or after October 1, 1991 based on a certification under § 412.29(c) regarding the inpatient population the hospital planned to treat in these new beds during that cost reporting period, if the inpatient population actually treated in the new beds during that cost reporting period did not meet the requirements of § 412.29(b).

(b) *Adjustment of payment.* (1) For cost reporting periods beginning before January 1, 2002, the intermediary adjusts the payment to the hospitals described in paragraph (a) of this section as follows:

(i) The intermediary calculates the difference between the amounts actually paid during the cost reporting period for which the hospital, unit, or beds were first excluded as a new hospital, new unit, or newly added beds under subpart B of this part, and the amount that would have been paid under the prospective payment systems specified in § 412.1(a)(1) for services furnished during that period.

(ii) The intermediary makes a retroactive adjustment for the difference between the amount paid to the hospital



based on the exclusion and the amount that would have been paid under the prospective payment systems specified in §412.1(a)(1).

(2) For cost reporting periods beginning on or after January 1, 2002, the intermediary adjusts the payment to the hospitals described in paragraph (a) of this section as follows:

(i) The intermediary calculates the difference between the amounts actually paid under subpart P of this part during the cost reporting period for which the hospital, unit, or beds were first classified as a new hospital, new unit, or newly added beds under subpart B of this part, and the amount that would have been paid under the prospective payment systems specified in §412.1(a)(1) for services furnished during that period.

(ii) The intermediary makes a retroactive adjustment for the difference between the amount paid to the hospital under subpart P of this part and the amount that would have been paid under the prospective payment systems specified in §412.1(a)(1).

[56 FR 43241, Aug. 30, 1991, as amended at 57 FR 39825, Sept. 1, 1992; 59 FR 45400, Sept. 1, 1994; 60 FR 45848, Sept. 1, 1995; 66 FR 41387, Aug. 7, 2001; 70 FR 66977, Nov. 15, 2005; 78 FR 47934, Aug. 6, 2013]

**§412.140 Participation, data submission, and validation requirements under the Hospital Inpatient Quality Reporting (IQR) Program.**

(a) *Participation in the Hospital IQR Program.* In order to participate in the Hospital IQR Program, a section 1886(d) of the hospital must—

(1) Register on QualityNet website, before it begins to report data;

(2) Identify and register a QualityNet security official as part of the registration process under paragraph (a)(1) of this section; and

(3) Submit a completed Notice of Participation Form to CMS if the hospital is participating in the program for the first time, has previously withdrawn from the program and would like to participate again, or has received a new CMS Certification Number (CCN).

(i) A hospital that would like to participate in the program for the first time (and to which paragraph (a)(3)(ii)

of this section does not apply), or that previously withdrew from the program and would now like to participate again, must submit to CMS a completed Notice of Participation Form by December 31 of the calendar year preceding the first quarter of the calendar year in which data submission is required for any given fiscal year.

(ii) A hospital that has received a new CCN and would like to participate in the program must submit a completed Notice of Participation Form to CMS no later than 180 days from the date identified as the open date on the approved CMS Quality Improvement Evaluation System (QIES).

(b) *Withdrawal from the Hospital IQR Program.* CMS will accept Hospital IQR Program withdrawal forms from hospitals on or before—

(1) Prior to the FY 2016 payment determination, August 15 of the fiscal year preceding the fiscal year for which a Hospital IQR determination will be made.

(2) Beginning with the FY 2016 payment determination, May 15 of the fiscal year preceding the fiscal year for which a Hospital IQR payment determination will be made.

(c) *Submission and validation of Hospital IQR Program data.* (1) *General rule.* Except as provided in paragraph (c)(2) of this section, subsection (d) hospitals that participate in the Hospital IQR Program must submit to CMS data on measures selected under section 1886(b)(3)(B)(viii) of the Act in a form and manner, and at a time, specified by CMS. A hospital must begin submitting data on the first day of the quarter following the date that the hospital submits a completed Notice of Participation form under paragraph (a)(3) of this section.

(2) *Extraordinary circumstances exceptions.* CMS may grant an exception with respect to quality data reporting requirements in the event of extraordinary circumstances beyond the control of the hospital. CMS may grant an exception as follows:

(i) For circumstances not relating to the reporting of electronic clinical quality measure data, a hospital participating in the Hospital IQR Program that wishes to request an exception with respect to quality data reporting

requirements must submit its request to CMS within 90 days of the date that the extraordinary circumstances occurred. For circumstances relating to the reporting of electronic clinical quality measures, a hospital participating in the Hospital IQR Program that wishes to request an exception must submit its request to CMS by April 1 following the end of the reporting calendar year in which the extraordinary circumstances occurred. Specific requirements for submission of a request for an exception are available on QualityNet website.

