

## § 412.150

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

the Secretary. In expanding the applicable conditions, the Secretary will seek endorsement of the entity with a contract under section 1890(a) of the Act, but may apply such measures without such an endorsement in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a) of the Act as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

*Applicable period* is, with respect to a fiscal year, the 3-year period (specified by the Secretary) from which data are collected in order to calculate excess readmission ratios and adjustments under the Hospital Readmissions Reduction Program.

(1) The applicable period for FY 2022 is the 3-year period from July 1, 2017 through June 30, 2020; and

(2) Beginning with the FY 2023 program year, the applicable period is the 3-year period advanced by 1-year from the prior year's period from which data are collected in order to calculate excess readmission ratios and adjustments under the Hospital Readmissions Reduction Program, unless otherwise specified by the Secretary.

*Applicable period for dual eligibility* is the 3-year data period corresponding to the applicable period for the Hospital Readmissions Reduction Program, unless otherwise established by the Secretary.

*Base operating DRG payment amount* is the wage-adjusted DRG operating payment plus any applicable new technology add-on payments under subpart F of this part. This amount is determined without regard to any payment adjustments under the Hospital Value-Based Purchasing Program, as specified under §412.162. This amount does not include any additional payments for indirect medical education under §412.105, the treatment of a disproportionate share of low-income patients under §412.106, outliers under subpart F of this part, and a low volume of discharges under §412.101. With respect to a sole community hospital that receives payments under §412.92(d) this

amount also does not include the difference between the hospital-specific payment rate and the Federal payment rate determined under subpart D of this part. With respect to a Medicare-dependent, small rural hospital that receives payments under §412.108(c), this amount includes the difference between the hospital-specific payment rate and the Federal payment rate determined under subpart D of this part. With respect to a hospital that is paid under section 1814(b)(3) of the Act, this amount is an amount equal to the wage-adjusted DRG payment amount plus new technology payments that would be paid to such hospitals, absent the provisions of section 1814(b)(3) of the Act.

*Dual-eligible*—(1) For payment adjustment factor calculations prior to the FY 2021 program year, is a patient beneficiary who has been identified as having full benefit status in both the Medicare and Medicaid programs in the State Medicare Authorization Act (MMA) files for the month the beneficiary was discharged from the hospital; and

(2) For payment adjustment factor calculations beginning in the FY 2021 program year, is a patient beneficiary who has been identified as having full benefit status in both the Medicare and Medicaid programs in data sourced from the State MMA files for the month the beneficiary was discharged from the hospital, except for those patient beneficiaries who die in the month of discharge, which will be identified using the previous month's data as sourced from the State MMA files.

*Excess readmissions ratio* is a hospital-specific ratio for each applicable condition for an applicable period, which is the ratio (but not less than 1.0) of risk-adjusted readmissions based on actual readmissions for an applicable hospital for each applicable condition to the risk-adjusted expected readmissions for the applicable hospital for the applicable condition.

*Floor adjustment factor* is the value that the readmissions adjustment factor cannot be less than for a given fiscal year. The floor adjustment factor is set at 0.99 for FY 2013, 0.98 for FY 2014, and 0.97 for FY 2015 and subsequent fiscal years.

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*Proportion of dual-eligibles* is the number of dual-eligible patients among all Medicare Fee-for-Service and Medicare Advantage stays during the applicable period.

*Readmission* is the case of an individual who is discharged from an applicable hospital, the admission of the individual to the same or another applicable hospital within a time period of 30 days from the date of such discharge.

*Readmissions adjustment factor* is equal to the greater of:

(1) 1 minus the ratio of the aggregate payments for excess readmissions to aggregate payments for all discharges; or

(2) The floor adjustment factor.

*Wage-adjusted DRG operating payment* is the applicable average standardized amount adjusted for resource utilization by the applicable MS-DRG relative weight and adjusted for differences in geographic costs by the applicable area wage index (and by the applicable cost-of-living adjustment for hospitals located in Alaska and Hawaii). This amount includes an applicable payment adjustment for transfers under § 412.4(f).

