CHAPTER 3

Hospital inpatient and outpatient services

RECOMMENDATION

3 For fiscal year 2025, the Congress should update the 2024 Medicare base payment rates for general acute care hospitals by the amount specified in current law plus 1.5 percent.

In addition, the Congress should:

- begin a transition to redistribute disproportionate share hospital and uncompensated care payments through the Medicare Safety-Net Index (MSNI);
- add $4 billion to the MSNI pool;
- scale fee-for-service MSNI payments in proportion to each hospital's MSNI and distribute the funds through a percentage add-on to payments under the inpatient and outpatient prospective payment systems; and
- pay commensurate MSNI amounts for services furnished to Medicare Advantage (MA) enrollees directly to hospitals and exclude them from MA benchmarks.

COMMISSIONER VOTES: YES 15 • NO 0 • NOT VOTING 2 • ABSENT 0

CHAPTER 3

Hospital inpatient and outpatient services

Chapter summary

General acute care hospitals (ACHs) primarily provide inpatient and outpatient services. To pay these hospitals for the facility share of providing services, fee-for-service (FFS) Medicare generally sets prospective payment rates under the inpatient prospective payment systems (IPPS) and the outpatient prospective payment system (OPPS). In 2022, the FFS Medicare program and its beneficiaries spent nearly $180 billion on IPPS and OPPS services at general ACHs, including $7.1 billion in uncompensated care payments made under the IPPS.

Assessment of payment adequacy

During the most recent year of data available, indicators regarding the adequacy of FFS Medicare payments to hospitals were mixed. Overall, general ACHs continued to have the capacity to care for FFS Medicare beneficiaries and a financial incentive to serve them; FFS Medicare beneficiaries' inpatient mortality and readmission rates improved; and investor demand for hospital bonds remained strong. However, in fiscal year (FY) 2022, the aggregate all-payer operating margin among ACHs paid under the IPPS fell to the lowest level since 2008, and their overall FFS Medicare margin across service lines declined to a record low, both in aggregate and for relatively efficient hospitals. These low all-payer and

In this chapter

FFS Medicare margins were largely driven by higher-than-expected input price inflation in 2022.

Beneficiaries' access to care—Indicators of beneficiaries' access to hospital inpatient and outpatient care were generally positive.

- ***Capacity and supply of providers—***In FY 2022, 67 percent of all general ACH beds were occupied by patients receiving inpatient, swing, or observation services, indicating that hospitals had available capacity in aggregate, though there was variation across hospitals. In addition, the number of inpatient beds remained stable, hospital employment increased, and the number of general ACHs that closed was similar to the number that opened. In 2023, hospital employment continued to grow; however, more ACHs closed than opened (18 vs. 11, respectively), with many of the hospitals citing declining patient volume as one of the reasons for closing. The number of closures would likely have been higher if not for a new Medicare policy—the rural emergency hospital (REH) designation—that allows hospitals to convert from full-service hospitals to REHs, preserving beneficiaries' access to emergency and hospital outpatient services.
- ***Volume of services—***The volume of both inpatient and outpatient services per FFS Medicare beneficiary declined from 2021 to 2022. This change, however, primarily reflects shifts in the setting where care is provided and declines in COVID-19 care rather than a decrease in beneficiary access to hospital care. In particular, joint replacement procedures continued to shift from inpatient to outpatient settings, and hospital emergency department visits continued to shift to urgent care centers. In addition, fewer beneficiaries were hospitalized with respiratory infections, and fewer COVID-19 vaccines and tests were provided in hospital outpatient departments.
- ***FFS Medicare marginal profit—***Hospitals' FFS Medicare marginal profit on IPPS and OPPS services declined from 2021 to 2022, but remained positive at 5 percent in aggregate, indicating that hospitals with available capacity continued to have a financial incentive to provide hospital inpatient and outpatient services to FFS Medicare beneficiaries.

Quality of care—In 2022, FFS Medicare beneficiaries' risk-adjusted hospital mortality rate improved relative to pandemic highs, falling to the level in 2019 (8.1 percent). FFS Medicare beneficiaries' risk-adjusted readmission rate also improved, to 14.7 percent, slightly lower than the rate in 2021 and about a percentage point better than the rates in the immediate prepandemic period.

However, most patient experience measures remained below prepandemic levels by several percentage points.

Providers' access to capital—From 2021 to 2022, IPPS hospitals' aggregate all-payer operating margin declined over 6 percentage points, reflecting both a decline in federal coronavirus relief funds and higher-than-expected inflation. IPPS hospitals' all-payer operating margin fell to 2.7 percent when including federal relief funds—the lowest level since 2008—and 1.9 percent exclusive of these funds. In addition, preliminary data from large hospital systems suggest that hospitals' aggregate all-payer operating margin remained below prepandemic levels in 2023. Hospitals' borrowing costs also increased in 2022 and 2023; however, this growth was slower than that of the general market, indicating continued investor demand for hospital bonds.

FFS Medicare payments and providers' costs—From 2021 to 2022, IPPS hospitals' overall FFS Medicare margin (across inpatient, outpatient, and certain other service lines) declined over 5 percentage points to a record low of −11.6 percent when including the FFS Medicare share of federal coronavirus relief funds (and declined to −12.7 percent exclusive of these funds). This decline was largely driven by input price inflation exceeding the market basket update, as well as a decline in federal coronavirus relief funds, an increase in high-cost outlier stays, and a decrease in Medicare uncompensated care payments. Nonetheless, some hospitals achieved much lower costs while still performing relatively well on a specified set of quality metrics. We refer to the subset of hospitals that meet a mix of cost and quality criteria as "relatively efficient"; the median FFS Medicare margin among these relatively efficient hospitals was about −2 percent when including relief funds (and −3 percent exclusive of these funds). In FY 2024, hospitals that participate in the 340B drug payment program are scheduled to receive $9 billion in remedy payments to correct for underpayments in calendar years 2018 to 2021. Including these one-time payments, we project that IPPS hospitals' aggregate FFS Medicare margin across service lines in 2024 will increase to −8 percent. However, excluding these one-time remedy payments, we project that IPPS hospitals' aggregate FFS Medicare margin will be about −13 percent, which, exclusive of federal coronavirus relief funds, is similar to the level in 2022. Similarly, we project the median FFS Medicare margin among our relatively efficient hospital group will remain at about −3 percent.

How should FFS Medicare payment change in 2025?

The current-law updates to payment rates for 2025 will not be finalized until summer 2024, but CMS's third-quarter 2023 forecasts and other required updates are currently projected to increase the IPPS and OPPS base rates by slightly less than 3 percent.

The recent volatility in hospital profit margins makes it particularly difficult to assess how FFS Medicare payments should change. Since the start of the coronavirus pandemic in 2020, hospitals' FFS Medicare margin reached a recent high in 2021 followed by a record low in 2022. Hospitals' all-payer operating margin has also fluctuated dramatically, driven by substantial federal coronavirus relief funds followed by substantial inflation that put cost pressure on hospitals.

After evaluating and discussing the payment adequacy indicators listed above, the Commission recommends that, for fiscal year 2025, the Congress increase base hospital payment rates for all hospitals and direct an enhanced pool of special payments to hospitals with high shares of Medicare patients, particularly low-income Medicare patients. These actions are conceptually and directionally consistent with the Commission's 2023 recommendation. However, given the worsened financial circumstances in 2022 and the approximately $3 billion decline in existing Medicare disproportionate share hospital and uncompensated care payments from 2019 to 2024, the Commission contends that all hospitals—and in particular those serving large shares of low-income Medicare patients—warrant greater support than the Commission recommended last year. Thus, the Commission recommends that the Congress update the 2024 Medicare base payment rates for general ACHs by the amount reflected in current law plus 1.5 percent; at the same time, the Congress should begin a transition to redistribute existing safety-net payments to hospitals using the Commission's Medicare Safety-Net Index (MSNI) and increase the MSNI pool by $4 billion (which would be distributed to hospitals for both their FFS and MA patients). This recommendation would better target limited Medicare resources toward those hospitals that are key sources of care for low-income Medicare beneficiaries and are facing particularly significant financial challenges. ■

Background

General acute care hospitals (ACHs) primarily provide inpatient care and various outpatient services. To pay these hospitals for the facility share of inpatient and outpatient services, fee-for-service (FFS) Medicare generally sets prospective payment rates under the inpatient prospective payment systems (IPPS) and outpatient prospective payment system (OPPS).[1] (Clinicians who provide services at hospitals are paid separately under the physician fee schedule.) In setting these prospective rates per inpatient stay or primary outpatient service, CMS adjusts IPPS and OPPS national base payment rates for factors generally outside of hospitals' control, such as regional wage rates and patient characteristics. Both the IPPS and OPPS also include separate payments not tied to the base payment rates. The IPPS includes uncompensated care payments to help support hospitals' costs of treating the uninsured. The OPPS sets payments for separately payable drugs based on the manufacturer's average sales price. In 2022, the FFS Medicare program and its beneficiaries spent nearly $180 billion on IPPS and OPPS services at general ACHs, including $7.1 billion in uncompensated care payments made under the IPPS and $19.1 billion for separately payable drugs (Table 3-1).[2] FFS beneficiaries' cost-sharing liability totaled 7 percent of hospital inpatient payments and 17 percent of outpatient payments.

The IPPS and OPPS payment rates affect more than FFS Medicare payments for general ACHs. Within the FFS Medicare program, the OPPS is used to pay for outpatient services at certain specialty hospitals and other facilities.[3] But more important, most Medicare Advantage (MA) plans pay IPPS hospitals using rates benchmarked to FFS Medicare rates (Berenson et al. 2015, Maeda and Nelson 2017), and hospitals must accept FFS rates for MA enrollees seeking care out of their plan's network. In addition, states have increasingly used FFS Medicare payments to hospitals to set rates in their state employee or state public option plans. Montana, Oregon, and North Carolina offer state employee health plans that are

TABLE 3–1

In 2022, FFS Medicare spent nearly $180 billion on IPPS and OPPS services at general acute care hospitals

	Medicare payment system	
	IPPS	**OPPS**
Number of hospitals	3,160	3,090
Number of users (in millions)	4.3	16.3
Volume of services (in millions)	6.6	127.4
Total Medicare payments (in billions)	$111.0	$68.8
Payments for base-rate-covered services	$103.9	$49.7
Other payments*	$7.1	$19.1
Beneficiary cost-sharing liability as share of total Medicare payments	7.1%	17%

Note: FFS (fee-for-service), IPPS (inpatient prospective payment systems), OPPS (outpatient prospective payment system). The number of general acute care hospitals that provided IPPS services is higher than the number that provided OPPS services primarily because Indian Health Services are paid under the IPPS but not OPPS. OPPS services at and payments to post-acute care and other specialty hospitals are not included. "Total Medicare payments" includes the program amount and beneficiary cost-sharing liability (which may be paid by the beneficiary, the beneficiaries' supplemental insurance, or become hospital bad debt). The given year (2022) refers to fiscal year for inpatient services and calendar year for outpatient services.
*In the case of the IPPS, "other payments" refers to uncompensated care payments. In the case of the OPPS, "other payments" refers to payments for separately payable drugs, devices, blood products, and brachytherapy sources.

Source: MedPAC analysis of Medicare Provider Analysis and Review data, IPPS final rule, and outpatient claims data.

benchmarked to FFS Medicare rates (North Carolina State Health Plan 2021, Schramm and Aters 2021). Likewise, Washington, Colorado, and Nevada offer state public option plans that are benchmarked to FFS Medicare rates (Washington State Health Care Authority 2020, Colorado Department of Regulatory Agencies 2021, Nevada Department of Health and Human Services 2021). Given the widespread use of FFS Medicare payment rates as benchmarks, any update to the FFS Medicare base payment amount affects many other payers (White et al. 2013).

Are FFS Medicare payments adequate in 2024?

Based on the most recent available data, indicators have been mixed regarding the adequacy of FFS Medicare payments to hospitals. General ACHs continued to have the capacity to care for FFS Medicare beneficiaries and a financial incentive to serve them; FFS Medicare beneficiaries' inpatient mortality and readmission rates improved; and investor demand for hospital bonds remained strong. However, in fiscal year (FY) 2022, IPPS hospitals' aggregate all-payer operating margin fell to the lowest level since 2008, and their overall FFS Medicare margin across service lines declined to a record low, both in aggregate and for relatively efficient hospitals. These low all-payer and FFS Medicare margins were largely driven by higher-than-expected input price inflation in 2022.

In 2024, hospitals that participate in the 340B drug payment program are scheduled to receive $9 billion in remedy payments to correct for underpayments in calendar years 2018 to 2021. We project that, including these one-time payments, IPPS hospitals' aggregate FFS Medicare margin across service lines will increase to a level higher than what was observed in the immediate prepandemic period. However, if we exclude these one-time remedy payments, we project that IPPS hospitals' aggregate FFS Medicare margin in 2024 will be about –13 percent, which is similar to the level in 2022 when excluding federal coronavirus relief funds. Similarly, we project that the median FFS Medicare margin among relatively efficient hospitals will remain at about –3 percent.

Beneficiaries maintained good access to hospital inpatient and outpatient services in 2022

In FY 2022, 67 percent of all general ACH beds were occupied by patients receiving inpatient, swing, or observation services, indicating that hospitals had available capacity in aggregate.[4] In addition, in 2022, the number of inpatient beds remained stable, hospital employment increased, and the number of general ACHs that closed was similar to the number that opened. In 2023, hospital employment continued to grow; however, more ACHs closed than opened (18 vs. 11, respectively), with many of the hospitals citing declining patient volume as one of the reasons for closing.

