On April 27, 2021, the Centers for Medicare & Medicaid Services (CMS) released the Fiscal Year (FY) 2022 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) Proposed Rule. The proposed rule provides for a 60-day comment period, which will be followed by a final rule expected around August 1, 2021. Provisions of the final rule would take effect on October 1, 2021. A link to the rule can be found at: https://www.govinfo.gov/content/pkg/FR-2021-05-10/pdf/2021-08888.pdf

Proposed Changes to Hospital Payment Rates – CMS is proposing a 2.8% increase in operating payments for hospitals that successfully participate in Medicare’s Hospital Inpatient Quality Reporting Program and that are meaningful electronic health record users. Due to the impact of COVID-19 on hospital admissions in FY 2020, CMS is proposing to use 2019 claims data to determine payment rates.

Graduate Medical Education - The Proposed Rule includes changes required in the Consolidated Appropriations Act of 2021, including three provisions related to payments for Graduate Medical Education (GME).

First, CMS proposes to fund and distribute 1,000 new medical residency positions starting in FY 2023, with up to 200 slots distributed per year. No hospital can receive more than 1.0 full-time equivalent (FTE) under the program. To qualify, hospitals must (1) be in rural areas; (2) have more residents than their current cap; (3) be located in states with new medical schools or new branches of existing medical schools; or (4) serve areas designated as Health Professional Shortage Areas (HPSAs).

CMS proposes two approaches for prioritizing hospitals for additional residency slots. Under the first approach, CMS would prioritize hospitals with the highest HPSA scores. Hospitals which do not serve HPSAs are not categorically excluded from applying for residency positions, however those applications would have the lowest priority. Under the second approach, CMS would prioritize hospitals that qualify under more than one of the four categories listed above. Applications for additional residents are due by January 31 of the preceding fiscal year. CMS estimates that this proposal will cost Medicare approximately $1.830 billion from FY 2023 through FY 2031.

Second, CMS proposes changes to the Promoting Rural Hospital GME Funding Opportunity to provide an increase to the GME cap for hospitals which establish Rural Training Track Programs. CMS estimates this proposal will cost of approximately $0.130 billion from FY 2024 through FY 2031.

Third, CMS proposes to allow hospitals with extremely low per resident amounts (PRAs) and with less than 3.0 FTEs on their cost report (starting Oct. 1, 1997 to Dec. 27, 2020) to reset and establish new PRAs for direct graduate medical education (DGME) payments if the hospital
begins training resident(s) in a cost reporting period beginning on or after December 27, 2020 and before December 26, 2025. (In general, Medicare direct GME payments are calculated by multiplying the hospital’s PRA by the weighted number of FTE residents working at the hospital, and the hospital’s Medicare share of total inpatient days.) These same hospitals also may establish new resident caps for DGME and indirect medical education. CMS estimates this proposal will cost approximately $1.380 billion from FY 2022 through FY 2031.

**Rate Setting for Immunotherapy** – In the FY 2021 IPPS Final Rule, CMS created a new MS-DRG for Chimeric Antigen Receptor (CAR) T-cell immunotherapy and set the payment at $373,000, the list price for Kymriah and Yescarta. In the proposed rule, CMS is proposing to add other immunotherapies (see chart below) to MS-DRG 018 and update the MS-DRG name to "Chimeric Antigen Receptor (CAR) T-cell and Other Immunotherapies" to account for the changes proposed for FY 2022. Base payment for MS-DRG 018 is proposed to remain at the FY 2021 rate of $373,000.

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<th>ICD-10-PCS Code</th>
<th>Description</th>
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<tr>
<td>XW033C7</td>
<td>Introduction of autologous engineered chimeric antigen receptor t-cell immunotherapy into peripheral vein, percutaneous approach, new technology group 7</td>
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<tr>
<td>XW033G7</td>
<td>Introduction of allogeneic engineered chimeric antigen receptor t-cell immunotherapy into peripheral vein, percutaneous approach, new technology group 7</td>
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<td>Introduction of autologous engineered chimeric antigen receptor t-cell immunotherapy into central vein, percutaneous approach, new technology group 7</td>
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New Technology Add-On Payment Provisions – As part of this rule, CMS instituted a process of identifying and ensuring adequate payment for new medical services and technologies. A new medical service or technology may be considered for new technology add-on payment (NTAP) if, based on the estimated costs incurred with respect to discharges involving such service or technology, the DRG prospective payment rate otherwise applicable to such discharges under this subsection is inadequate. The NTAP is provided for a 2 - 3-year period, which would provide adequate time for the cost of the new technologies to be incorporated into the MS-DRG base payment rate.