[77 FR 53674, Aug. 31, 2012, as amended at 78 FR 50967, Aug. 19, 2013; 83 FR 41704, Aug. 17, 2018; 84 FR 42613, Aug. 16, 2019; 85 FR 59022, Sept. 18, 2020]

### § 412.154 Payment adjustments under the Hospital Readmissions Reduction Program.

(a) *Scope.* This section sets forth the requirements for determining the payment adjustments under the Hospital Readmissions Reduction Program for applicable hospitals to account for excess readmissions in the hospital.

(b) *Payment adjustment.* (1) *General.* To account for excess readmissions, except as provided for in paragraph (d) of this section, an applicable hospital's base operating DRG payment amount is adjusted for each discharge occurring during the fiscal year. The payment adjustment for each discharge is determined by subtracting the product of the base operating DRG payment amount (as defined in § 412.152) for such discharge by the hospital's readmission payment adjustment factor for the fiscal year (determined under paragraph

(c) of this section) from the base operating DRG payment amount for such discharge.

(2) *Special treatment for sole community hospitals.* In the case of a sole community hospital that receives payments under § 412.92(d) based on the hospital-specific rate, the difference between the hospital-specific rate payment and the Federal rate payment determined under subpart D of this part is not affected by this payment adjustment.

(c) *Methodology to calculate the readmissions payment adjustment factor.* A hospital's readmissions payment adjustment factor is the higher of the ratio described in paragraph (c)(1) of this section or the floor adjustment factor set forth in paragraph (c)(2) of this section.

(1) *Ratio.* The ratio is equal to 1 minus the ratio of the aggregate payments for excess readmissions as defined in § 412.152 and the aggregate payments for all discharges as defined in § 412.152.

(2) *Floor adjustment factor.* The floor adjustment factor is:

(i) For FY 2013, 0.99;

(ii) For FY 2014, 0.98; and

(iii) For FY 2015 and subsequent fiscal years, 0.97.

(d) [Reserved]

(e) *Limitations on review.* There is no administrative or judicial review under this subpart of the following:

(1) The determination of base operating DRG payment amounts.

(2) The methodology for determining the adjustment factor under paragraph (c) of this section, including the excess readmissions ratio, aggregate payments for excess readmissions, and aggregate payments for all discharges.

(3) The applicable period.

(4) The neutrality modifier.

(5) The proportion of dual-eligibles.

(6) The applicable conditions.

(f) *Reporting of hospital-specific information.* CMS will make information available to the public regarding readmissions rates of each applicable hospital (as defined in § 412.152) under the Hospital Readmissions Reduction Program.

(1) To ensure that an applicable hospital has the opportunity to review and

submit corrections for its excess readmission ratios for the applicable conditions for a fiscal year that are used to determine its readmissions payment adjustment factor under paragraph (c) of this section, CMS will provide each applicable hospital with confidential hospital-specific reports and discharge level information used in the calculation of its excess readmission ratios.

(2) Applicable hospitals will have a period of 30 days after receipt of the information provided in paragraph (f)(1) of this section to review and submit corrections for the excess readmission ratios for each applicable condition that are used to calculate the readmissions payment adjustment factor under paragraph (c) of this section for the fiscal year.

(3) The administrative claims data used to calculate an applicable hospital's excess readmission ratios for the applicable conditions for a fiscal year are not subject to review and correction under paragraph (f)(1) of this section.

(4) CMS posts the excess readmission ratios for the applicable conditions for a fiscal year for each applicable hospital on the Hospital Compare website or successor website(s).

