

(iii) *Application of measure removal factors.* The benefits of removing a 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; 89 FR 69912, Aug. 28, 2024]

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-Acquired 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.

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