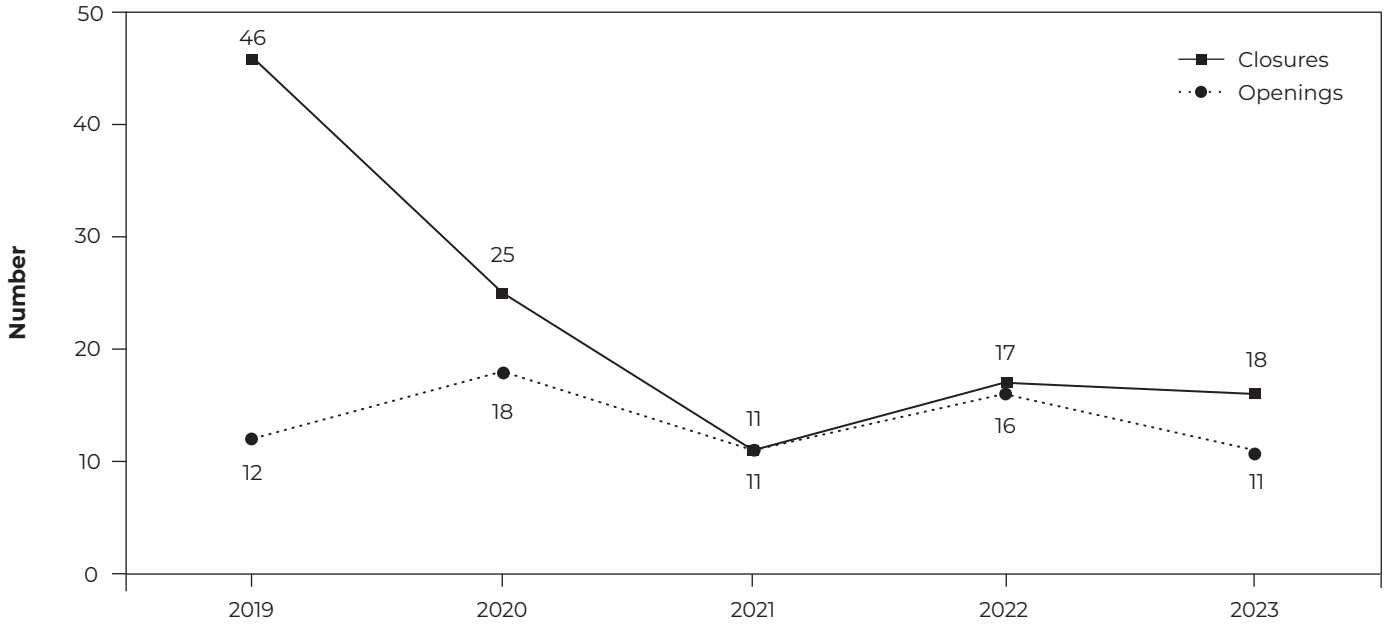
Adequate hospital capacity in aggregate, but considerable variation

Trends in three metrics suggest that the capacity of general ACHs remained adequate in aggregate to provide inpatient and outpatient hospital services to FFS Medicare beneficiaries:

- ***The number of inpatient beds remained steady.*** From FY 2021 to FY 2022, the number of inpatient beds at general ACHs was steady at nearly 650,000.
- ***Hospitals had available capacity.*** In 2022, 67 percent of all general ACH beds were occupied by a patient receiving inpatient, swing, or observation services.[5] This figure is slightly higher than in prior years but indicates available capacity in aggregate.
- ***Hospital employment increased.*** After declining in 2020, hospital employment has consistently grown each year; by 2022, it had rebounded above the levels in the immediate prepandemic period. In 2023, hospital employment grew an additional 3 percent to over 6.4 million employees (Bureau of Labor Statistics 2023).[6]

However, consistent with past years, capacity varied considerably across hospitals, with some nearing capacity while others had excess capacity. For example, in 2022, 5 percent of hospitals had occupancy rates of over 85 percent while 5 percent had occupancy rates below 15 percent. These hospitals with significant excess capacity were more likely to be small rural hospitals, while those with higher occupancy rates were more likely to be large hospitals with over 250 beds or more than 100 medical residents.

FIGURE 3–1 **Number of general acute care hospital closures exceeded openings in fiscal year 2023**



Note: "Closure" refers to a general acute care hospital that ceased inpatient services and did not convert to a rural emergency hospital, while "opening" refers to a new location for general acute care inpatient services. The counts do not include the relocation of inpatient services from one hospital to another under common ownership within 10 miles, nor does it include hospitals that both opened and closed within a 5-year period. The number of hospital closures and openings in a given year can change over time as hospitals reopen or dates of closure are updated.

Source: MedPAC analysis of the CMS Provider of Services file and internet searches.

Although hospital employment has increased to above prepandemic levels, some hospitals continued to report staffing shortages. We do not know the complete share of hospitals experiencing critical staffing shortages because only a small share of hospitals reported data to the Department of Health and Human Services in 2023. However, anecdotal reports suggest that staffing shortages in 2023 led to some hospitals temporarily postponing some elective surgeries and reducing their inpatient capacity (Belanger 2023, Chouinard 2023). To address these staffing shortages, some hospitals are attempting to bolster staff recruitment and retention through the creation of workforce development programs (Cooney 2023, Kurman 2023).

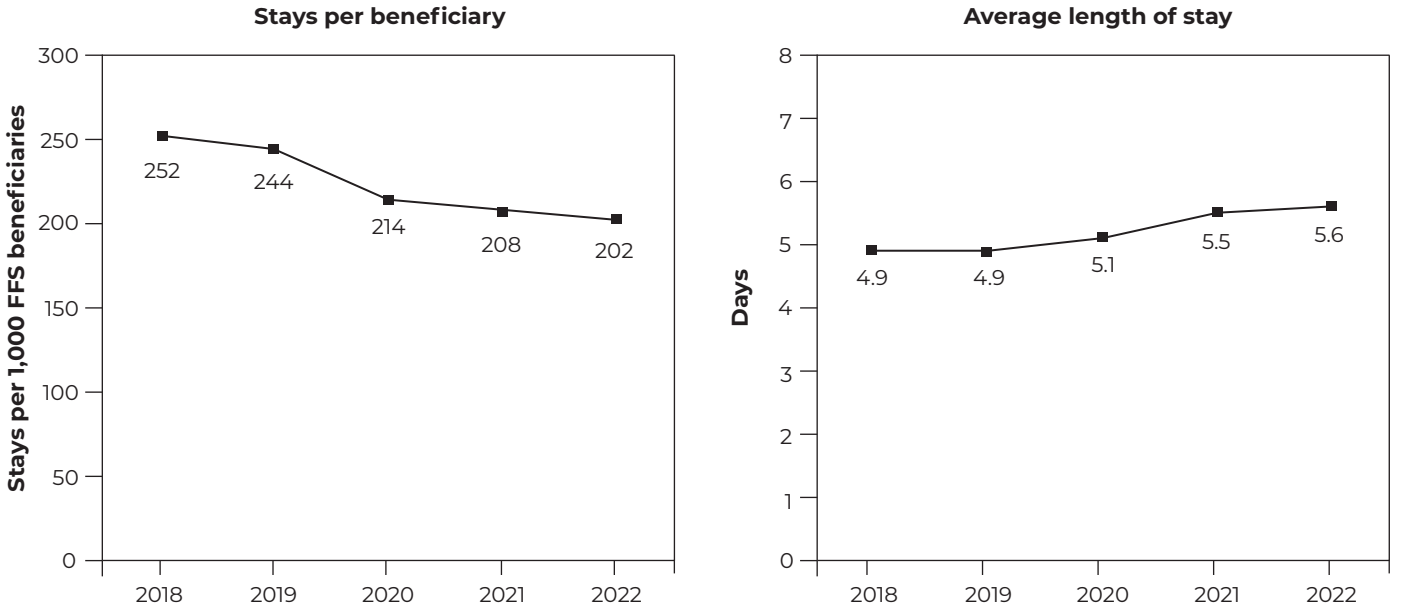
Slight decrease in supply of hospitals in 2023

In FY 2023, 18 general ACHs closed and 11 opened, leading to a slight net decrease in the number of hospitals providing inpatient services to Medicare beneficiaries (Figure 3-1). In addition to these changes, about 20 hospitals converted to the new rural emergency hospital (REH) designation, and some of the hospitals that closed are considering reopening as REHs (see Chapter 15). The decrease in the supply of hospitals in FY 2023 was a contrast to FY 2021 and FY 2022, in which the supply was steady. However, it is similar to the slight decrease in 2020 and markedly smaller than the large decrease in 2019.

The characteristics of the 18 hospitals that closed in FY 2023 varied. Half were in metropolitan areas and half were in micropolitan or other rural areas. Two were critical access hospitals (CAHs) and eight received additional FFS Medicare payments through the Medicare-dependent hospital, sole community hospital, or low-volume hospital programs. Nine of the closing facilities had fewer than 50 beds. Of the 9 micropolitan and other rural closures, all but 2 were

FIGURE 3–2

In fiscal year 2022, inpatient stays per FFS Medicare beneficiary continued to decline while length of stay continued to increase



Note: FFS (fee-for-service). Results differ from the results in our March 2023 report because this figure is based on FFS Medicare Part A enrollment during the fiscal year and includes only beneficiaries living in the 50 states and the District of Columbia.

Source: MedPAC analysis of Medicare Provider Analysis and Common Medicare Environment data.

within 25 miles of the next-nearest hospital, suggesting that most beneficiaries who had been served by the closed facilities continued to have access to inpatient and emergency services in their region, though some faced longer travel times. Hospitals that opened in FY 2023 were generally located in metropolitan areas (7 of 11) and, except for 1, were all less than or equal to 25 miles from the next-nearest hospital.

According to hospital press releases, several factors broader than FFS Medicare's payment rates contributed to the financial difficulties of the hospitals that closed in FY 2023. Most of the hospitals that closed cited declining patient volume as a driving factor for the closure. Other contributing factors cited by hospitals included rising labor and supply costs and high levels of uncompensated care.[7] Declining admissions are often the greatest challenge that rural hospitals face; the decrease is in part due to rural beneficiaries increasingly using urban hospitals.

A new Medicare payment policy that began in 2023 allowed small rural hospitals to convert to REHs and maintain beneficiaries' access to emergency and hospital outpatient services (see Chapter 15). The number of rural hospital closures would likely have been higher if not for the new REH designation.

Certain types of care continued to shift from inpatient to outpatient settings

From 2021 to 2022, the number of general ACH inpatient stays per FFS Medicare beneficiary declined while the average length of stay increased (Figure 3-2). Both of these changes continued prior-year trends. From 2018 to 2022, the number of inpatient stays per FFS Medicare beneficiary declined 20 percent (from

252 stays per 1,000 FFS Medicare beneficiaries to 202), while the average length of stay increased 13 percent (from 4.9 days per stay to 5.6 days per stay).

The change in FFS Medicare stays per beneficiary from the immediate prepandemic period to 2022 varied significantly across types of inpatient stays:

- ***Inpatient stays per FFS Medicare beneficiary for conditions that can be safely treated in outpatient settings declined substantially.*** In particular, following the removal of knee replacements and hip replacements from the inpatient-only lists in 2018 and 2020, respectively, the number of inpatient stays per FFS Medicare beneficiary for joint replacements without major comorbidities and complications declined substantially from 2018 to 2022 (from 12 stays per 1,000 FFS Medicare beneficiaries to 3).
- ***Inpatient stays per FFS Medicare beneficiary for respiratory infections surged during the pandemic and has begun to fall.*** In the immediate prepandemic period, there were 2 stays per 1,000 FFS Medicare beneficiaries for respiratory infections and inflammations with major comorbidities and complications. By 2021, volume had surged to 12 stays per 1,000 FFS Medicare beneficiaries, reflecting the coronavirus pandemic. In 2022, volume fell to 9 stays per 1,000 beneficiaries.
- ***Inpatient stays per FFS Medicare beneficiary for critical conditions remained relatively steady.*** For example, inpatient stays per capita for septicemia and heart failure both somewhat declined at the start of the pandemic but by 2022 had returned to levels near those of the immediate prepandemic period (at 16 and 10 stays per 1,000 FFS Medicare beneficiaries, respectively).

This shift in the type of inpatient stay resulted in a longer average length of stay. The types of stays that dramatically increased at the start of the pandemic—such as those for severe respiratory conditions—were generally longer stays. In contrast, those that decreased—such as joint replacements—were generally shorter. As the number of respiratory stays began to fall and the rate of decline in joint replacements slowed in 2022, growth in the average length of stay also slowed.

