

amount equal to the amount of the reduction made to its base-operating DRG payment amounts.

[86 FR 45520, Aug. 13, 2021, as amended at 87 FR 49404, Aug. 10, 2022]

§ 412.169 [Reserved]

PAYMENT ADJUSTMENTS UNDER THE HOSPITAL-ACQUIRED CONDITION REDUCTION PROGRAM

§ 412.170 Definitions for the Hospital-Acquired Condition Reduction Program.

As used in this section and § 412.172, the following definitions apply:

Applicable hospital is a hospital described in section 1886(d)(1)(B) of the Act (including a hospital in Maryland that is paid under the waiver under section 1814(b)(3) of the Act and that, absent the waiver specified by section 1814(b)(3) of the Act, would have been paid under the hospital inpatient prospective payment system) as long as the hospital meets the criteria specified under § 412.172(e).

Applicable period is, unless otherwise specified by the Secretary, with respect to a fiscal year, the 2-year period (specified by the Secretary) from which data are collected in order to calculate the total hospital-acquired condition score under the Hospital-Acquired Condition Reduction Program.

(1) The applicable period for FY 2022—

(i) For the CMS PSI 90 measure, is the 24-month period from July 1, 2018 through June 30, 2020; and

(ii) For the CDC NHSN HAI measures, is the 24-month period from January 1, 2019 through December 31, 2020.

(2) Beginning with the FY 2023 program year, the applicable period is the 24-month period advanced by 1-year from the prior fiscal year's period from which data are collected in order to calculate the total hospital-acquired condition score under the Hospital-Acquired Condition Reduction Program, unless otherwise specified by the Secretary.

CDC NHSN HAI stands for Centers for Disease Control and Prevention National Healthcare Safety Network healthcare-associated infection measures.

CMS PSI 90 stands for Patient Safety and Adverse Events Composite for Selected Indicators (modified version of PSI 90).

Hospital-acquired condition is a condition as described in section 1886(d)(4)(D)(iv) of the Act and any other condition determined appropriate by the Secretary that an individual acquires during a stay in an applicable hospital, as determined by the Secretary.

[78 FR 50967, Aug. 19, 2013, as amended at 81 FR 57268, Aug. 22, 2016; 85 FR 59022, Sept. 18, 2020]

§ 412.172 Payment adjustments under the Hospital-Acquired Condition Reduction Program.

(a) *Scope*. This section sets forth the requirements for determining the payment adjustments under the Hospital-Acquired Condition Reduction Program for hospitals that meet the criteria described under paragraph (e) of this section.

(b) *Payment adjustment*. With respect to all discharges from an applicable hospital occurring during FY 2015 or a subsequent year, the amount of payment under this section, or section 1814(b)(3) of the Act as applicable, for such discharges during the fiscal year will be equal to 99 percent of the amount of payment that would otherwise apply to these discharges under this section or section 1814(b)(3) of the Act (determined after the application of the payment adjustment under the Hospital Readmissions Reduction Program under § 412.154 and the adjustment made under the Hospital Value-Based Purchasing Program under § 412.162 and section 1814(l)(4) of the Act but without regard to section 1886(p) of the Act).

(c) [Reserved]

(d) *Risk adjustment*. In carrying out the provisions of paragraph (e) of this section, CMS will establish and apply an appropriate risk-adjustment methodology.

(e) *Criteria for applicable hospitals*. (1) *General*. With respect to a subsection (d) hospital, CMS will identify the top quartile of all subsection (d) hospitals with respect to hospital-acquired conditions as measured during the applicable period.

(2) *Use of total hospital-acquired condition scores.* CMS will use total hospital-acquired condition scores to identify applicable hospitals. CMS will identify the 25 percent of hospitals with the highest total scores.

(3) *Methodology for calculating total hospital-acquired condition scores.* CMS will calculate the total hospital-acquired condition scores by weighing the selected measures according to the established methodology.

(f) *Reporting of hospital-specific information.* CMS will make information available to the public regarding hospital-acquired condition rates of all hospitals under the Hospital-Acquired Condition Reduction Program.

(1) CMS will provide each hospital with confidential hospital-specific reports and discharge level information used in the calculation of its total hospital-acquired condition score.

(2) Hospitals will have a period of 30 days after the receipt of the information provided under paragraph (f)(1) of this section to review and submit corrections for the hospital-acquired condition program scores for each condition that is used to calculate the total hospital-acquired condition score for the fiscal year.

(3) The administrative claims data used to calculate a hospital's total hospital-acquired condition score for a condition for a fiscal year are not subject to review and correction under paragraph (f)(2) of this section.