(ii) CMS may grant an exception to one or more hospitals that have not requested an exception if: CMS determines that a systemic problem with CMS data collection systems directly affected the ability of the hospital to submit data; or if CMS determines that an extraordinary circumstance has affected an entire region or locale.

(d) *Validation of Hospital IQR Program data.* CMS may validate one or more measures selected under section 1886(b)(3)(B)(viii) of the Act by reviewing patient charts submitted by selected participating hospitals.

(1) Upon written request by CMS or its contractor, a hospital must submit to CMS a sample of patient charts that the hospital used for purposes of data submission under the program. The specific sample that a hospital must submit will be identified in the written request. A hospital must submit the patient charts to CMS or its contractor within 30 days of the date identified on the written request.

(2)(i) A hospital meets the chart-abstracted validation requirement with respect to a fiscal year if it achieves a 75-percent score, as determined by CMS.

(ii) A hospital meets the eCQM validation requirement with respect to a fiscal year if it submits at 100 percent of sampled eCQM measure medical records in a timely and complete manner, as determined by CMS.

(e) *Reconsiderations and appeals of Hospital IQR Program decisions.* (1) A hospital may request reconsideration of a decision by CMS that the hospital has not met the requirements of the Hospital IQR Program for a particular fiscal year. Except as provided in para-

graph (c)(2) of this section, a hospital must submit a reconsideration request to CMS no later than 30 days from the date identified on the Hospital Inpatient Quality Reporting Program Annual Payment Update Notification Letter provided to the hospital.

(2) A reconsideration request must contain the following information:

(i) The hospital's CMS Certification Number (CCN);

(ii) The name of the hospital;

(iii) Contact information for the hospital's chief executive officer and QualityNet security official, including each individual's name, e-mail address, telephone number, and physical mailing address;

(iv) A summary of the reason(s), as set forth in the Hospital Inpatient Quality Reporting Program Annual Payment Update Notification Letter, that CMS concluded the hospital did not meet the requirements of the Hospital IQR Program;

(v) A detailed explanation of why the hospital believes that it complied with the requirements of the Hospital IQR Program for the applicable fiscal year;

(vi) Any evidence that supports the hospital's reconsideration request, including copies of patient charts, e-mails and other documents; and

(vii) If the hospital has requested reconsideration on the basis that CMS concluded it did not meet the validation requirement set forth in paragraph (d) of this section, the reconsideration request must contain the following additional information:

(A) A copy of each patient chart that the hospital timely submitted to CMS or its contractor in response to a request made under paragraph (d)(1) of this section; and

(B) A detailed explanation identifying which data the hospital believes was improperly validated by CMS and why the hospital believes that such data are correct.

(3) A hospital that is dissatisfied with a decision made by CMS on its reconsideration request may file an appeal with the Provider Reimbursement Review Board under part 405, subpart R of this chapter.

(f) *Patient experience of care data (HCAHPS survey).* HCAHPS is the Hospital Consumer Assessment of

Healthcare Providers and Systems survey that measures patient experience of care after a recent hospital stay.

(1) Approved HCAHPS survey vendors and self-administering hospitals must fully comply with all HCAHPS oversight activities, including allowing CMS and its HCAHPS Project Team to perform site visits at the hospitals' and survey vendors' company locations.

(2) CMS approves an application for an entity to administer the HCAHPS survey as an approved HCAHPS survey vendor on behalf of one or more hospitals when an applicant has met the Minimum Survey Requirements and Rules of Participation that can be found on the official HCAHPS On-Line Web site, and agree to comply with the current survey administration protocols that can be found on the official HCAHPS On-Line Web site. An entity must be an approved HCAHPS survey vendor in order to administer and submit HCAHPS data to CMS on behalf of one or more hospitals.

(g) *Retention and removal of quality measures under the Hospital IQR Program*—(1) *General rule for the retention of quality measures.* Quality measures adopted for the Hospital IQR Program measure set for a previous payment determination year are retained for use in subsequent payment determination years, except when they are removed, suspended, or replaced as set forth in paragraphs (g)(2) and (3) of this section.

(2) *Immediate measure removal.* For cases in which CMS believes that the continued use of a measure raises specific patient safety concerns, CMS will immediately remove a quality measure from the Hospital IQR Program and will promptly notify hospitals and the public of the removal of the measure and the reasons for its removal through the Hospital IQR Program ListServ and the QualityNet website, as applicable.

(3) *Measure removal, suspension, or replacement through the rulemaking process.* Unless a measure raises specific safety concerns as set forth in paragraph (g)(2) of this section, CMS will use the regular rulemaking process to remove, suspend, or replace quality measures in the Hospital IQR Program to allow for public comment.

(i) *Factors for consideration of removal of quality measures.* CMS will weigh whether to remove a measure based on the following factors:

(A) *Factor 1.* Measure performance among hospitals is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made ("topped out" measure).

(B) *Factor 2.* A measure does not align with current clinical guidelines or practice.