Relatively steady hospital outpatient services per FFS Medicare beneficiary and shift of some services between sites of care

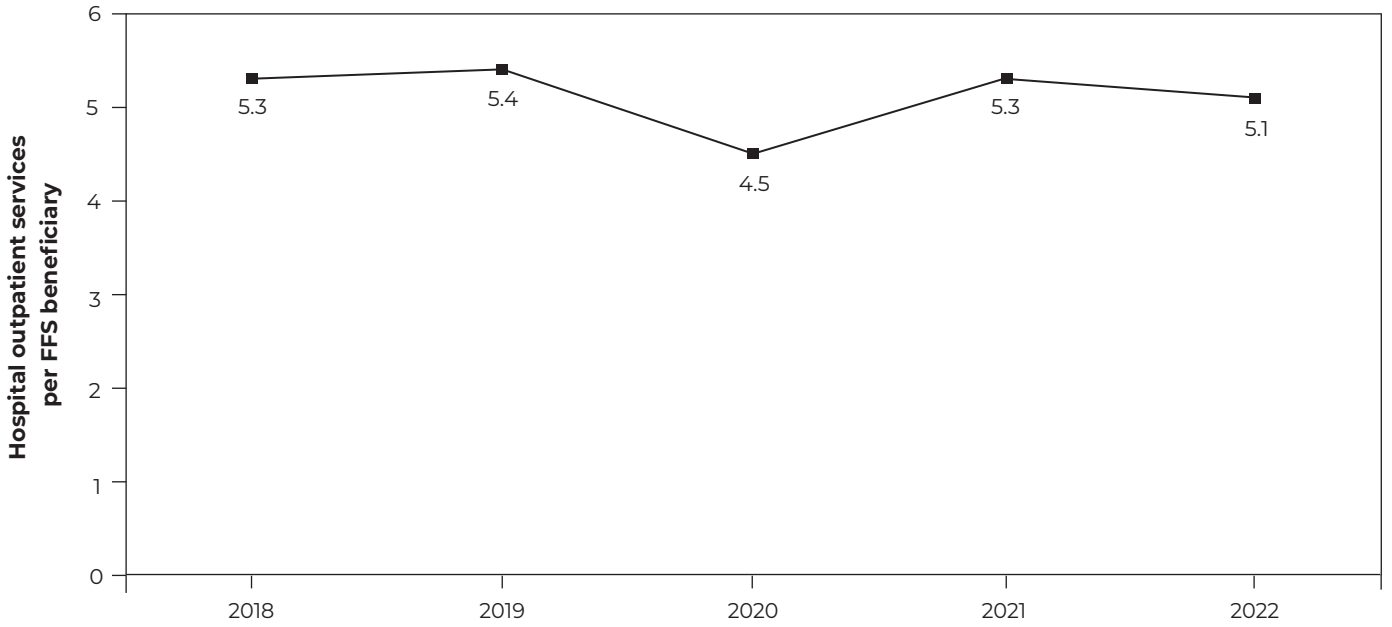
From calendar year 2021 to 2022, the number of general ACH outpatient services per FFS Medicare beneficiary declined slightly but remained near levels in the immediate prepandemic period (Figure 3-3, p. 60). In calendar year 2021, the large increase in outpatient services per beneficiary was in part driven by a surge in COVID-19-related care, including vaccine administration, specimen collection, and chest X-rays. In 2022, this care decreased by 0.3 services per beneficiary (7.7 million services). When excluding this COVID-19-related care, general ACH outpatient services per FFS Medicare beneficiary increased substantially from 2020 to 2021 and slightly from 2021 to 2022 (data not shown).

While many types of hospital outpatient services largely rebounded in 2022 to near prepandemic levels, other types of services remained well below the level in 2019. In particular, emergency department visits per FFS Medicare beneficiary remained about 15 percent below the level in 2019, with most of this care being offset by an increase in urgent care visits. This shift could reflect the beginning of a new normal in which FFS Medicare beneficiaries avoid hospital emergency departments for certain types of care in favor of other settings, such as urgent care centers.

Historically, some services have also shifted from freestanding physician offices to hospital outpatient departments, where payment rates are higher (Medicare Payment Advisory Commission 2021). The Commission contends that, to prevent unwarranted shifts in the volume of services from physician offices to hospitals, the Medicare program should not pay more for services provided in a high-cost setting when it is safe and appropriate to provide those services in a lower-cost setting when doing so does not pose a risk to access (Medicare Payment Advisory Commission 2023a). For example, the Commission has recommended that payment rates for physician office visits should be "site neutral" and that Medicare should not pay hospital-based clinics more for those visits than freestanding clinics because the hospital setting is not necessary for those services. The implementation of site-neutral policies is discussed in more detail in our June 2023 report to the Congress (Medicare Payment Advisory Commission 2023a).

FIGURE 3–3

In calendar year 2022, general ACH outpatient services per FFS beneficiary remained near prepandemic levels



Note: ACH (acute care hospital), FFS (fee-for-service). Results differ from the results in our March 2023 report because this figure is based on FFS Medicare Part B enrollment during the calendar year and includes only beneficiaries living in the 50 states and the District of Columbia.

Source: MedPAC analysis of hospital outpatient claims and Common Medicare Environment data.

Continued financial incentive for hospitals with available capacity to provide inpatient and outpatient services to FFS beneficiaries

In 2022, hospitals' aggregate FFS Medicare marginal profit on IPPS and OPPS services was about 5 percent—below the level in 2021 but similar to the level in 2020. We calculate hospitals' FFS Medicare marginal profit by comparing Medicare's IPPS and OPPS payments with the variable cost of treating an additional FFS Medicare patient. To make a conservative estimate of hospitals' FFS Medicare marginal profit, we use a broad definition of variable costs that is consistent with our prior estimates of the share of costs that varied over a one-year period. We have consistently found that roughly 80 percent of costs are variable; to the extent that a higher share of hospitals' costs are fixed, the marginal profit would be higher. The positive FFS Medicare marginal profit indicates that, in aggregate, IPPS and OPPS payment rates provide financial incentive for hospitals to furnish inpatient and outpatient services to FFS Medicare beneficiaries, given available capacity.

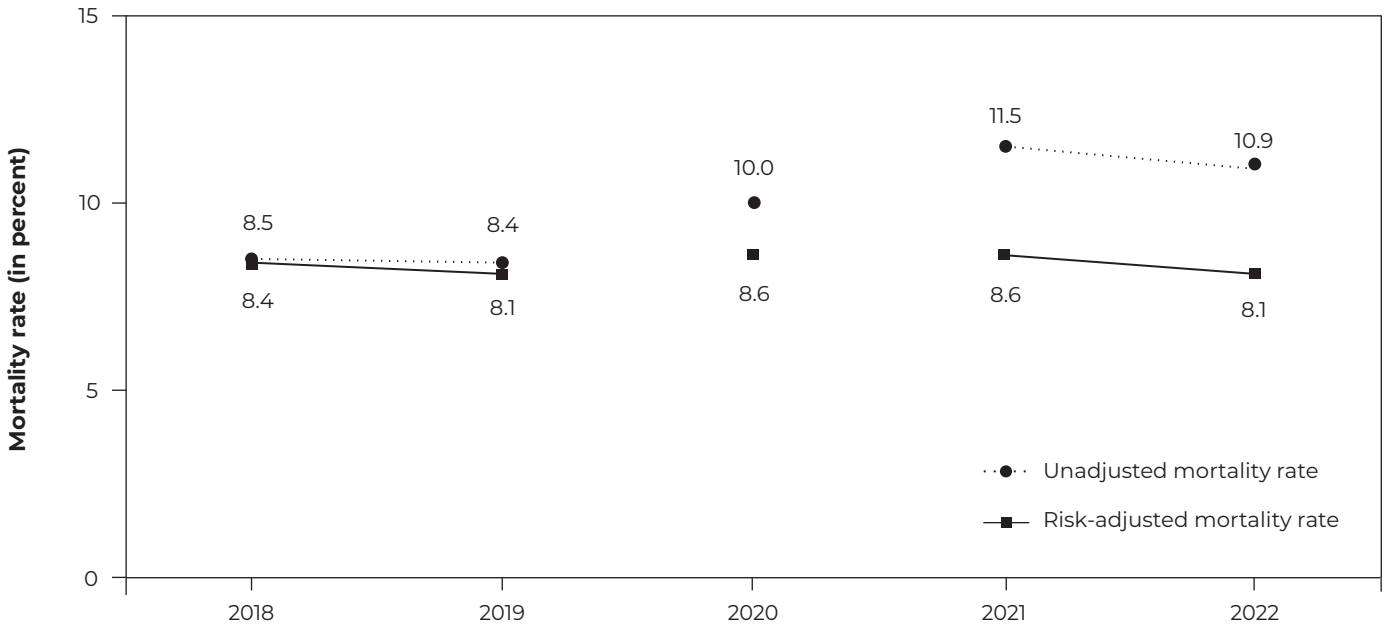
In 2022, the FFS Medicare marginal profit on IPPS and OPPS services continued to vary significantly across hospitals. For-profit hospitals continued to have a much higher Medicare marginal profit than nonprofit hospitals (16 percent vs. 3 percent). Rural nonmicropolitan hospitals also continued to have a much higher Medicare marginal profit than micropolitan or urban hospitals (11 percent vs. 7 percent and 5 percent, respectively), driven by the additional FFS Medicare inpatient payments that most of these rural hospitals receive.

Quality of hospital care in 2022 was mixed relative to prepandemic level

FFS Medicare beneficiaries' risk-adjusted hospital mortality rate improved relative to pandemic

FIGURE 3–4

In 2022, FFS Medicare beneficiaries' hospital mortality rate improved



Note: FFS (fee-for-service). "Mortality rate" refers to the share of inpatient says at general acute care hospitals that result in a death during or within 30 days after the inpatient stay. The values for 2019 to 2021 are not connected because we cannot draw conclusions on the quality of care in 2020 due to the effects of the coronavirus pandemic.

Source: MedPAC analysis of Medicare Provider Analysis and Review data.

highs, falling to the level in 2019. FFS beneficiaries' risk-adjusted readmission rate improved to about a percentage point better than the immediate prepandemic period. However, most patient experience measures remained below prepandemic levels by several percentage points.

Improvement in hospital mortality rate

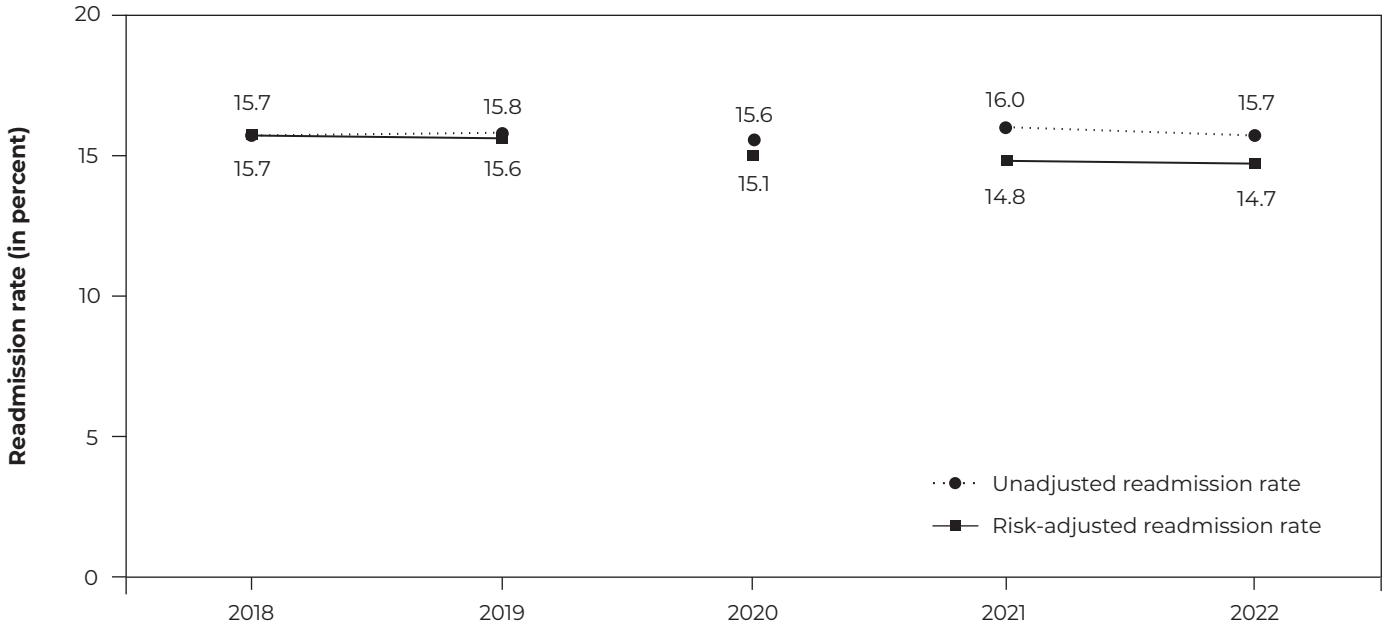
From the start of the coronavirus pandemic, FFS Medicare beneficiaries' unadjusted hospital mortality rate increased substantially. However, from 2021 to 2022, FFS Medicare beneficiaries' hospital mortality rate improved on both an unadjusted and risk-adjusted basis (Figure 3-4). The unadjusted mortality rate—defined as the share of inpatient stays at general ACHs that result in a death during or within 30 days after the stay—decreased (that is, improved) by 0.6 percentage points, from 11.5 percent to 10.9 percent. The risk-adjusted mortality rate improved by 0.5 percentage points, from 8.6 percent to 8.1 percent. Since the start of the pandemic, the risk-adjusted mortality rate has been increasingly lower than the unadjusted mortality rate because beneficiaries admitted to hospitals in recent years tend to have more comorbidities and a higher risk of mortality, and patients with a lower risk of mortality (such as knee-replacement patients) are increasingly moving out of the inpatient setting and thus no longer factor into the average mortality rate.

Improvement in risk-adjusted hospital readmission rate

From 2021 to 2022, FFS Medicare beneficiaries' hospital readmission rate improved on both an unadjusted and risk-adjusted basis (Figure 3-5, p. 62). The unadjusted readmission rate—defined as the share of beneficiaries

FIGURE 3–5

In 2022, FFS Medicare beneficiaries' risk-adjusted hospital readmission rate improved slightly



Note: FFS (fee-for-service). "Readmission rate" refers to the share of inpatient stays at general acute care hospitals that result in a readmission for any condition during or within 30 days after the initial inpatient stay. The values for 2019 to 2021 are not connected because we cannot draw conclusions on the quality of care in 2020 due to the effects of the coronavirus pandemic. Results differ from results we published in the March 2023 report because this figure includes critical access hospital stays in the group of initial inpatient stays.