[77 FR 53674, Aug. 31, 2012, as amended at 78 FR 50967, Aug. 19, 2013; 79 FR 50354, Aug. 22, 2014; 84 FR 42614, Aug. 16, 2019; 86 FR 45520, Aug. 13, 2021]

#### §§ 412.155–412.159 [Reserved]

#### INCENTIVE PAYMENTS UNDER THE HOSPITAL VALUE-BASED PURCHASING PROGRAM

#### § 412.160 Definitions for the Hospital Value-Based Purchasing (VBP) Program.

As used in this section and in §§ 412.161 through 412.168:

*Achievement threshold (or achievement performance standard)* means the median (50th percentile) of hospital performance on a measure during a baseline period with respect to a fiscal year, for Hospital VBP Program measures other than the measures in the Efficiency and Cost Reduction domain, and the median (50th percentile) of hospital performance on a measure during the performance period with respect to

a fiscal year, for the measures in the Efficiency and Cost Reduction domain.

*Applicable percent* means the following:

- (1) For FY 2013, 1.0 percent;
- (2) For FY 2014, 1.25 percent;
- (3) For FY 2015, 1.50 percent;
- (4) For FY 2016, 1.75 percent; and
- (5) For FY 2017 and subsequent fiscal years, 2.0 percent.

*Base operating DRG payment amount* means the following:

(1) With respect to a subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Act), the wage-adjusted DRG operating payment plus any applicable new technology add-on payments under subpart F of this part. This amount is determined without regard to any payment adjustments under the Hospital Readmissions Reduction Program, as specified under § 412.154. This amount does not include any additional payments for indirect medical education under § 412.105, the treatment of a disproportionate share of low-income patients under § 412.106, outliers under subpart F of this part, or a low volume of discharges under § 412.101.

(2) With respect to a Medicare-dependent, small rural hospital that receives payments under § 412.108(c) or a sole community hospital that receives payments under § 412.92(d), the wage-adjusted DRG operating payment plus any applicable new technology add-on payments under subpart F of this part. This amount does not include any additional payments for indirect medical education under § 412.105, the treatment of a disproportionate share of low-income patients under § 412.106, outliers under subpart F of this part, or a low volume of discharges under § 412.101. With respect to a Medicare-dependent, small rural hospital that receives payments under § 412.108(c) (for discharges occurring in FY 2013) or a sole community hospital that receives payments under § 412.92(d), this amount also does not include the difference between the hospital-specific payment rate and the Federal payment rate determined under subpart D of this part.

*Benchmark* means the arithmetic mean of the top decile of hospital performance on a measure during the baseline period with respect to a fiscal

year, for Hospital VBP Program measures other than the measures in the Efficiency and Cost Reduction domain, and the arithmetic mean of the top decile of hospital performance on a measure during the performance period with respect to a fiscal year, for the measures in the Efficiency and Cost Reduction domain.

*Cited for deficiencies that pose immediate jeopardy* means that, during the applicable performance period, the Secretary cited the hospital for immediate jeopardy on at least three surveys using the Form CMS-2567, Statement of Deficiencies and Plan of Correction. CMS assigns an immediate jeopardy citation to a performance period as follows:

(1) If the Form CMS-2567 only contains one or more EMTALA-related immediate jeopardy citations, CMS uses the date that the Form CMS-2567 is issued to the hospital;

(2) If the Form CMS-2567 only contains one or more Medicare conditions of participation immediate jeopardy citations, CMS uses the survey end date generated in ASPEN; and

(3) If the Form CMS-2567 contains both one or more EMTALA-related immediate jeopardy citations and one or more Medicare conditions of participation immediate jeopardy citations, CMS uses the survey end date generated in ASPEN.

*Domain* means a grouping of measures used for purposes of calculating the Total Performance Score for each hospital with respect to a fiscal year.

*Domain score* means the total number of points awarded to a hospital for a domain.

*Health equity adjustment bonus points* means the points that a hospital can earn for a fiscal year based on its performance and proportion of inpatient stays for patients with dual eligibility status.

*Hospital* means a hospital described in section 1886(d)(1)(B) of the Act, but does not include a hospital, with respect to a fiscal year, for which one or more of the following applies:

(1) The hospital is subject to the payment reduction under section 1886(b)(3)(B)(viii)(I) of the Act for the fiscal year;

(2) The Secretary cited the hospital for deficiencies that pose immediate jeopardy to the health or safety of patients during the performance period that applies with respect to the fiscal year;

(3) There are not a minimum number of measures that apply to the hospital for the performance period for the fiscal year; or

(4) There are not a minimum number of cases for the measures that apply to the hospital for the performance period for the fiscal year.

