

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 ≤ 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.