Source: MedPAC analysis of Medicare Provider Analysis and Review data.

over age 65 readmitted to a general ACH within 30 days after discharge—decreased by 0.3 percentage points, from 16.0 percent to 15.7 percent. The risk-adjusted rate of readmissions decreased by 0.1 percentage points, from 14.8 percent to 14.7 percent. Although unadjusted readmission rates were relatively stable from 2018 to 2022, risk-adjusted readmission rates decreased, as did mortality rates, because beneficiaries admitted to hospitals in recent years tend to have more comorbidities and thus a higher expected rate of readmission.

Decline in patient experience measures

Hospital patient experience measures continued to decline in 2022 (Table 3-2). Hospitals collect Hospital Consumer Assessment of Healthcare Providers and Systems® (H–CAHPS®) surveys from a sample of admitted patients, which CMS uses to calculate results for 10 measures of patient experience included in hospitals' overall ratings.[8] The H–CAHPS measures key components of quality by assessing whether something that should happen during a hospital stay (such as clear communication) actually happened or how often it happened. In 2022, 70 percent of surveyed patients rated their overall hospital experience a 9 or 10 on a 10-point scale, which is a 3 percentage point decrease from 2018.[9] Receipt of discharge information had the highest score: 86 percent of surveyed patients answered with the most positive response. The care-transition measure continued to get the lowest score, with only 51 percent of surveyed patients "strongly agreeing" that they understood their care plan when they left the hospital.

TABLE 3–2 **Hospital patient experience measures continued to decline in 2022**

H–CAHPS® measure	2018	2019	2020	2021	2022	Percentage point change, 2018–2022
Share of patients rating the hospital a 9 or 10 out of 10	73%	73%	72%	72%	70%	–3
Share of patients who would definitely recommend the hospital	72	72	71	70	69	–3
Share of patients giving top ratings for:						
Communication with nurses	81	81	80	80	79	–2
Communication with doctors	81	82	81	80	79	–2
Responsiveness of hospital staff	70	70	67	66	65	–5
Communication about medicines	66	66	63	62	62	–4
Cleanliness of hospital environment	75	76	73	73	72	–3
Quietness of hospital environment	62	62	63	62	62	0
Understanding their care when they left the hospital (care transitions)	53	54	52	52	51	–2
Share of patients who received discharge information	87	87	86	86	86	–1

Note: H–CAHPS® (Hospital Consumer Assessment of Healthcare Providers and Systems®). H–CAHPS is a standardized 32-item survey of patients' evaluations of hospital care. The survey items are combined to calculate measures of patient experience for each hospital. The H–CAHPS measures included in the table are "top box," or the most positive, response to H–CAHPS survey items. Each year's results are based on a sample of surveys of hospitals' patients from January to December. Results in 2020 include surveys only from patients discharged July to December 2020 rather than the customary full year. H–CAHPS response rates from 2018 to 2022 range from 24 percent to 26 percent.

Source: CMS summary of H–CAHPS public report of survey results tables.

While H–CAHPS surveys a sample of all hospital patients, not just Medicare patients, the patient experience metrics are inversely correlated with FFS Medicare beneficiaries' risk-adjusted mortality and readmission rates. This relationship suggests that the quality measures are consistent: Hospitals with higher patient experience ratings tended to have better (that is, lower) FFS Medicare mortality and readmission rates.

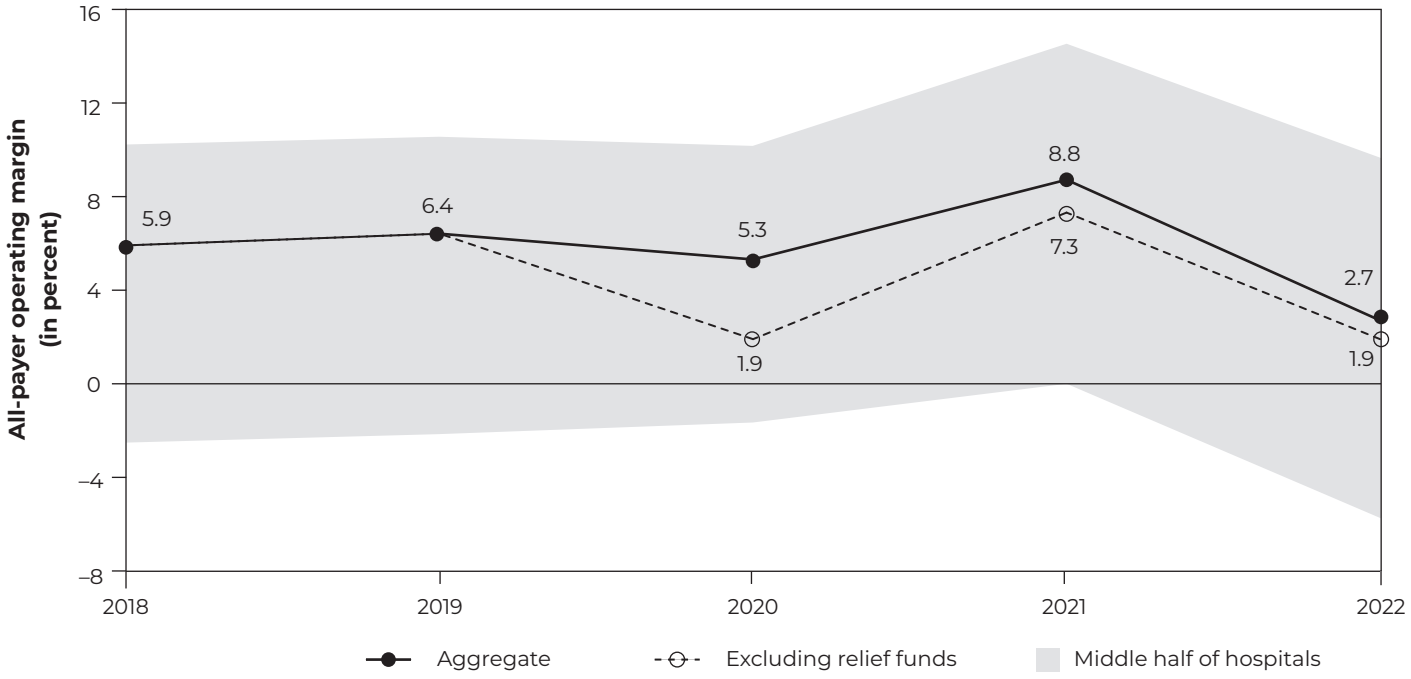
Medicare's hospital quality payment programs should be redesigned

Although FFS Medicare beneficiaries' quality of hospital care improved for some indicators in 2022, the Commission has repeatedly stated that Medicare's hospital quality programs should be redesigned to improve incentives for hospitals to provide high-quality care.

In March 2019, the Commission recommended that the Congress replace Medicare's current hospital quality programs (including the penalty-only programs) with a single, outcome-focused quality-based payment program for hospitals—a hospital value incentive program (HVIP)—that would balance rewards and penalties and have the potential to drive further improvement in hospital quality (Medicare Payment Advisory Commission 2019). Initially, the HVIP could incorporate existing measure domains such as readmissions, mortality, spending per beneficiary, patient experience, and hospital-acquired conditions (or infection rates). A key feature of the Commission's HVIP design is that it accounts for differences in providers' patient populations by incorporating a peer-grouping methodology. Quality-based payments would be distributed to hospitals separated into peer groups

FIGURE 3–6

IPPS hospitals' all-payer operating margin fell from a record high in 2021 to a relative low in 2022



Note: IPPS (inpatient prospective payment systems). Hospitals' margins are calculated as aggregate payments minus aggregate costs, divided by aggregate payments. The "all-payer" margin includes payments from all payers. The "operating" margin excludes revenue from investments and donations, and, for 2020 through 2022, these margins are reported with and without federal coronavirus relief funds (Provider Relief Fund payments and forgiven loans from the Paycheck Protection Program). Data are for IPPS hospitals that had a complete cost report with a midpoint in the fiscal year and had non-outlier data as of our analysis.

Source: MedPAC analysis of hospital cost reports.

defined by the social risk of their patient populations, such as the share of beneficiaries receiving the Part D low-income subsidy, used as a proxy for income. Arranging hospitals into peer groups that serve similar populations would make payment adjustments more equitable than existing quality payment programs.

Some indicators of access to capital declined, and preliminary data suggest that hospitals' all-payer margin remained low in 2023

IPPS hospitals' all-payer operating margin fell from a record high in 2021 to a relative low in 2022, driven primarily by higher-than-expected inflation. In addition, preliminary data from large hospital systems suggest hospitals' aggregate all-payer operating margin remained below prepandemic levels in 2023, and rating agencies have mixed outlooks for the nonprofit hospital sector in 2024. Hospitals' borrowing costs also increased in 2022 and 2023; however, investors reduced the risk premium (above treasury bond yields) that they demanded in order to purchase hospitals' municipal bonds.

Hospitals' all-payer operating margin declined in 2022

From 2021 to 2022, IPPS hospitals' aggregate all-payer operating margin declined from a record high of 8.8 percent to 2.7 percent—the lowest level since 2008 (Figure 3-6). Excluding federal relief funds for

the coronavirus pandemic, IPPS hospitals' operating margin was 1.9 percent, the same level as in 2020, when the pandemic began.[10] As in prior years, there was significant variation within this aggregate: A quarter of hospitals had an all-payer operating margin below −6 percent, while a quarter had a margin above 10 percent.

The roughly 6 percentage point decline in IPPS hospitals' aggregate operating margin resulted from a growth in operating revenue of about 2 percent (including federal coronavirus relief funds) and growth in operating costs of about 8 percent. When excluding relief funds, the growth in operating revenue was about 1 percent. Federal relief funds contributed a much smaller amount to revenue in 2022. Hospitals reported receiving about $9 billion in these funds, down from $18 billion in 2021. The operating cost growth in part reflects growth of more than 6 percent in hospitals' salaries per employee and growth in ancillary costs of more than 7 percent.

All-payer operating margin varied across hospital types

While there was variation within types of hospitals, in aggregate, the all-payer operating margin continued to be higher at for-profit hospitals and, to a lesser extent, urban hospitals (Figure 3-7, p. 66).

Compared with the prepandemic period, patterns of all-payer operating margins across groups have changed:

- ***For-profit hospitals' operating margin remained above levels in the immediate prepandemic periods, while nonprofits' margin fell below.*** In 2022, for-profit hospitals' aggregate all-payer operating margin declined less than 3 percentage points, as their operating revenue grew about 2 percent while they constrained their cost growth to about 4 percent. In contrast, nonprofit hospitals' operating margin declined 7 percentage points; they had a similar growth in operating revenue, but their costs grew about 9 percent. In part, this difference in cost growth resulted from for-profit hospitals constraining the growth in salaries per employee to under 5 percent. In contrast, nonprofit hospitals had a nearly 7 percent growth in average salary. Nonprofit hospitals also had higher growth in ancillary costs, particularly for drugs.
- ***Both urban and rural hospitals' operating margin fell below levels in the immediate prepandemic period, but federal coronavirus relief funds narrowed the gap.*** In 2022, metropolitan, rural micropolitan, and other rural IPPS hospitals' aggregate all-payer operating margins all declined as their operating revenue grew slower than their costs. However, rural hospitals received targeted relief funds that narrowed the gap between urban and rural hospitals' operating margins in 2020, 2021, and 2022.

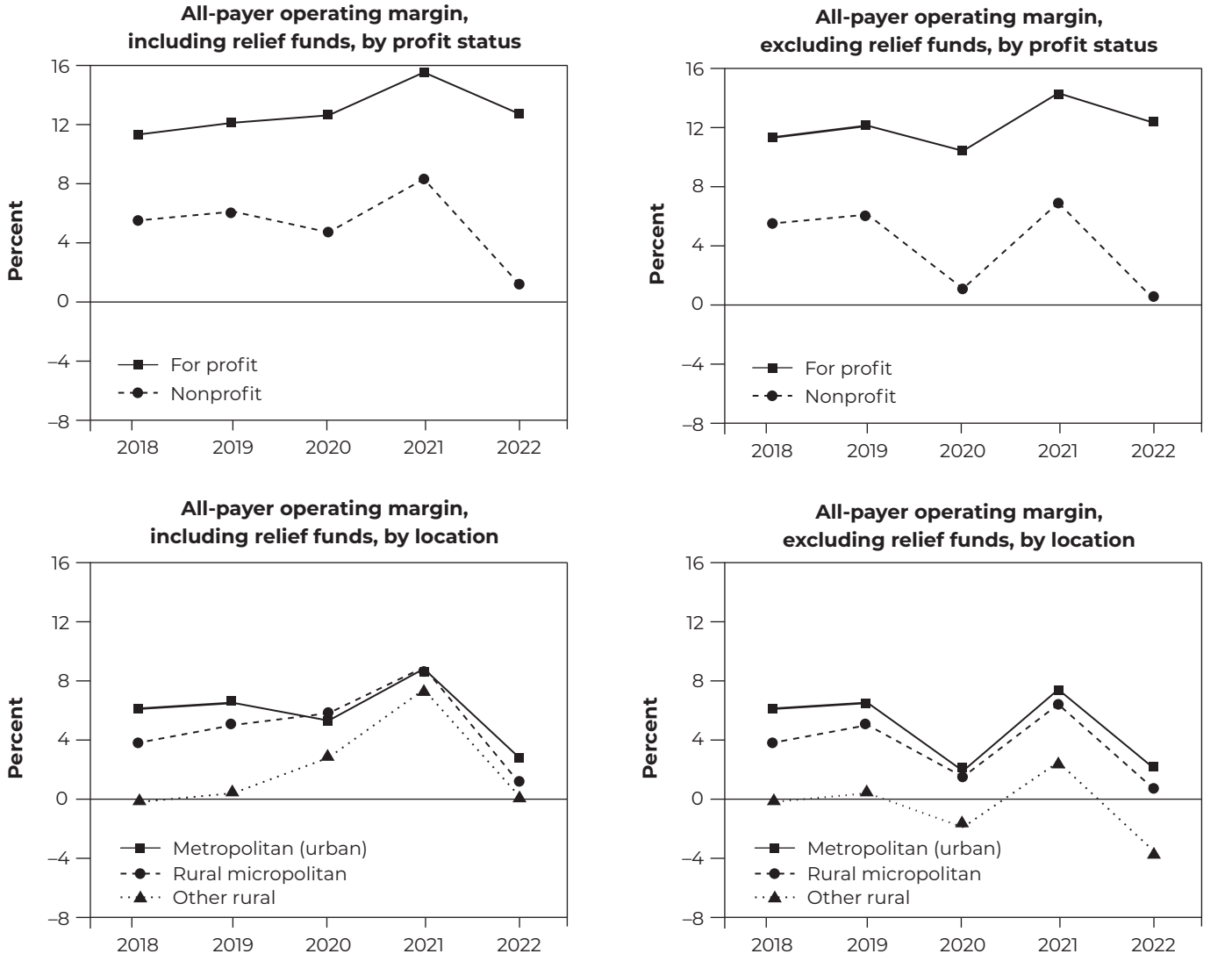
Preliminary data suggest that hospitals' 2023 aggregate all-payer operating margin remained below prepandemic levels