*Immediate jeopardy* has the same meaning as that term is defined in § 489.3 of this chapter.

*Improvement threshold* (or improvement performance standard) means an individual hospital's performance level on a measure during the baseline period with respect to a fiscal year.

*Linear Exchange Function* is the means to translate a hospital's total performance score into a value-based incentive payment percentage such that:

(1) Each eligible hospital's value-based incentive payment percentage is based on its total performance score; and

(2) The total amount of value-based incentive payments to all hospitals in a fiscal year is equal to the total amount available for value-based incentive payments in such fiscal year.

*Measure performance scaler* means the sum of the points awarded to a hospital for each domain for the fiscal year based on the hospital's performance on the measures in those domains.

*Performance period* means the time period during which data are collected for the purpose of calculating hospital performance on measures with respect to a fiscal year.

*Performance standards* are the levels of performance that hospitals must meet or exceed in order to earn points under the Hospital VBP Program, and are calculated with respect to a measure for a fiscal year no later than 60 days prior to the start of the performance period for that measure for that fiscal year. The performance standards for a measure may be updated as follows:

(1) To make a single correction to correct a calculation error, data issue,

or other problem that would significantly change the performance standards; or

(2) To incorporate nonsubstantive technical updates made to the measure between the time that CMS first displays the performance standards for that measure for a fiscal year and the time that CMS calculates hospital performance on that measure at the conclusion of the performance period for that measure for a fiscal year.

*Total Performance Score* means the numeric score awarded to each hospital based on its performance under the Hospital VBP Program with respect to a fiscal year.

*Underserved multiplier* means the mathematical result of applying a logistic function to the number of hospital inpatient stays for patients in the underserved population out of the hospital's total Medicare inpatient population during the calendar year that is 2 years prior to the applicable fiscal year.

*Underserved population*, as used in this section, means hospital inpatients who are Medicare beneficiaries and also dually eligible for full Medicaid benefits during the month of discharge or, if a patient died during that month, during the previous month.

*Value-based incentive payment adjustment factor* is the number that will be multiplied by the base operating DRG payment amount for each discharge from a hospital, during a fiscal year, in order to adjust the hospital's payment as a result of its performance under the Hospital VBP Program.

*Value-based incentive payment percentage* means the percentage of the base operating DRG payment amount for each discharge that a hospital has earned with respect to a fiscal year, based on its Total Performance Score for that fiscal year.

*Wage-adjusted DRG operating payment* is the applicable average standardized amount adjusted for—

(1) Resource utilization by the applicable MS-DRG relative weight;

(2) Differences in geographic costs by the applicable area wage index (and by the applicable cost-of-living adjustment for hospitals located in Alaska and Hawaii); and

(3) Any applicable payment adjustment for transfers under §412.4(f).

[77 FR 53674, Aug. 31, 2012, as amended at 78 FR 50967, Aug. 19, 2013; 79 FR 50354, Aug. 22, 2014; 81 FR 57268, Aug. 22, 2016; 86 FR 45520, Aug. 13, 2021; 88 FR 59333, Aug. 28, 2023]

#### **§412.161 Applicability of the Hospital Value-Based Purchasing (VBP) Program.**

The Hospital VBP Program applies to hospitals, as that term is defined in §412.160.

[79 FR 50355, Aug. 22, 2014]

#### **§412.162 Process for reducing the base operating DRG payment amount and applying the value-based incentive payment amount adjustment under the Hospital Value-Based Purchasing (VBP) Program.**

(a) *General*. If a hospital meets or exceeds the performance standards that apply to the Hospital VBP Program for a fiscal year, CMS will make value-based incentive payments to the hospital under the requirements and conditions specified in this section.