(4) CMS posts the total hospital-acquired condition score, the domain score, and the score on each measure for each hospital on the Hospital Compare website or successor website.

(g) *Limitations on review.* There is no administrative or judicial review under § 412.170 and this section for the following:

(1) The criteria describing applicable hospitals.

(2) The applicable period.

(3) The specification of hospital-acquired conditions.

(4) The provision of reports to hospitals and the information made available to the public.

[78 FR 50967, Aug. 19, 2013, as amended at 79 FR 50355, Aug. 22, 2014; 84 FR 42614, Aug. 16, 2019; 86 FR 45520, Aug. 13, 2021]

§ 412.190 Overall Hospital Quality Star Rating.

(a) *Purpose.* (1) The Overall Hospital Quality Star Rating (Overall Star Rating) is a summary of certain publicly reported hospital measure data for the benefit of stakeholders, such as patients, consumers, and hospitals.

(2) The guiding principles of the Overall Star Rating are as follows. In developing and maintaining the Overall Star Ratings, we strive to:

(i) Use scientifically valid methods that are inclusive of hospitals and measure information and able to accommodate underlying measure changes;

(ii) Align with *Hospital Compare* or its successor website and CMS programs;

(iii) Provide transparency of the methods for calculating the Overall Star Rating; and

(iv) Be responsive to stakeholder input.

(b) *Data included in Overall Star Rating—(1) Source of data.* The Overall Star Rating is calculated based on measure data collected and publicly reported on *Hospital Compare* or its successor site under the following CMS hospital inpatient and outpatient programs:

(i) Hospital Inpatient Quality Reporting (IQR) Program—section 1886(b)(3)(B)(viii)(VII) of the Act.

(ii) Hospital-Acquired Condition Reduction Program—section 1886(p)(6)(A) of the Act.

(iii) Hospital Value-based Purchasing Program—section 1886(o)(10)(A) of the Act.

(iv) Hospital Readmissions Reduction Program—section 1886(q)(6)(A) of the Act.

(v) Hospital Outpatient Quality Reporting (OQR) Program—section 1833(t)(17)(e) of the Act.

(2) *Hospitals included in Overall Star Rating.* Subsection (d) hospitals subject to the CMS quality programs specified in paragraph (b)(1) of this section that also have their data publicly reported on one of CMS' websites are included in the Overall Star Rating.

(3) *Critical Access Hospitals.* Critical Access Hospitals (CAHs) that wish to be voluntarily included in the Overall Star Rating must have elected to—

(i) Voluntarily submit quality measures included in and as specified under CMS hospital programs; and

(ii) Publicly report their quality measure data on *Hospital Compare* or its successor site.

(c) Frequency of publication and data used. The Overall Star Rating are published once annually using data publicly reported on *Hospital Compare* or its successor website from a quarter within the previous 12 months.

(d) *Methodology*—(1) *Selection of measures*. Measures are selected from those publicly reported on *Hospital Compare* or its successor website through certain CMS quality programs under paragraph (b)(1) of this section.

(i) From this group of measures, measures falling into one or more of the exclusions in paragraphs (d)(1)(i)(A) through (E) of this section will be removed from consideration:

(A) Measures that 100 hospitals or less publicly report. These measures would not produce reliable measure group scores based on too few hospitals;

(B) Measures that cannot be standardized to a single, common scale and otherwise not amenable to inclusion in a summary score calculation alongside process and outcome measures or measures that cannot be combined in a meaningful way. This includes measures that cannot be as easily combined with other measures captured on a continuous scale with more granular data;

(C) Non-directional measures for which it is unclear whether a higher or lower score is better. These measures cannot be standardized to be combined with other measures and form an aggregate measure group score;

(D) Measures not required for reporting on *Hospital Compare* or its successor websites through CMS programs; or

(E) Measures that overlap with another measure in terms of cohort or outcome, including component measures that are part of an already-included composite measure.

(ii) [Reserved]

(2) *Measure score standardization*. All measure scores are standardized by calculating Z-scores so that all measures are on a single, common scale to be consistent in terms of direction (that is, higher scores are better) and numer-

ical magnitude. This is calculated by subtracting the national mean measure score from each hospital's measure score and dividing the difference by the measure standard deviation in order to standardize measures.

(3) *Grouping measures*. Measures are grouped into one of the five clinical groups as follows:

(i) Mortality.

(ii) Safety of Care.

(iii) Readmission.

(iv) Patient Experience.

(v) Timely and Effective Care.

