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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)

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

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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.

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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.