(b) *Value-based incentive payment amount*. (1) *Available amount*. The value-based incentive payment amount for a discharge is the portion of the payment amount that is attributable to the Hospital VBP Program. The total amount available for value based incentive payments to all hospitals for a fiscal year is equal to the total amount of base-operating DRG payment reductions for that fiscal year, as estimated by the Secretary.

(2) *Calculation of the value-based incentive payment amount*. The value-based incentive payment amount is calculated by multiplying the base operating DRG payment amount by the value-based incentive payment percentage.

(3) *Calculation of the value-based incentive payment percentage*. The value-based incentive payment percentage is calculated as the product of all of the following:

(i) The applicable percent as defined in §412.160.

(ii)(A) For fiscal years before FY 2026, the hospital's Total Performance Score divided by 100; or

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(B) Beginning with FY 2026, the hospital's Total Performance Score divided by 110; and

(iii) The linear exchange function slope.

(c) *Methodology to calculate the value-based incentive payment adjustment factor.* The value-based incentive payment adjustment factor for each discharge is determined by subtracting the applicable percent as specified in § 412.160 from the value-based incentive payment percentage and then adding that difference to one.

[77 FR 53674, Aug. 31, 2012, as amended at 88 FR 59333, Aug. 28, 2023]

### **§ 412.163 Process for making hospital-specific performance information under the Hospital Value-Based Purchasing (VBP) Program available to the public.**

(a) CMS will make information available to the public regarding the performance of each hospital under the Hospital VBP Program.

(b) To ensure that a hospital has the opportunity to review and submit corrections for the information to be made public under this section, CMS will provide each hospital with confidential hospital-specific reports and discharge level information used in the calculation of its performance with respect to each measure, condition, and domain, and the calculation of its Total Performance Score.

(c) Hospitals will have a period of 30 days after CMS provides the information specified in paragraph (b) of this section to review and submit corrections for the information.

(d) CMS will post the information specified in paragraph (b) for each hospital on the the *Hospital Compare* website, which can be accessed via the Care Compare website at <https://www.medicare.gov/care-compare/>.

[50 FR 12741, Mar. 29, 1985, as amended at 86 FR 45520, Aug. 13, 2021]

### **§ 412.164 Measure selection under the Hospital Value-Based Purchasing (VBP) Program.**

(a) CMS will select measures, other than measures of readmissions, for purposes of the Hospital VBP Program. The measures will be selected from the measures specified under section

1886(b)(3)(B)(viii) of the Act (the Hospital Inpatient Quality Reporting Program).

(b) CMS will post data on each measure on the *Hospital Compare* website, which can be accessed via the Care Compare website at <https://www.medicare.gov/care-compare/>, for at least 1 year prior to the beginning of a performance period for the measure under the Hospital VBP Program.

(c)(1) *Updating of measure specifications.* CMS uses rulemaking to make substantive updates to the specifications of measures used in the Hospital VBP Program. CMS announces technical measure specification updates through the QualityNet website (<https://qualitynet.cms.gov>) and listserv announcements.

(2) *Measure retention.* All measures selected under paragraph (a) of this section remain in the measure set unless CMS, through rulemaking, removes or replaces them.

(3) *Measure removal factors*—(i) *General rule.* CMS may remove or replace a measure based on one of 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” measures), defined as: statistically indistinguishable performance at the 75th and 90th percentiles; and truncated coefficient of variation  $\leq 0.10$ .

(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) *Application of measure removal factors.* CMS assesses the benefits of removing a measure from the Hospital VBP Program on a case-by-case basis.

(iii) *Patient safety exception.* Upon a determination by CMS that the continued requirement for hospitals to submit data on a measure raises specific patient safety concerns, CMS may elect to immediately remove the measure from the Hospital VBP measure set. CMS will, upon removal of the measure—

(A) Provide notice to hospitals and the public at the time CMS removes the measure, along with a statement of the specific patient safety concerns

that would be raised if hospitals continued to submit data on the measure; and

(B) Provide notice of the removal in the FEDERAL REGISTER.