(4) *Calculate measure group scores*. A score is calculated for each measure group for which a hospital has measure data using a simple average of measure scores, as follows:

(i) Each measure group score is standardized by calculating Z-scores for each measure group so that all measure group scores are centered near zero with a standard deviation of one.

(ii) We take 100 percent divided by the number of measures reported in a measure group to determine the percentage of each measure's weight.

(iii) The measure weight is then multiplied by the standardized measure score to calculate the measure's weighted score.

(iv) Then, all of the individual measure weighted scores within a measure group are added together to calculate the measure group score.

(5) *Reporting thresholds*. In order to receive an Overall Star Rating, a hospital must report at least three measures within at least three measure groups, one of which must specifically be the Mortality or Safety of Care outcome group.

(6) *Hospital summary score*. A summary score is calculated by multiplying the standardized measure group scores by the assigned measure group weights and then summing the weighted measure group scores.

(i) *Standard measure group weighting*.

(A) Each of the Mortality, Safety of Care, Readmission, and Patient Experience groups are weighted 22 percent; and

(B) The Timely and Effective Care group is weighted 12 percent.

(ii) *Reweightings*. (A) Hospitals may have too few cases to report particular measures and, in those cases, may not

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report enough measures in one or more measure groups.

(B) When a hospital does not have enough measures in one or more measure groups due to too few cases CMS may re-distribute one or more of the missing measure group's weight proportionally across the remaining measure groups by subtracting the standard weight percentage of the group or groups with insufficient measures from 100 percent; and then dividing the resulting percentage across the remaining measure groups, giving new re-proportioned weights.

(7) *Peer grouping.* Hospitals are assigned to one of three peer groups based on the number of measure groups for which they report at least three measures: three, four, or five measure groups.

(8) *Star ratings assignment.* Hospitals in each peer group are then assigned between one and five stars where one star is the lowest and five stars is the highest using k-means clustering to complete convergence.

(e) *Preview period prior to publication.* CMS provides hospitals the opportunity to preview their Overall Star Rating prior to publication. Hospitals have at least 30 days to preview their results, and if necessary, can reach out to CMS with questions.

(f) *Suppression of Overall Star Rating—*
(1) *Subsection (d) hospitals.* CMS may consider suppressing Overall Star Rating for subsection (d) hospitals only under extenuating circumstances that affect numerous hospitals (as in, not an individualized or localized issue) as determined by CMS, or when CMS is at fault, including but not limited to when:

(i) There is an Overall Star Rating calculation error by CMS;

(ii) There is a systemic error at the CMS quality program level that substantively affects the Overall Star Rating calculation; or

(iii) If a Public Health Emergency, as defined in § 400.200 of this chapter, substantially affects the underlying measure data.

(2) *CAHs.* (i) CAHs may request to withhold their Overall Star Rating from publication on *Hospital Compare* or its successor website so long as the request for withholding is made, at the

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latest, during the Overall Star Rating preview period.

(ii) CAHs may request to have their Overall Star Rating withheld from publication on *Hospital Compare* or its successor website, as well as their data from the public input file, so long as the request is made during the CMS quality program-level 30-day confidential preview period for the *Hospital Compare* refresh data used to calculate the Overall Star Ratings.

[85 FR 86300, Dec. 29, 2020, as amended at 87 FR 72287, Nov. 23, 2022]

Subpart J [Reserved]

Subpart K—Prospective Payment System for Inpatient Operating Costs for Hospitals Located in Puerto Rico

SOURCE: 52 FR 33058, Sept. 1, 1987, unless otherwise noted.

§ 412.200 General provisions.

Beginning with discharges occurring on or after October 1, 1987, hospitals located in Puerto Rico are subject to the rules governing the prospective payment system for inpatient operating costs. Except as provided in this subpart, the provisions of subparts A, B, C, F, G, and H of this part apply to hospitals located in Puerto Rico. Except for § 412.60, which deals with DRG classification and weighting factors, or as otherwise specified, the provisions of subparts D and E, which describe the methodology used to determine prospective payment rates for inpatient operating costs for hospitals, do not apply to hospitals located in Puerto Rico. Instead, the methodology for determining prospective payment rates for inpatient operating costs for these hospitals is set forth in §§ 412.204 through 412.212.

[83 FR 41704, Aug. 17 2018]

§ 412.204 Payment to hospitals located in Puerto Rico.

(a) *FY 1988 through FY 1997.* For discharges occurring on or after October 1, 1987 and before October 1, 1997, payments for inpatient operating costs to hospitals located in Puerto Rico that