CMS Releases the FY 2022 Hospital Inpatient Prospective Payment System Final Rule

On Aug. 2, 2021, the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FY) 2022 Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) final rule. The final rule updates Medicare payment policies and rates for operating and capital-related costs of acute care hospitals and for certain hospitals and hospital units excluded from the IPPS for FY 2022. CMS received more than 6,500 public comments based on the proposed rule. The final rule is effective Oct. 1, 2021.

CMS pays acute care hospitals for inpatient stays under the IPPS. The agency sets base payment rates prospectively for inpatient stays based on the patient's diagnosis and severity of illness. Law requires CMS to update payment rates for IPPS hospitals annually and to account for changes in the prices of goods and services used by hospitals treating Medicare patients. The increase in operating payment rates for general acute care hospitals paid under IPPS that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful electronic health record (EHR) users is approximately 2.5%. CMS estimates hospital payments will increase by $2.3 billion for FY 2022.

The FY 2022 IPPS proposed rule addressed several provisions relating to direct graduate medical education (GME). The Consolidated Appropriations Act, 2021 (CAA) contained three provisions affecting Medicare direct GME and indirect medical education (IME) payments to teaching hospitals:

- Section 126 of the CAA makes available 1,000 new Medicare-funded GME positions, but not more than 200 new positions for a fiscal year, to be distributed beginning in FY 2023, with priority given to specific hospitals categories.
- Section 127 of the CAA makes statutory changes relating to the determination of both an urban and rural hospital's FTE resident limit for direct GME and IME payment purposes with regard to residents training in an accredited rural training track (RTT), and the three-year rolling average set out at section 1886(h)(4)(G)(i) of the Act used to calculate payments for these hospitals.
- Section 131 of the CAA makes statutory changes to the determination of direct GME per resident amounts (PRAs) and direct GME and IME FTE resident limits of hospitals that hosted a small number of residents for a short duration.

Based on the extensive comments, CMS intends to address these policies and associated comments in a separate document.

In this final rule, CMS approved 19 technologies that applied for new technology add-on payments (NTAP) for FY 2022. This includes nine technologies under the alternative pathway for new medical devices that are part of the U.S. Food and Drug Administration (FDA) Breakthrough Devices Program and two technologies approved under the alternative pathway for products that received FDA Qualified Infectious Disease Product (QIDP) designation. After CMS's consideration of public comments, the agency also approved seven technologies submitted under the traditional new technology add-on payment pathway criteria.

CMS did not approve the NTAP application for Aidoc Briefcase for PE as the agency found that they did not meet the substantial clinical improvement requirement. When responding to comments, CMS noted they will continue to consider how technologies may be used to identify a unique mechanism of action; how updates to artificial intelligence (AI), an algorithm or software would affect an already approved technology or a competing technology; whether software changes for an already approved technology could be considered a new mechanism of action; and whether an improved algorithm by competing technologies would represent a unique mechanism of action if the outcome is the same as an already approved AI new technology.