(C) *Factor 3.* The availability of a more broadly applicable measure (across settings or populations), or the availability of a measure that is more proximal in time to desired patient outcomes for the particular topic.

(D) *Factor 4.* Performance or improvement on a measure does not result in better patient outcomes.

(E) *Factor 5.* The availability of a measure that is more strongly associated with desired patient outcomes for the particular topic.

(F) *Factor 6.* Collection or public reporting of a measure leads to negative unintended consequences other than patient harm.

(G) *Factor 7.* It is not feasible to implement the measure specifications.

(H) *Factor 8.* The costs associated with a measure outweigh the benefit of its continued use in the program.

(ii) *Criteria to determine topped-out measures.* For the purposes of the Hospital IQR Program, a measure is considered to be topped-out under paragraph (g)(3)(i)(A) of this section when it meets both of the following criteria:

(A) Statistically indistinguishable performance at the 75th and 90th percentiles (defined as when the difference between the 75th and 90th percentiles for a hospital's measure is within 2 times the standard error of the full data set).

(B) A truncated coefficient of variation less than or equal to 0.10.

(iii) *Application of measure removal factors.* The benefits of removing a

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measure from the Hospital IQR Program will be assessed on a case-by-case basis.

[76 FR 51782, Aug. 18, 2011, as amended at 77 FR 53674, Aug. 31, 2012; 78 FR 50966, Aug. 19, 2013; 79 FR 50354, Aug. 22, 2014; 81 FR 57267, Aug. 22, 2016; 82 FR 38511, Aug. 14, 2017; 86 FR 45520, Aug. 13, 2021; 87 FR 49404, Aug. 10, 2022; 88 FR 59332, Aug. 28, 2023]

### **Subpart I—Adjustments to the Base Operating DRG Payment Amounts Under the Prospective Payment Systems for Inpatient Operating Costs**

SOURCE: 77 FR 53674, Aug. 31, 2012, unless otherwise noted.

#### **§ 412.150 Basis and scope of subpart.**

(a) Section 1886(q) of the Act requires the Secretary to establish a Hospital Readmissions Reduction program, under which payments to applicable hospitals are reduced in order to account for certain excess readmissions, effective for discharges beginning on October 1, 2012. The rules for determining the payment adjustment under the Hospital Readmission Reductions Program are specified in §§ 412.152 and 412.154.

(b) Section 1886(o) of the Act requires the Secretary to establish a Value-Based Purchasing (VBP) Program for inpatient hospitals (Hospital VBP Program), which requires CMS to make value-based incentive payments to hospitals that meet performance standards for applicable performance periods, effective for discharges beginning on October 1, 2012. The rules for determining the payment adjustment under the Hospital Value-Based Purchasing Program are specified in §§ 412.160 through 412.167.

(c) Section 1886(p) of the Act requires the Secretary to establish an adjustment to hospital payments for hospital-acquired conditions, or a Hospital-Acquired Condition Reduction Program, under which payments to applicable hospitals are adjusted to provide an incentive to reduce hospital-acquired conditions, effective for discharges beginning on October 1, 2014. The rules for determining the payment adjustment under the Hospital-Ac-

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quired Condition Reduction Program are specified in §§ 412.170 and 412.172.

[77 FR 53674, Aug. 31, 2012, as amended at 78 FR 50966, Aug. 19, 2013]

### **PAYMENT ADJUSTMENTS UNDER THE HOSPITAL READMISSIONS REDUCTION PROGRAM**

#### **§ 412.152 Definitions for the Hospital Readmissions Reduction Program.**

As used in this section and in § 412.154, the following definitions apply:

*Aggregate payments for all discharges* is, for a hospital for the applicable period, the sum of the base operating DRG payment amounts for all discharges for all conditions from such hospital for such applicable period.

*Aggregate payments for excess readmissions* is, for a hospital for the applicable period, the sum, for the applicable conditions, of the product for each applicable condition of:

(1) The base operating DRG payment amount for the hospital for the applicable period for such condition or procedure;

(2) The number of admissions for such condition or procedure for the hospital for the applicable period;

(3) The excess readmission ratio for the hospital for the applicable period minus the peer-group median excess readmission ratio (ERR); and

(4) The neutrality modifier, a multiplicative factor that equates total Medicare savings under the current stratified methodology to the previous non-stratified methodology.

*Applicable condition* is a condition or procedure selected by the Secretary—

(1) Among the conditions and procedures for which—

(i) Readmissions represent conditions or procedures that are high volume or high expenditures; and

(ii) Measures of such readmissions have been endorsed by the entity with a contract under section 1890(a) of the Act and such endorsed measures have exclusions for readmissions that are unrelated to the prior discharge (such as a planned readmission or transfer to another applicable hospital); or

(2) Among other conditions and procedures as determined appropriate by