[77 FR 53674, Aug. 31, 2012, as amended at 83 FR 41704, Aug. 17, 2018; 86 FR 45520, Aug. 13, 2021; 88 FR 59333, Aug. 28, 2023]

**§412.165 Performance scoring under the Hospital Value-Based Purchasing (VBP) Program.**

(a) *Points awarded based on hospital performance.* (1) CMS will award points to hospitals for performance on each measure for which the hospital reports the applicable minimum number of cases during the applicable performance period. The applicable minimum number of cases are set forth as follows:

TABLE 1 TO PARAGRAPH (a)(1)—MINIMUM CASE NUMBER REQUIREMENTS FOR HOSPITAL VBP PROGRAM

Measure short name	Minimum number of cases
<b>Person and Community Engagement Domain</b>	
HCAHPS .....	Hospitals must report a minimum number of 100 completed Hospital Consumer Assessment of Healthcare providers and Systems (HCAHPS) surveys.
<b>Clinical Outcomes Domain</b>	
MORT-30-AMI .....	Hospitals must report a minimum number of 25 cases.
MORT-30-HF .....	Hospitals must report a minimum number of 25 cases.
MORT-30-PN (updated cohort) .....	Hospitals must report a minimum number of 25 cases.
MORT-30-COPD .....	Hospitals must report a minimum number of 25 cases.
MORT-30-CABG .....	Hospitals must report a minimum number of 25 cases.
COMP-HIP-KNEE .....	Hospitals must report a minimum number of 25 cases.
<b>Safety Domain</b>	
CAUTI .....	Hospitals have a minimum of 1,000 predicted infections as calculated by the Centers for Disease Control and Prevention (CDC).
CLABSI .....	Hospitals have a minimum of 1,000 predicted infections as calculated by the CDC.
Colon and Abdominal Hysterectomy SSI .....	Hospitals have a minimum of 1,000 predicted infections as calculated by the CDC.
MRSA Bacteremia .....	Hospitals have a minimum of 1,000 predicted infections as calculated by the CDC.
CDI .....	Hospitals have a minimum of 1,000 predicted infections as calculated by the CDC.
SEP-1 .....	Hospitals must report a minimum number of 25 cases.
<b>Efficiency and Cost Reduction Domain</b>	
MSPB .....	Hospitals must report a minimum number of 25 cases.

(2) CMS will award from 1 to 9 points for achievement to each hospital whose performance on a measure during the applicable performance period meets or exceeds the achievement threshold but is less than the benchmark for that measure.

(3) CMS will award from 0 to 9 points for improvement to each hospital whose performance on a measure during the applicable performance period exceeds the improvement threshold but is less than the benchmark for that measure.

(4) CMS will award 10 points to a hospital whose performance on a measure during the applicable performance period meets or exceeds the benchmark for that measure.

(b) *Calculation of the Total Performance Score.* The hospital's Total Performance Score for a program year is calculated as follows:

(1) CMS will calculate a domain score for a hospital when it reports the minimum number of measures in the domain.

(2) CMS will sum all points awarded for each measure in a domain to calculate an unweighted domain score.

(3) CMS will normalize each domain score to ensure that it is expressed as a percentage of points earned out of 100.

(4) CMS will weight the domain scores with the finalized domain weights for each fiscal year.

(5) Beginning with FY 2026, CMS will calculate the number of health equity adjustment bonus points the hospital has earned for the fiscal year as follows:

(i) Calculating the measure performance scaler for each domain in which the hospital reported the minimum number of cases by—

(A) Awarding 4 points where the hospital's performance on the domain for the fiscal year meets or exceeds the top third of performance of all hospitals on the domain for the same fiscal year;

(B) Awarding 2 points where the hospital's performance on the domain for the fiscal year meets or exceeds the middle third of performance, but is less than the top third of performance, of all hospitals on the domain for the same fiscal year;

(C) Awarding 0 points where the hospital's performance on the domain is less than the middle third of performance of all hospitals on the domain for the fiscal year; and

(D) Summing the points awarded under paragraph (b)(5)(i) of this section to calculate the measure performance scaler for the hospital.