Preliminary data from six large hospital systems suggest that hospitals' all-payer operating margin in 2023 remained below prepandemic levels in aggregate, but with considerable variation. Looking at the most recent quarter of data (July through September 2023), the all-payer operating margin across these six systems varied considerably, ranging from −5 percent to positive 10 percent.[11] In aggregate across these six systems, the operating margin declined by 1 percentage point relative to the same quarter in the prior year (2.8 percent vs. 3.9 percent). However, the trends were mixed, with some systems reporting improvements and others reporting declines—relative to both the same quarter in the prior year and prepandemic levels. Several systems attributed their change in operating margin to favorable trends in patient volumes but higher labor and supply costs, as well as the end of federal coronavirus relief funds. The extent to which these factors outweighed the others varied by system.

Looking forward, rating agencies have mixed outlooks for the nonprofit hospital sector in 2024 but generally agree that gradual aggregate improvements in volume and liquidity measures will be tempered by persistent labor challenges—particularly for hospitals already at the lower end of the rating scale (Fitch Ratings 2023, Moody's Investors Service 2023, S&P Global Ratings 2023). Most nonprofit hospitals' credit ratings are expected to remain stable, but the credit gap between the best- and worst-performing hospitals is anticipated to grow, with operational deterioration among a subset of struggling hospitals. A driver of this gap is hospitals' ability to mitigate labor pressure through successfully recruiting and retaining staff, reducing the use of

FIGURE 3–7

Magnitude of 2022 decrease in IPPS hospitals' all-payer operating margin varied by type, with less decline among for-profit hospitals



Note: IPPS (inpatient prospective payment systems). Hospitals' margins are calculated as aggregate payments minus aggregate costs, divided by aggregate payments. The "all-payer" margin includes payments from all payers. The "operating" margin excludes revenue from investments and donations and, for 2020 through 2022, is reported with and without reported federal coronavirus relief funds (Provider Relief Fund payments and Paycheck Protection Program forgiven loans). Metropolitan (urban) counties contain an urban cluster of 50,000 or more people; rural micropolitan counties contain a cluster of 10,000 to 50,000 people; all other counties are classified as "other rural." Data are for IPPS hospitals that had a complete cost report with a midpoint in the fiscal year and had non-outlier data as of our analysis. Some results look different from previous reports due to newer data and updated group definitions.

Source: MedPAC analysis of hospital cost reports and census geographic files.

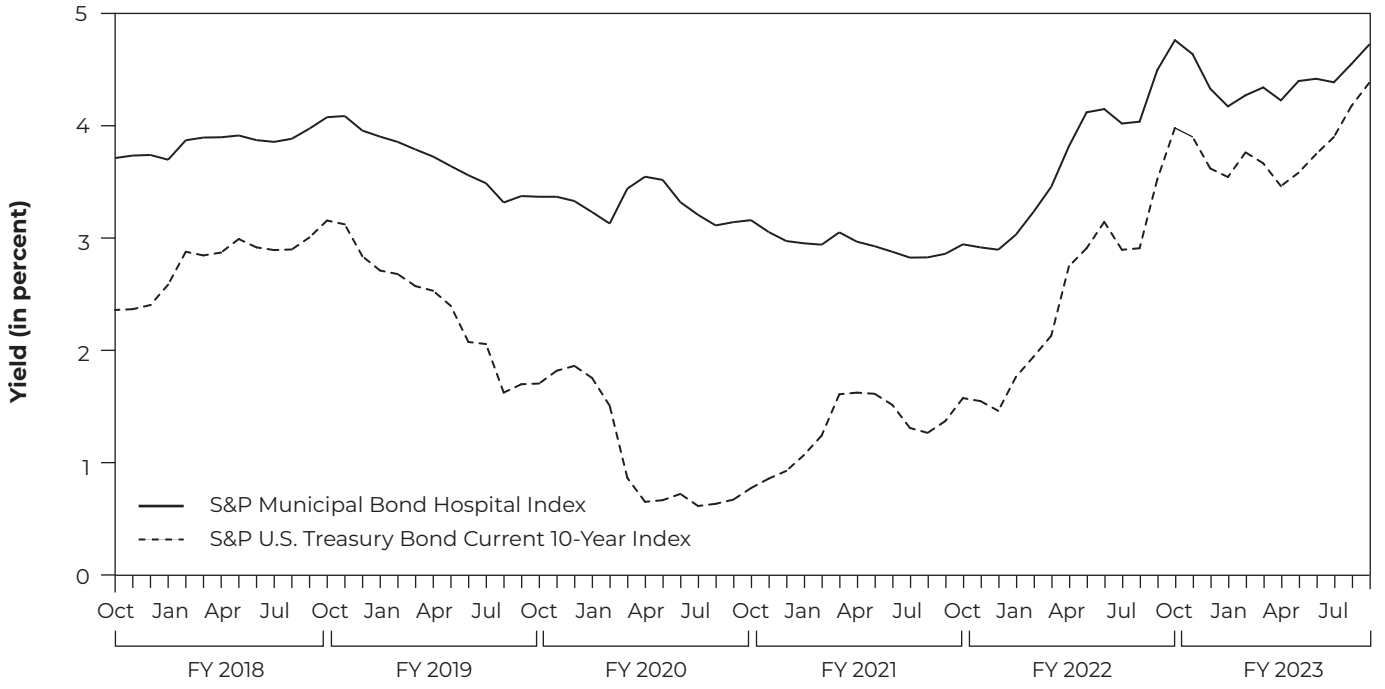
contract labor, and increasing workplace efficiencies. These factors—in addition to variation in volume demand, payer mix, and strength of liquidity metrics—will continue to drive the gap in nonprofit hospital performance and credit ratings.

Hospitals' borrowing costs increased, but by less than the general market

In 2022 and 2023, hospitals' borrowing costs (i.e., costs of accessing capital by issuing bonds) increased, but by less than borrowing costs in the general market

FIGURE 3–8

Hospitals' borrowing costs increased in 2022 and 2023, but by less than general market



Note: FY (fiscal year). "Yield" is the average monthly yield to maturity.

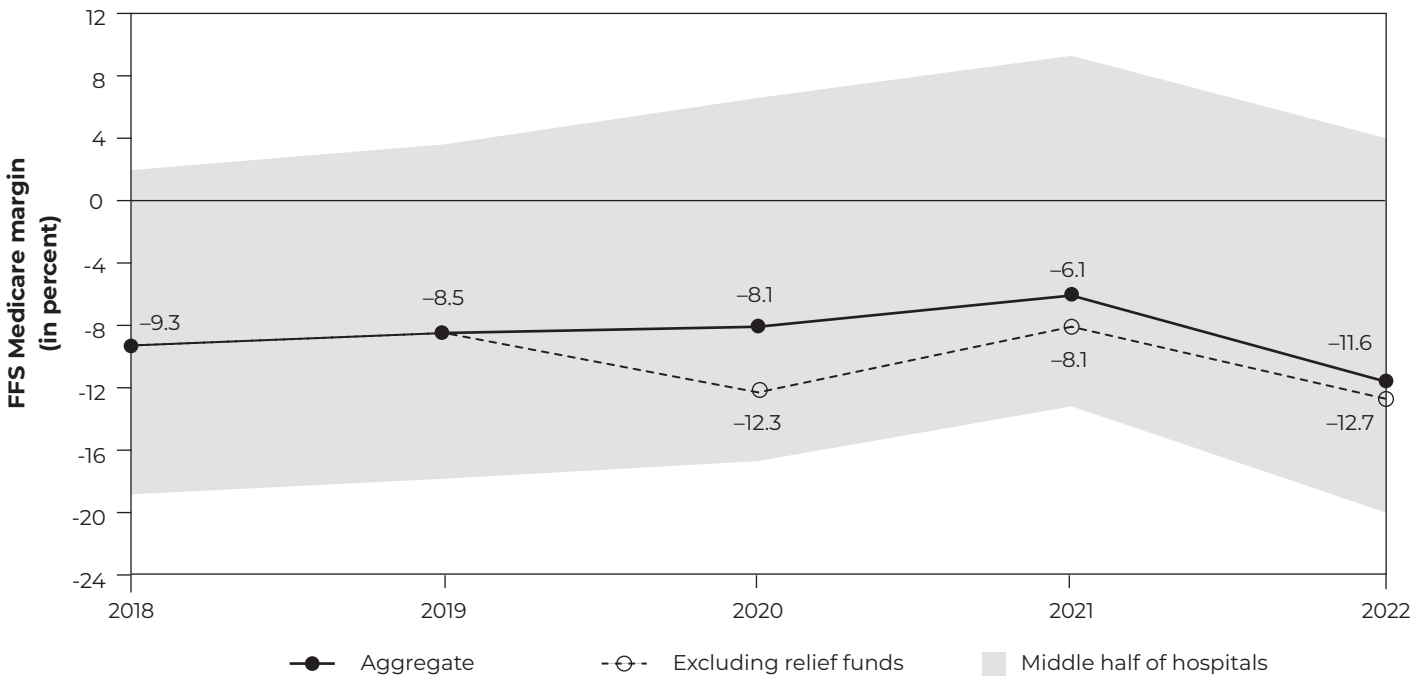
Source: MedPAC analysis of S&P bond data.

(Figure 3-8). During the start of the coronavirus pandemic in spring 2020, the federal government's borrowing costs declined while hospitals' borrowing costs spiked, reflecting investors' demands for a much larger risk premium to hold hospital bonds. By the start of 2021, the general economy began to improve—resulting in higher borrowing costs as measured by yields on treasury bonds—while hospitals' borrowing costs slowly fell. In 2022 and 2023, hospitals' borrowing costs began to climb as the Federal Reserve increased interest rates; however, hospitals' borrowing costs increased by less than the general market. By the end of FY 2023, the yield on the hospital bond index increased to about 5 percent, only slightly above the yield on treasury bonds (S&P Global 2023). This decrease in the risk premium that investors demand suggests that bond investors see little risk of default by the large hospitals issuing municipal bonds and that demand for hospital bonds remains strong. Since the end of FY 2023, the yield on both hospital and treasury bonds has fallen by similar amounts (data not shown).

FFS Medicare payments to hospitals were lower than hospitals' costs in 2022

In FY 2022, IPPS hospitals' overall FFS Medicare margin across service lines declined to a record low, both in aggregate and for relatively efficient hospitals. This decline largely reflected higher-than-expected inflation that caused hospitals' costs to grow faster than FFS Medicare payments. However, broader payment policy changes also contributed, such as the reinstatement of the 2 percent sequestration on Medicare payments and declining federal coronavirus relief funds, as well as other Medicare payment policies, such as declining uncompensated care payments.

FIGURE 3–9 **IPPS hospitals' FFS Medicare margin across service lines fell to a record low in 2022**



Note: IPPS (inpatient prospective payment systems), FFS (fee-for-service). Hospitals' "FFS Medicare margin" is calculated as aggregate FFS Medicare payments minus aggregate allowable FFS Medicare costs, divided by aggregate FFS Medicare payments. Payments and costs include multiple hospital service lines (including inpatient, outpatient, swing bed, skilled nursing, rehabilitation, psychiatric, and home health services) as well as direct graduate medical education and uncompensated care payments. Also, for 2020 through 2022, these margins are reported with and without federal coronavirus relief funds (Provider Relief Fund payments and forgiven loans from the Paycheck Protection Program). Data are for IPPS hospitals that had a complete cost report with a midpoint in the fiscal year and had non-outlier data as of our analysis.

Source: MedPAC analysis of hospital cost reports.

Record decline in hospitals' FFS Medicare margin

In 2022, IPPS hospitals' overall FFS Medicare margin across service lines fell to a record low of –11.6, even after accounting for Medicare's share of federal coronavirus relief funds (Figure 3-9).[12] As in prior years, there was significant variation within this aggregate: A quarter of hospitals had a FFS Medicare margin below –20 percent, while a quarter had a margin above 3 percent.