The rule includes three lists of services and technologies where NTAP payment will be provided in 2022 or is proposed in 2022. Each list includes technologies of interest to hematologists:

1. Services and technologies that are in their second year of receiving NTAP will receive the same NTAP as is FY 2021.
2. Services and technologies that will receive an additional year of NTAP to account for the impact of COVID-19 on hospital admissions will receive the same NTAP as FY 2021.
3. Services and technologies applying for NTAP for the first time, including:
   a. Breyanzi (June Therapeutics) for large B-cell Lymphoma
   b. Ciltacabtagene autoleucel (Janssen) for Multiple Myeloma
   c. ABECMA (Celgene) for Multiple Myeloma
   d. Tecartus (Kite Pharma) for Mantle Cell Lymphoma

Request for Information on Closing the Health Equity Gap in CMS Quality Programs -
CMS is requesting information on its Equity Plan for Improving Quality in Medicare. The Equity Plan outlines ideas to improve data collection to better measure and analyze disparities across programs and policies.

Stratification of Existing Quality Measures by Social Factors
Currently, in its Hospital Readmissions Reduction Program, CMS provides results from the CMS Disparity Methods in confidential reports to hospitals. Under the Disparity Methods, CMS
stratifies six condition/procedure specific readmission measures\(^1\) by beneficiaries’ dual eligibility for Medicaid and Medicare status. CMS now proposes to expand stratification of these six measures by race and ethnicity.

Similarly, under its Hospital Inpatient Quality Reporting Program, CMS proposes creation of a new confidential, stratified report for the Hospital-Wide All-Cause Unplanned Readmission Measure (NQF# 1789) using dual eligibility and race and ethnicity. CMS also is considering stratifying the Hospital-Wide All-Cause Unplanned Readmission Measure by disability status and is seeking suggestions for appropriate measures of disability status that could be derived from administrative data or self-reporting. Initially, the reports described above would be confidential. However, CMS discusses making them public on the Care Compare website in the future following additional rulemaking.

Feedback on Demographic Data Collection
CMS is soliciting comments on current data collection practices by hospitals to capture demographic data elements (e.g., race, ethnicity, sex, sexual orientation, gender identity, language preference, tribal membership, and disability status). CMS is interested in potential challenges facing hospital collection, at the time of admission, of a minimum set of demographic data elements in alignment with national data collection standards.

New Quality Measures Related to Health Equity
CMS also is interested in creating two new, broader measures of health equity in Medicare.

First, CMS proposes development of a Hospital Equity Score, modeled off the Health Equity Summary Score used for Medicare Advantage plans, for hospitals. The Hospital Equity Score would be adapted to the context of risk-adjusted hospital outcome measures and summarize performance in the CMS Disparity methods described above, but also potentially include other hospital quality measures used by CMS programs.

Second, CMS proposes establishing a structural measure to assess the degree of hospital leadership’s engagement in health equity performance data. Data collection would include attestation-based metrics and CMS requests feedback on measurement priorities for better illuminating organizational commitment to health equity.

\(^1\) (1) Pneumonia Readmission measure (NQF#0506) (2) Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Acute Myocardial Infarction (AMI) Hospitalization (NQF #0505) (AMI Readmission measure); (3) Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Coronary Artery Bypass Graft (CABG) Surgery (NQF #2515) (CABG Readmission measure); (4) Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization (NQF #1891) (COPD Readmission measure); (5) Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Heart Failure (HF) Hospitalization (NQF #0330) (HF Readmission measure); and (6) Hospital-Level 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #1551) (THA/TKA Readmission measure)