(ii) Calculating the underserved multiplier for the hospital.

(iii) Multiplying the measure performance scaler calculated under paragraph (b)(5)(i) of this section by the underserved multiplier and, if the result-

ing product is greater than 10, capping that product at 10.

(6) The hospital's Total Performance Score for the fiscal year is as follows:

(i) For fiscal years before FY 2026, the sum of the weighted domain scores up to a maximum score of 100.

(ii) Beginning with FY 2026, the sum of the weighted domain scores and the health equity adjustment bonus points up to a maximum score of 110.

(c) *Extraordinary circumstances exception.* (1) A hospital may request and CMS may grant exceptions to the Hospital VBP Program's requirements under this section when there are certain extraordinary circumstances beyond the control of the hospital.

(2) A hospital may request an exception within 90 calendar days of the date that the extraordinary circumstances occurred by submitting a completed Extraordinary Circumstances Request Form (available on the Hospital Value-Based Purchasing (HVBP) Program section of the QualityNet website (<https://qualitynet.cms.gov/>)), and any available evidence of the impact of the extraordinary circumstances on the hospital's quality measure performance. The form must be sent via secure file transfer via the *QualityNet Secure portal*, secure fax, email, or conventional mail.

(3) Following receipt of the request form, CMS will provide a written acknowledgement using the contact information provided in the request, to the CEO and any additional designated personnel, notifying them that the hospital's request has been received, and provide a written response to the CEO and any additional designated personnel using the contact information provided in the request.

(4) CMS may grant an exception to one or more hospitals that have not requested an exception if CMS determines that an extraordinary circumstance has affected an entire region or locale, which may include the entire United States. CMS will notify hospitals that it has granted an exception under this paragraph via multiple methods, which may include memos,

emails, and notices posted on the public QualityNet website (<https://qualitynet.cms.gov/>).

[50 FR 12741, Mar. 29, 1985, as amended at 85 FR 27621, May, 8, 2020; 86 FR 45520, Aug. 13, 2021; 88 FR 59333, Aug. 28, 2023]

**§ 412.167 Appeal under the Hospital Value-Based Purchasing (VBP) Program.**

(a) A hospital may appeal the following issues:

(1) CMS' decision to deny a hospital's correction request that the hospital submitted under the review and corrections process;

(2) Whether the achievement/improvement points were calculated correctly;

(3) Whether CMS properly used the higher of the achievement/improvement points in calculating the hospital's measure/dimension score;

(4) Whether CMS correctly calculated the domain scores, including the normalization calculation;

(5) Whether CMS used the proper lowest dimension score in calculating the hospital's HCAHPS consistency points;

(6) Whether CMS calculated the HCAHPS consistency points correctly;

(7) Whether the correct domain scores were used to calculate the Total Performance Score;

(8) Whether each domain was weighted properly;

(9) Whether the weighted domain scores were properly summed to arrive at the Total Performance Score; and,

(10) Whether the hospital's open/closed status (including mergers and acquisitions) is properly specified in CMS' systems.

(b) Appeals must be submitted within 30 days of CMS' decision to deny a corrections request under § 412.163 or within 30 days of the conclusion of the review and corrections period, as applicable, and must contain the following information:

(1) Hospital's CMS Certification Number (CCN).

(2) Hospital name.

(3) Hospital's basis for requesting an appeal. This must identify the hospital's specific reason(s) for appealing the hospital's Total Performance Score or performance assessment with respect to the performance standards.

(4) CEO contact information, including name, email address, telephone number, and mailing address (must include the physical address, not just the post office box).

(5) QualityNet security official contact information, including name, email address, telephone number, and mailing address (must include the physical address, not just the post office box).

(c) If a hospital is dissatisfied with CMS' decision on an appeal request submitted under paragraph (b) of this section, the hospital may request an independent CMS review of that decision.