Both FFS Medicare payment policies and broader statutory and environmental changes affected IPPS hospitals' aggregate 2022 FFS Medicare margin across service lines. The key factors that contributed to the 5.5 percentage point decline in hospitals' FFS Medicare margin were the following:[13]

- ***Higher-than-expected inflation.*** When setting payment rates in summer 2021 for 2022, CMS projected that hospitals' input costs would grow by 2.7 percent in 2022. However, hospitals' input costs actually grew by 5.7 percent, meaning that CMS underestimated these costs by 3 percentage points. Medicare's PPSs generally do not have a forecast error adjustment.[14] Historically, positive and negative forecast errors have tended to balance each other out. As we noted last year, the rapid response to the coronavirus pandemic demonstrated that many hospitals can quickly and substantially lower their costs in response to lower volume. However, hospitals have less ability to constrain costs in response to rapid inflation.

- ***Decline in federal coronavirus relief funds.*** While hospitals continued to record some federal coronavirus relief funds in their 2022 cost reports, the overall amounts—and therefore Medicare's share—declined in 2022. The decline in relief funds reduced the FFS Medicare margin by nearly 1 percentage point.
- ***Reinstatement of sequestration on Medicare payments.*** The Congress suspended the 2 percent sequestration on Medicare program payments from May 1, 2020, through March 31, 2022. The Congress partially applied sequestration at a 1 percent reduction from April 1, 2022, through June 30, 2022, and then reverted to the full 2 percent reduction beginning July 1, 2022. Collectively, this phase-in reduced Medicare's payments to hospitals in FY 2022 by less than 1 percent.
- ***Increased high-cost outlier inpatient stays.*** Medicare's IPPS outlier payments increased by nearly $0.5 billion in 2022 despite a slight increase in the fixed loss amount (from about $29,000 to $31,000), indicating that hospitals' costs for outlier stays grew rapidly. Under the IPPS, Medicare covers a portion of hospitals' costs for high-cost outlier stays: generally 80 percent of hospitals' costs for the stay that are above the sum of the standard IPPS rate and a fixed loss amount. In 2022, outlier payments totaled nearly 7 percent of base IPPS payments, well above the target of 5.1 percent. These unexpectedly large outlier payments were driven in part by an increase in costly stays related to infectious diseases.
- ***Decrease in uncompensated care payments.*** From 2021 to 2022, CMS decreased aggregate Medicare uncompensated care payments by about $1.2 billion. This decline resulted from CMS's estimate that disproportionate share hospital payments under prior law and the national uninsured rate would both decline. By design, when CMS estimates a decline in hospitals' share of low-income beneficiaries (i.e., lower disproportionate share hospital payments under prior law) or a decline in hospitals' uncompensated care burden (i.e., the national uninsured rate), Medicare's uncompensated care payments decline.

One countervailing factor that led to higher FFS Medicare payments for some hospitals was the start of 340B Drug Pricing Program remedy payments. In response to court rulings, CMS reprocessed calendar year 2022 hospital outpatient payments for drugs obtained under the program, resulting in an additional $1.6 billion paid to participating hospitals (see text box on 340B drugs and outpatient payments, p. 70). Approximately half of these remedy payments were recorded in hospitals' FY 2022 cost reporting periods (because only nonprofit hospitals are eligible for the 340B Drug Pricing Program, and nonprofit hospitals' most common cost reporting period is July to June).

Hospitals' inpatient costs exceeded FFS Medicare payments by a greater amount than their costs for outpatient services did. In 2022, hospitals' inpatient costs per FFS Medicare stay grew three times as fast as IPPS payments per stay: The costs increased 8.3 percent, to $18,700, while IPPS payments per stay increased 2.7 percent, to $15,900. Meanwhile, hospitals' outpatient costs per FFS Medicare beneficiary grew moderately faster than OPPS payments per beneficiary: Hospitals' outpatient costs per FFS Part B beneficiary increased 8.1 percent, to $2,600, while OPPS payments per beneficiary increased 6.9 percent, to $2,200.

FFS Medicare margin continued to vary across hospital groups, including positive margin among for-profit hospitals

While there was variation within each group of IPPS hospitals, in aggregate, the FFS Medicare margin across service lines continued to be higher at for-profit hospitals, rural hospitals, and hospitals under high fiscal pressure (Figure 3-10, p. 71).[15] Consistent with prior years, for-profit IPPS hospitals and those under high fiscal pressure have been able to maintain relatively higher FFS Medicare margins primarily because they have constrained costs more than nonprofits or hospitals under less financial pressure have. In contrast, rural hospitals—especially those in nonmicropolitan areas—have continued to have a higher FFS Medicare margin primarily because most IPPS hospitals in rural nonmicropolitan areas benefit from one or more special designations that provide additional FFS Medicare payments above IPPS and/or OPPS payments. In addition, both rural hospitals and hospitals with low all-payer margins received targeted federal coronavirus relief funds, causing their FFS Medicare margin including relief funds to disproportionately increase in 2020 and 2021.

Changes in outpatient payments as a result of recent court cases concerning 340B drugs

In calendar year 2018, CMS implemented a policy that reduced the outpatient prospective payment system (OPPS) rates for most separately payable non-pass-through drugs that hospitals obtained through the 340B Drug Pricing Program from the default rate of average sales price plus 6 percent to average sales price minus 22.5 percent. To satisfy budget-neutrality requirements under the Social Security Act, CMS increased the payment rates for all covered OPPS nondrug items and services by 3.19 percent.

Hospitals challenged this policy, and, in 2022, the Supreme Court ruled that the approach CMS used to establish the reduced payment rates for 340B drugs violated parts of the Social Security Act. The Supreme Court remanded this case to the District Court for the District of Columbia, which issued a decision that gave CMS the opportunity to determine a remedy that would fully offset the reduced OPPS payment rates for 340B drugs and the increased OPPS payment rates for nondrug items and services.

CMS estimated that, in aggregate, the 340B drug payment policy lowered OPPS payments to 340B hospitals by $10.6 billion since fee-for-service Medicare beneficiaries' drug utilization increased faster than CMS expected. CMS also estimated that the 3.19 percent increase to OPPS payment rates for nondrug items and services increased payments to all OPPS hospitals by $7.8 billion (Centers for Medicare & Medicaid Services 2023).

CMS concluded that the remedy for the reduced payments for 340B drugs must be budget neutral. Therefore, the agency finalized a plan to provide $10.6 billion in remedy payments to 340B hospitals and to gradually reduce OPPS payments to recoup the estimated $7.8 billion in increased OPPS payments for nondrug items and services from calendar years 2018 through 2022.

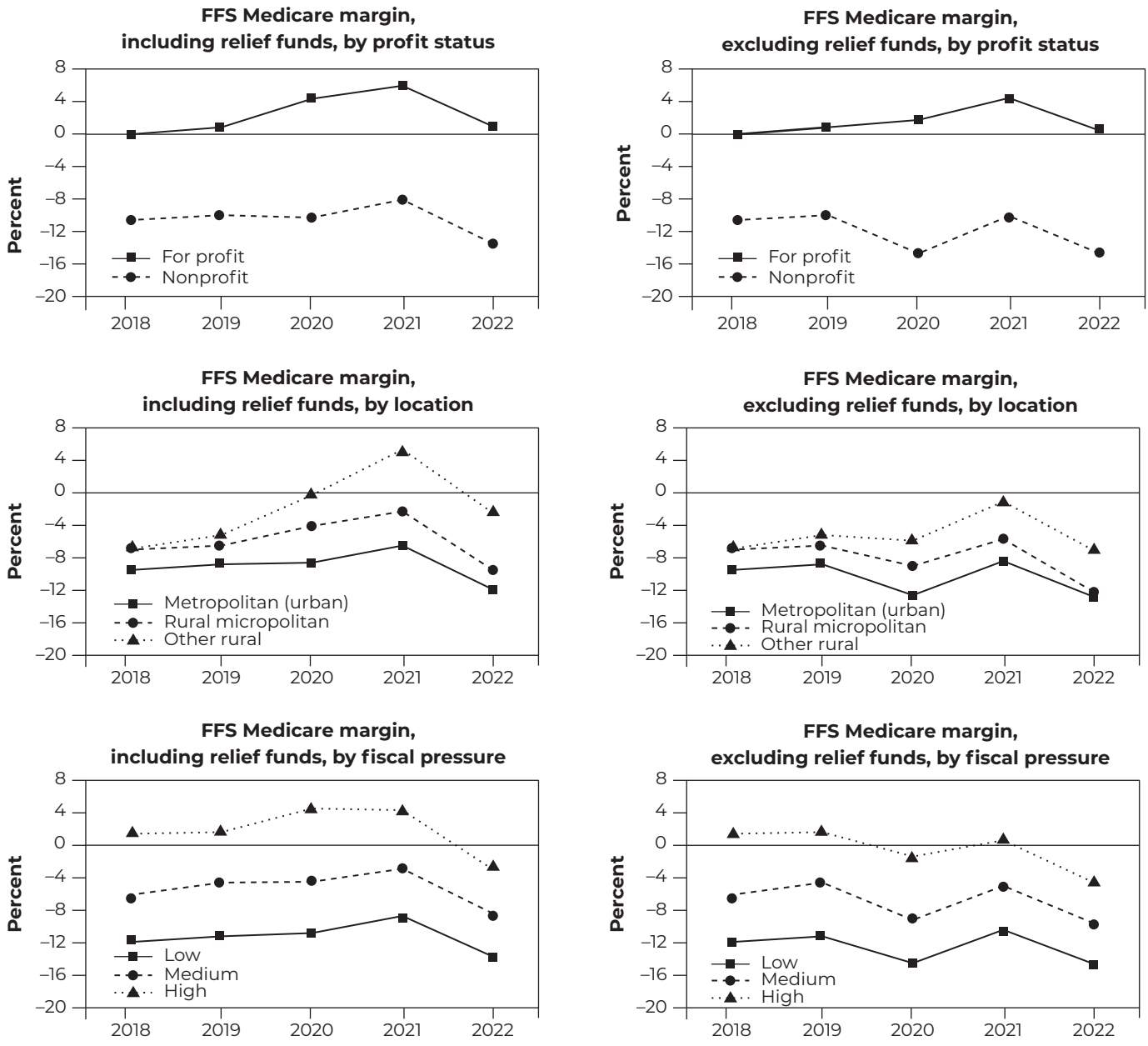
CMS has already taken a step to address the $10.6 billion in remedy payments for 340B drugs by reprocessing most OPPS claims for the 2022 payments for 340B drugs affected by the 340B policy. This claims reprocessing has provided 340B hospitals with $1.6 billion in remedy payments. To address the remaining $9.0 billion in remedy payments for 340B drugs, CMS finalized a policy to provide one-time lump-sum payments to each affected 340B hospital at the end of calendar year 2023 or the beginning of 2024.

To offset the increased OPPS payments for nondrug items and services from calendar years 2018 through 2022, CMS finalized a 0.5 percent decrease to the OPPS conversion factor beginning in calendar year 2026. The 0.5 percent decrease will remain in place until the $7.8 billion offset is reached, which CMS estimates will take 16 years. ■

However, the spread in the FFS Medicare margins across groups differed somewhat relative to the levels in the immediate prepandemic period. In particular, only for-profit hospitals were able to maintain a FFS Medicare margin near the levels in the immediate prepandemic period. From 2021 to 2022, for-profit IPPS hospitals' FFS Medicare margin across service lines declined from highs in 2020 and 2021 to a level similar to 2019. In contrast, nonprofit IPPS hospitals' FFS Medicare margin declined from a level similar to 2019 to a record low. This low 2022 FFS Medicare margin at nonprofit hospitals occurred despite nonprofit hospitals receiving substantial 304B drug remedy payments during their 2022 cost reporting periods. The other group of hospitals that had been able to maintain a positive FFS Medicare margin in the immediate prepandemic period—hospitals under high fiscal pressure—did not maintain a positive FFS Medicare margin in 2022.

FIGURE 3–10

IPPS hospitals' FFS Medicare margin varied across groups, including higher margins at for-profit, rural, and fiscally pressured hospitals



Note: IPPS (inpatient prospective payment systems), FFS (fee-for-service). Hospitals' "FFS Medicare margin" is calculated as aggregate FFS Medicare payments minus aggregate allowable FFS Medicare costs, divided by aggregate FFS Medicare payments. Hospitals' FFS Medicare margin includes multiple hospital service lines (including inpatient, outpatient, swing bed, skilled nursing, rehabilitation, psychiatric, and home health services) as well as direct graduate medical education and uncompensated care payments. For 2020 through 2022, this margin is reported with and without federal coronavirus relief funds (Provider Relief Fund payments and forgiven loans from the Paycheck Protection Program). Metropolitan (urban) counties contain an urban cluster of 50,000 or more people; rural micropolitan counties contain a cluster of 10,000 to 50,000 people; all other counties are classified as "other rural." "Low fiscal pressure" hospitals are defined as those with a median non-Medicare margin greater than 5 percent over five years and a net worth that would have grown by more than 1 percent per year over that period if the hospital's Medicare profits had been zero. "High fiscal pressure" hospitals are defined as those with a median non-Medicare margin of 1 percent or less over five years and a net worth that would have grown by less than 1 percent per year. Data are for IPPS hospitals that had a complete cost report with a midpoint in the fiscal year and had non-outlier data as of our analysis. Some results look different from prior-year reports' results due to newer data and updated group definitions.

Source: MedPAC analysis of hospital cost reports and census geographic files.

