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, 20191 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