(d) *Limitations on review.* There is no administrative or judicial review of the following:

(1) The methodology used to determine the amount of the value-based incentive payment under section 1886(o)(6) of the Act and the determination of such amount.

(2) The determination of the amount of funding available for value-based incentive payments under section 1886(o)(7)(A) of the Act and the payment reduction under section 1886(o)(7)(B)(i) of the Act.

(3) The establishment of the performance standards under section 1886(o)(3) of the Act and the performance period under section 1886(o)(4) of the Act.

(4) The measures specified under section 1886(b)(3)(B)(viii) of the Act and the measures selected under section 1886(o)(2) of the Act.

(5) The methodology developed under section 1886(o)(5) of the Act that is used to calculate hospital performance scores and the calculation of such scores.

(6) The validation methodology that is specified under section 1886(b)(3)(B)(viii)(XI) of the Act.

[50 FR 12741, Mar. 29, 1985, as amended at 78 FR 75196, Dec. 10, 2013; 86 FR 45520, Aug. 13, 2021]

**§ 412.168 Special rules for FY 2022 and FY 2023.**

(a) This section sets forth the scoring and payment methodology for each of fiscal years 2022 and 2023 Hospital VBP Program.

(b) CMS calculates a measure rate for all measures selected under § 412.164(a)

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for fiscal year 2022 but only applies § 412.165(a) to the measures included in the Clinical Outcomes Domain for that fiscal year, which are the following:

(1) Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction (AMI) Hospitalization (MORT-30-AMI).

(2) Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure (HF) Hospitalization (MORT-30-HF).

(3) Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization (MORT-30-PN (updated cohort)).

(4) Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization (MORT-30-COPD).

(5) Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Coronary Artery Bypass Graft (CABG) Surgery (MORT-30-CABG).

(6) Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (COMP-HIP-KNEE).

(c) CMS calculates a domain score for the measures described in paragraph (b)(1) of this section for hospitals that report the minimum number of measures in the Clinical Outcomes Domain.

(d) CMS does not award a Total Performance Score to any hospital.

(e) The total amount available for value-based incentive payments for fiscal year 2022 is equal to the total amount of base-operating DRG payment reductions for that fiscal year, as estimated by the Secretary.

(f) CMS awards value-based incentive payment percentages (as defined in § 412.160) for all hospitals to ensure that each hospital receives an incentive payment amount equal to the amount of the reduction made to its base-operating DRG payment amounts.

(g) CMS calculates a measure rate for all measures selected under § 412.164(a) for fiscal year 2023 but only applies § 412.165(a) to the measures included in the Clinical Outcomes Domain and the Efficiency and Cost Reduction Domain for that fiscal year, which are the following:

(1) Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction (AMI) Hospitalization (MORT-30-AMI).

(2) Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure (HF) Hospitalization (MORT-30-HF).

(3) Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization (MORT-30-PN (updated cohort)).

(4) Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization (MORT-30-COPD).

(5) Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Coronary Artery Bypass Graft (CABG) Surgery (MORT-30-CABG).

(6) Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (COMP-HIP-KNEE).

(7) Medicare Spending Per Beneficiary (MSPB)—Hospital.

(h) CMS calculates—

(1) A Clinical Outcomes Domain score for fiscal year 2023 for hospitals that report the minimum number of cases and measures with respect to the measures described in paragraphs (g)(1) through (6) of this section; and

(2) An Efficiency and Cost Reduction Domain score for fiscal year 2023 for hospitals that report the minimum number of cases with respect to the measure described in paragraph (g)(7) of this section.

(i) CMS does not award a Total Performance Score to any hospital for fiscal year 2023.

(j) The total amount available for value-based incentive payments for fiscal year 2023 is equal to the total amount of base-operating DRG payment reductions for that fiscal year, as estimated by the Secretary.

(k) CMS awards a value-based incentive payment percentage (as defined in § 412.160) for fiscal year 2023 to all hospitals to ensure that each hospital receives a value-based incentive payment

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