TABLE 3–3

Relatively efficient hospitals performed better than other hospitals but still had a negative median FFS Medicare margin in 2022

	Relatively efficient hospitals	Other hospitals
Number of hospitals	135	1,900
Share of hospitals in our study sample	7%	93%
Historical performance, 2018, 2019, 2021 (percentage of national median)		
Standardized Medicare costs per unit	91%	102%
Mortality rate	85	101
Readmission rate	93	101
Performance metrics, 2022 (percentage of national median)		
Standardized Medicare costs per unit	91%	102%
Mortality rate	90	101
Readmission rate	94	101
Share of patients rating the hospital a 9 or 10 (out of 10)	103	100
Median FFS Medicare margin, 2022		
FFS Medicare margin with federal coronavirus relief funds	–2%	–9%
FFS Medicare margin excluding relief funds	–3	–10
Median all-payer operating margin with relief funds, 2022	4	3

Note: FFS (fee-for-service). "Relatively efficient hospitals" and "other hospitals" were identified based on their mean performance during 2018, 2019, and 2021 relative to the median hospital's performance during those years (see text box on our identification methodology, pp. 74–75). "Standardized Medicare cost per unit" combines standardized costs per inpatient stay with standardized costs per outpatient service (relative to their respective national medians) using two-thirds and one-third weighting based on the overall inpatient and outpatient shares of Medicare payments in 2021. "Standardized Medicare costs per unit" are standardized for area wage rates, case-mix severity, prevalence of outlier and transfer cases, interest expense, low-income shares, and teaching intensity. "Mortality rate" refers to the (risk-adjusted) share of inpatient stays at general acute care hospitals that resulted in a death during or within 30 days after the inpatient stay. "Readmission rate" refers to the risk-adjusted share of inpatient stays at general acute care hospitals that resulted in a readmission for any condition within 30 days after the initial inpatient stay. "Share of patients rating the hospital a 9 or 10 (out of 10)" is based on Hospital Consumer Assessment of Healthcare Providers and Systems® (H–CAHPS®) survey data collected from patients discharged between January and December 2022. Hospitals' "FFS Medicare margin" is calculated as aggregate FFS Medicare payments minus aggregate allowable FFS Medicare costs, divided by aggregate FFS Medicare payments. Hospitals' FFS Medicare margin includes multiple hospital service lines (including inpatient, outpatient, swing bed, skilled nursing, rehabilitation, psychiatric, and home health services) as well as direct graduate medical education and uncompensated care payments.

Source: MedPAC analysis of CMS cost report and claims data and CMS's summary of H–CAHPS public reports of survey results tables.

Relatively efficient hospitals' median FFS Medicare margin was negative

Each year, as part of our assessment of payment adequacy, the Commission calculates a median FFS Medicare margin for a group of hospitals that perform relatively well on a set of quality metrics (measures of mortality and readmissions) while keeping unit costs relatively low. We refer to the group of hospitals identified by our method as "relatively efficient" because hospitals had to perform relatively better on selected measures of quality and cost for inclusion. However, our method does not seek to identify all efficient hospitals. For example, we screen out hospitals that have few Medicare or Medicaid patients or that have poor performance on our measures in a single year, even though these hospitals may

be relatively efficient. In addition, we note that the hospitals we identify as relatively efficient perform relatively well in the domains we are measuring. Use of other quality and cost measures (e.g., hospital-acquired conditions, transition to post-acute care, or spending per episode) to identify relative efficiency likely would yield a different set of hospitals. Still, the median margin for our group of relatively efficient hospitals provides one source of information about whether Medicare's payments are adequate to cover the costs of providing hospital care efficiently.

In 2022, the median FFS Medicare margin among the IPPS hospitals we identified as relatively efficient was –2 percent when including Medicare's share of federal coronavirus relief funds and –3 percent when excluding these funds (Table 3-3). This margin is lower than the last few years, when relatively efficient hospitals approximately broke even on Medicare (when excluding relief funds). The lower median FFS Medicare margin among relatively efficient hospitals this year is consistent with the lower FFS Medicare margin among all IPPS hospitals discussed above.

As in prior years, we identified a subset of hospitals that were never in the worst third on any quality or cost metrics during the prior three years (using 2018, 2019, and 2021 to limit the effect of the start of the pandemic) and consistently performed in the best third in either costs or mortality. We then assess the adequacy of FFS Medicare payments (using performance in 2022) for these relatively efficient hospitals. This year, we improved the method for identifying relatively efficient hospitals by incorporating hospital outpatient costs and using more rigorous thresholds for quality of care (see text box for more detail on our method, pp. 74–75).

Among our sample of 135 relatively efficient hospitals in 2022, costs per unit (combining inpatient and outpatient costs per unit) were 91 percent of the national median, allowing these hospitals to generate better FFS Medicare margins than the other hospitals in the comparison group (Table 3-3). In 2022, the relatively efficient hospitals also continued to have better mortality and readmission metrics than the national median. The mortality rate for relatively efficient hospitals was better (i.e., lower) than what we published in prior years because we applied more rigorous criteria in our improved methodology. Relatively efficient hospitals also had better patient satisfaction, performing above the national median on the share of H–CAHPS respondents rating the hospital a 9 or 10 in 2022.

As in past years, relatively efficient hospitals were spread across the country and represented diverse categories of hospitals, including teaching, nonteaching, rural, urban, for-profit, and nonprofit hospitals, as well as hospitals serving large shares of low-income patients. While most types of hospitals were represented in the efficient group, a disproportionate share of relatively efficient hospitals had relatively high inpatient volume. Volume primarily affects our efficiency measures in two ways. First, higher-volume hospitals tended to have lower risk-adjusted mortality rates. Second, we require some consistency of results over three years and remove from the relatively efficient group any hospital that performed in the bottom third on any metric in a single year.[16] Low-volume hospitals may be more subject to random variation that can make them likely to be excluded from our efficient group. The relatively efficient hospitals were also less likely to be located in rural areas and tended to have lower shares of low-income Medicare patients.[17] Among both for-profit and nonprofit hospitals, the shares of hospitals categorized as relatively efficient were generally similar. Although for-profit hospitals tend to have lower costs, nonprofit hospitals tend to have higher quality metrics.

Projected increase in hospitals' FFS Medicare margin in 2024 due to one-time 340B drug remedy payments

In 2024, hospitals that participate in the 340B drug payment program are scheduled to receive $9 billion in remedy payments to correct for underpayments in calendar years 2018 to 2021 (see text box on 340B drugs and outpatient payments, p. 70). Including these one-time payments, we project that IPPS hospitals' aggregate FFS Medicare margin across service lines will increase to –8 percent. The projection for relatively efficient IPPS hospitals' aggregate FFS Medicare margin would increase to –2 percent. However, excluding these 2024 remedy payments, we project IPPS hospitals' aggregate FFS Medicare margin to be –13 percent, similar to the level in 2022 exclusive of federal coronavirus relief funds. Similarly, we project the median FFS Medicare margin among relatively efficient hospitals to be about –3 percent, in line with 2022. These projections are based on actual payments

Identifying relatively efficient hospitals: Updated methodology

The Commission follows two principles when identifying a set of relatively efficient providers. First, the providers must do relatively well on cost and quality metrics. Second, the performance has to be consistent, meaning that the provider cannot have poor performance on any metric over a period of three years. Our assessment of efficiency is not in absolute terms, but rather relative to a comparison group of other hospitals paid under Medicare's inpatient and outpatient prospective payment systems (IPPS and OPPS).

Our objective is to identify a sample of hospitals that consistently perform at an above-average level on at least one measure (cost or mortality) and that always perform reasonably well on all our measures. Our methodology does not seek to identify all efficient hospitals, only a subsample of relatively efficient hospitals. For example, we screen out hospitals that have few Medicare or Medicaid patients or have poor performance in a single year, even though these hospitals may be relatively efficient.

Categorizing hospitals as relatively efficient

As in prior years, we assigned IPPS hospitals that met minimum volume criteria to the relatively efficient group or the control group according to each hospital's performance relative to the national median on a set of risk-adjusted cost and quality metrics for the three years prior to the most recent cost report year.[18] Costs were standardized to account for hospital characteristics that affect costs but are generally outside the hospital's control, such as teaching status and shares of patients with low incomes.[19] A hospital was identified as relatively efficient if it met the following criteria in each of the three prior years:

- Risk-adjusted mortality rate or standardized cost was among the best one-third of hospitals in all years.
- Risk-adjusted mortality rate was not among the worst third in any year.
- Risk-adjusted readmission rate was not among the worst third in any year.
- Standardized cost was not among the worst third in any year.

We also use the Hospital Consumer Assessment of Healthcare Providers and Systems® survey to require that at least 50 percent of the hospital's patients rated it a 9 or 10 on a 10-point scale (in the year prior to the performance period).

Updated methods

Recently, the Commission undertook a review of the method for identifying relatively efficient hospitals and implemented two substantive improvements:

(continued next page)

and costs from the most recent year of complete data (2022); partial data from 2023; and policy, inflation, and coronavirus pandemic–related changes that took place in 2023 and are anticipated in 2024.

When we exclude one-time 340B drug remedy payments, we expect IPPS hospitals' FFS Medicare margin in 2024 to be similar to the level in 2022. We anticipate this result because we project several factors that roughly offset each other, including:

- ***Increase in 340B drug payments starting in 2022 and projected continued volume growth.*** In 2022, as a result of recent court rulings, CMS increased the payments for 340B drugs from average sales price minus 22.5 to average sales price plus 6 percent. Because only nonprofit hospitals are eligible for

Identifying relatively efficient hospitals: Updated methodology (cont.)

- ***We incorporated Medicare outpatient costs:*** Historically, we considered only inpatient costs per stay in assessing hospital costs, but outpatient services are a growing share of Medicare payments to hospitals. To better capture hospitals' overall Medicare costs, we combined standardized costs per inpatient stay with standardized costs per outpatient service (relative to their respective national medians) using two-thirds and one-third weighting based on the overall inpatient and outpatient shares of Medicare payments in the most recent prior year (see Table 3-1 in the Commission's March 2023 report (Medicare Payment Advisory Commission 2023b)).[20] This combined metric was used to determine whether hospitals met the cost criteria to be classified as relatively efficient.

- ***We defined thresholds for quality of care more rigorously:*** To determine the thresholds for classifying hospitals on risk-adjusted mortality and readmissions measures, we considered only the hospitals in our analysis file instead of all general acute care hospitals (which we had done in prior years). Our analysis file contained IPPS and OPPS hospitals with valid cost and claims data during baseline and performance years that met annual volume minimums and served at least a minimal amount of Medicaid patients.[21] The removal of small hospitals, such as critical access hospitals, resulted in higher quality on average, making it more difficult for a hospital to exceed the threshold and be classified in the top third.

To assess the effect of methodological differences on results, we applied the prior methods to the same data. We found that our improved method resulted in identifying relatively efficient hospitals in 2022 that had a median fee-for-service (FFS) Medicare margin that was about 3 percentage points higher than the prior method and a median mortality rate 1 percentage point lower. (Applying our improved method to the most recent data that was available last year (2021 data) resulted in relatively efficient hospitals having a median FFS Medicare margin 1 percentage point higher than the results reported last year.) The more rigorous criterion for high-quality care also contributed to classifying a smaller number and share of hospitals as relatively efficient than in the past (7 percent compared with 15 percent).

The updated method better represents both the costs and quality of hospitals used in the analysis, thereby improving the identification of a group of relatively efficient hospitals for use in assessing the adequacy of Medicare's payments. ■

the 340B drug payment program and most of these hospitals' cost reports are from July to June, the higher payment rate was in effect for only part of hospitals' 2022 cost reporting periods. However, these higher payments are scheduled to be in effect for all of 2023 and 2024. We also project the volume of 340B drugs to continue to grow.

- ***Increase in hospital productivity and coding.*** Prior to the pandemic, hospitals' costs per inpatient stay grew about 1 percentage point slower than their input costs and case mix, reflecting a combination of increased hospital productivity and/or higher coding. While this pattern changed during the pandemic, we expect it will revert to the norm in 2024, with hospitals able to resume prepandemic levels of productivity and/or coding.

- ***Phase-out of special Medicare payment policies in 2022 and 2023.*** During the pandemic, the Congress suspended the 2 percent sequester on Medicare payments. During 2022, the Congress began to partially reapply the sequester. These lower payments were applied to a portion of hospitals'

2022 cost reporting period but are scheduled to be in effect for all of 2023 and 2024. Special Medicare payment policies to support hospitals during the pandemic—the additional 20 percent payment for COVID-19 inpatient stays and payments for new COVID technologies—both expired in 2023.

- ***Underestimate of input price inflation in 2023.*** When setting payment rates in summer 2022 for 2023, CMS projected that hospitals' input costs would grow by 4.1 percent in 2023 based on data available at the time. However, based on actual data through the second quarter of 2023, hospitals' input costs grew by 4.8 percent, 0.7 percentage points more than expected. Actual inflation for the rest of 2023 and 2024 is not yet known; we use CMS's current estimates of input price inflation because they represent the best estimates available at this time.
- ***Declines in Medicare's uncompensated care payments in 2023 and 2024.*** Medicare's uncompensated care pool in 2022 was $7.2 billion (prior to sequestration), declined in 2023 to $6.9 billion, and will decline again in 2024 to $5.9 billion. These declines reflect CMS's projections of a decrease in disproportionate share hospital payments and in the national uninsured rate.
- ***End of statutory increase to inpatient payments in 2024.*** The Medicare Access and CHIP Reauthorization Act of 2015 required that, for 2018 through 2023, inpatient operating payments be increased by 0.5 percentage points to reverse prior temporary reductions for past documentation and coding changes.

There are no currently scheduled FFS Medicare policy changes or anticipated environmental factors that would materially change hospitals' FFS Medicare margin in 2025 relative to 2024.[22]

Like all projections, ours are subject to uncertainty. In particular, there is uncertainty about whether the coronavirus pandemic will continue to abate and about the accuracy of CMS's estimates of future input price inflation. For 2025, there are additional unknowns, such as the level of Medicare's uncompensated care payments and how hospitals will spend the scheduled $9 billion in 340B drug remedy payments they receive in 2024. We will update with data on actual experience in our next recommendation cycle. We will also continue to look for additional measures of payment adequacy to include in future recommendation cycles.

How should FFS Medicare payments change in 2025?

Under current law, CMS sets the percentage update to IPPS and OPPS payment rates based on CMS's forecasts of market basket increases less a forecasted increase in productivity, as well as any other statutory or policy updates. The final hospital updates for 2025 will not be set until summer 2024. However, based on current CMS forecasts through the third quarter of 2023, the 2025 updates would include:

- a 2.8 percent increase in the IPPS operating and OPPS base payment rates (resulting from 3.1 percent growth in the market basket less 0.3 percentage points in productivity), and
- a 2.5 percent increase in the IPPS capital base rate, plus a forecast error adjustment.

Our hospital payment adequacy indicators were mixed and suggest that FFS Medicare payments to general ACHs were below costs for most hospitals. We also project that this disparity will persist under current-law updates.

In considering how Medicare payments to general ACHs should change in 2025, the Commission contends that scarce Medicare resources should be used efficiently. To meet this goal, Medicare should aim to balance several objectives:

- support hospitals with payments high enough to ensure beneficiaries' access to care;
- maintain payments close to hospitals' cost of providing high-quality care efficiently to ensure value for taxpayers;
- maintain fiscal pressure on hospitals to constrain costs;
- minimize differences in payment rates for similar services across sites of care;

- be cautious about how much emphasis is placed on a single year of data, especially in volatile periods; and
- avoid implementing large, across-the-board payment rate increases to support a subset of hospitals with specific needs.

Given the recent volatility in hospital profit margins, it is particularly difficult to assess how FFS Medicare payments should change in 2025. Since the start of the coronavirus pandemic in 2020, hospitals' FFS Medicare margin reached a recent high in 2021 followed by a record low in 2022. Hospitals' all-payer operating margin has also fluctuated dramatically, driven by substantial federal coronavirus relief funds followed by substantial inflation. Periods of volatility and rapid inflation make it extremely difficult for hospitals to constrain costs or plan for the future.

Last year we concluded that payment adequacy indicators for hospitals were generally positive when looking at historical data. However, we projected declines in hospitals' finances due to unanticipated increases in input price inflation. In recognition of this projection and out of particular concern for the effect on hospitals that serve large shares of low-income Medicare beneficiaries, in March 2023 the Commission recommended a record-high update to IPPS and OPPS payments for fiscal year 2024—equal to current law plus 1 percent—as well as transitioning existing safety-net payments to the Commission-developed Medicare Safety-Net Index (MSNI) and adding $2 billion to the MSNI pool (to be split between FFS and MA) (see text box on safety-net hospitals, p. 78). This recommendation was not enacted. As expected, in 2022, hospitals' all-payer and FFS Medicare margins fell dramatically, reflecting a historically difficult financial year.

Looking forward, we expect hospitals' FFS Medicare margin to improve in 2024 because the nonprofit hospitals that participate in the 340B drug program are scheduled to receive $9 billion in 340B remedy payments (equivalent to 5 percent of all IPPS and OPPS payments). However, the 2024 remedy payments are a one-time adjustment. Therefore, we expect that hospitals will once again have relatively low FFS Medicare margins in 2025 if current law holds.

RECOMMENDATION 3

For fiscal year 2025, the Congress should update the 2024 Medicare base payment rates for general acute care hospitals by the amount specified in current law plus 1.5 percent.

In addition, the Congress should:

- **begin a transition to redistribute disproportionate share hospital and uncompensated care payments through the Medicare Safety-Net Index (MSNI);**
- **add $4 billion to the MSNI pool;**
- **scale fee-for-service MSNI payments in proportion to each hospital's MSNI and distribute the funds through a percentage add-on to payments under the inpatient and outpatient prospective payment systems; and**
- **pay commensurate MSNI amounts for services furnished to Medicare Advantage (MA) enrollees directly to hospitals and exclude them from MA benchmarks.**

RATIONALE 3

Hospitals' payment adequacy indicators were mixed, based on the most recent available data. Hospitals maintained excess capacity in aggregate, maintained a financial incentive to serve FFS Medicare beneficiaries, improved their mortality and readmission rates, and maintained strong access to bond markets. However, IPPS hospitals' aggregate all-payer operating margin and their FFS Medicare margin both declined in 2022. While some hospitals were able to maintain a positive FFS Medicare margin, many were not. For 2024, we project that IPPS hospitals' FFS Medicare margin will increase to −8 percent, inclusive of the 340B remedy payments scheduled for that year. Excluding these one-time payments, we project that the 2024 margin will be about −13 percent and that the relatively efficient hospitals' median FFS Medicare margin will be about −3 percent.

The Commission continues to underline the importance of prudently using scarce Medicare resources by targeting them toward Medicare safety-net hospitals. Therefore, we contend that the best balance is a small update above current law to all general ACHs and more significant support to Medicare safety-net hospitals (as defined in our June 2022 and March 2023 reports). Similar to last year,

Supporting Medicare safety-net hospitals through the Commission-developed Medicare Safety-Net Index

Because the Medicare program strives to ensure access to care for all beneficiaries and adequately pay providers for that access, additional Medicare payments to Medicare safety-net providers are warranted. Medicare already provides substantial safety-net funding to hospitals, but there are several problems with the way Medicare distributes these funds, including omitting a hospital's Medicare share from its computation of disproportionate share and uncompensated care per claim add-on amounts in favor of subsidizing Medicaid payments, making supplemental payments only for inpatient services, and having an uncompensated care payment formula that favors hospitals with few fee-for-service (FFS) Medicare patients. The Commission's view is that Medicare safety-net payments should be used primarily to support Medicare safety-net hospitals—those that provide care to large shares of low-income Medicare beneficiaries. We note that this measure of "safety-net" status is Medicare-centric by design; safety-net definitions used by Medicaid and other payers would likely differ.

The Commission-developed Medicare Safety-Net Index (MSNI) is computed using three components: (1) the share of a hospital's Medicare volume associated with low-income beneficiaries (identified as those who receive the Part D low-income subsidy); (2) the share of revenue the hospital spends on uncompensated care (bad debts and charity care); and (3) the share of total volume associated with Medicare beneficiaries. The Commission found that the MSNI is a better indicator of the financial status of hospitals serving large shares of low-income Medicare beneficiaries than the current disproportionate share hospital metric.

Our March 2023 report modeled the effects of redistributing the nearly $12 billion in 2019 disproportionate share and uncompensated care payments via the MSNI, and of adding $1 billion in FFS MSNI payments. On net, the policy change was expected to increase FFS payments by about 0.5 percent on average, with rural hospitals' payments increasing by 2.3 percent on average and government hospitals experiencing a decline of 1.5 percent on average. In general, hospitals with a large share of low-income Medicare patients (often rural hospitals) would have gained Medicare revenue, and hospitals with few Medicare patients but large shares of Medicaid and uninsured patients (often government hospitals) would have received less Medicare revenue under last year's proposal, using 2019 data for modeling purposes. As we discussed at length in last year's report, the financial effects of the proposed policy are to redirect Medicare safety-net funding toward supporting Medicare patients (Medicare Payment Advisory Commission 2023b).

However, since 2019, existing safety-net payments have steadily decreased; for 2024, CMS estimated that safety-net payments will be slightly over $9 billion, about a $3 billion decline from 2019. Because the pool of dollars to be redistributed has declined, hospitals with relatively few Medicare patients, which had benefited under the old policy (often government hospitals), will have less to lose in a redistribution of existing funds. ■

the recommendation would redistribute Medicare's current safety-net payments (disproportionate share and uncompensated care payments) using the Commission-developed MSNI. However, in recognition of the worsened financial performance in 2022 and the roughly $3 billion decline in existing Medicare disproportionate share and uncompensated care payments from 2019 to 2024, the Commission contends that all hospitals warrant greater support than the Commission recommended last year, with the largest increase in payment rates directed toward hospitals serving high shares of low-income Medicare patients.

Our recommendation would increase IPPS and OPPS base payment rates for all hospitals by 1.5 percent above current law. In addition, the recommendation would add $4 billion to existing disproportionate share and uncompensated care payments and redistribute the total pool of dollars through the MSNI. About half would go to hospitals for their care of FFS beneficiaries and half for MA beneficiaries. This roughly $2 billion of FFS MSNI payments would be similar to a 1.3 percent increase to IPPS and OPPS base payments. The combined effects of the two parts of our recommendation would effectively increase IPPS and OPPS payments by 2.8 percent more than the current-law update.

While our recommended 1.5 percent increase to IPPS and OPPS base rates would affect all hospitals equally, the shift from the current disproportionate share and uncompensated care payment model to the MSNI model would have distributional impacts. The current disproportionate share and uncompensated care payments are primarily used to partly reimburse hospitals for the bad debts and charity care costs of non-Medicare patients. The problems with the current safety-net payments are discussed in detail in our March 2023 report to the Congress (Medicare Payment Advisory Commission 2023b). The hospitals that tend to benefit most from this system are disproportionate share hospitals with high uncompensated care costs but relatively few FFS Medicare patients. In contrast, the new MSNI payments would be distributed through an add-on to FFS Medicare payment rates (and an add-on to what FFS payments would have been for MA beneficiaries), so Medicare dollars would follow Medicare patients. The hospitals that would benefit most from the new MSNI approach are hospitals with high shares of Medicare patients and, in particular, high shares of low-income Medicare patients.

While all major categories of hospitals (e.g., teaching, nonteaching, rural, urban, for profit, nonprofit, government) would see increased Medicare payments under our recommendation, the largest gains would be for rural hospitals. Rural hospitals tend to have high Medicare shares and high shares of low-income Medicare patients. On average, we expect that the recommendation would increase rural hospitals' FFS Medicare payments by about 5 percent more than current law, almost double the 2.8 percent average across all hospitals. In contrast, some large government hospitals have relatively few Medicare patients. While some government hospitals would receive large increases in Medicare payments, in aggregate we expect that our recommendation would increase government hospitals' FFS Medicare payments by about 1 percent over current law.

The Commission recommendation specifies that MSNI payments for MA enrollees be made directly to hospitals and excluded from MA benchmarks. This method would be similar to the way indirect medical education payments are currently made to hospitals for their MA patients. Making MSNI payments for enrollees directly to hospitals would reduce current incentives for MA plans to steer patients away from hospitals that receive high levels of safety-net payments from Medicare.

The Commission anticipates that a 2025 update to hospital payment rates of current law plus 1.5 percent and about $2 billion in FFS MSNI funds (since about half of the $4 billion in additional MSNI funds would go toward services for FFS beneficiaries and about half toward services for MA beneficiaries) would generally be adequate to maintain FFS beneficiaries' access to hospital inpatient and outpatient care. These funds would raise IPPS and OPPS payment rates close to the cost of delivering high-quality care efficiently. We expect the additional MSNI funds to be immediately distributed in 2025 and future years; the $4 billion add-on could grow annually by the hospital market basket.

IMPLICATIONS 3

Spending

- This recommendation would increase spending relative to current law by $5 billion to $10 billion in one year and $25 billion to $50 billion over five years.

Beneficiary and provider

- We expect that this recommendation will help ensure Medicare beneficiaries' access to care by increasing hospitals' willingness and ability to treat beneficiaries, especially those with low incomes. ■

Endnotes

1 Throughout this chapter, we use the term "FFS Medicare" as equivalent to the CMS term "Original Medicare." Medicare uses different payment methodologies to pay certain other general ACHs for services provided to FFS beneficiaries and to pay for certain services at general ACHs. For example, Medicare pays about 1,350 small rural hospitals designated as critical access hospitals based on their costs and pays about 50 general ACHs in Maryland based on an all-payer global budget. Medicare also pays separately for services provided to FFS beneficiaries in separate hospital units (such as hospital-based psychiatric units and post-acute care units) and for certain costs (such as hospitals' organ acquisition costs and direct costs of graduate medical education). These payment methodologies are beyond the scope of this chapter.

2 Unless otherwise noted, all years referring to inpatient services refer to fiscal year while those referring to outpatient services refer to calendar year, consistent with when CMS updates these payment systems. Under the IPPS and OPPS, FFS Medicare pays the prospective rate minus any beneficiary cost-sharing liabilities. Medicare reimburses hospitals for 65 percent of bad debts resulting from beneficiaries' nonpayment of cost sharing after hospitals have made reasonable efforts to collect the unpaid amounts. (A more detailed description of the IPPS and OPPS can be found in our *Payment Basics* series at https://www.medpac.gov/document-type/ payment-basic/.)

3 Medicare uses the OPPS to pay for the facility share of providing outpatient services at post-acute care hospitals (i.e., long-term care and rehabilitation hospitals), at certain specialized short-term acute care hospitals (i.e., psychiatric, cancer, and children's hospitals), and at community mental health centers.

4 While this chapter focuses on assessing the adequacy of FFS Medicare's IPPS and OPPS payment rates, we include all general ACHs—defined as ACHs paid under the IPPS, as well as critical access hospitals and ACHs in Maryland and U.S. territories—in our indicators of beneficiaries' access to care because they also provide inpatient and outpatient general ACH services.

5 The denominator includes all "available" beds, which is generally the same as the number of licensed beds and does not necessarily mean the bed was fully staffed throughout the cost reporting period.

6 Hospital employment includes all persons on the hospital payroll, potentially including physicians.

7 We reviewed the press releases, websites, and regulatory documents of closing hospitals to identify the factors that facilities listed as contributing to their decision to close. When those sources were not available or did not provide sufficient detail, we considered popular press coverage that included quotations from hospital representatives. We did not independently verify all the factors cited by each facility.

8 CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.

9 The H-CAHPS response rate for 2022 was 24 percent. The response rate for other provider-focused CAHPS surveys are similar (i.e., the Home Health Care CAHPS response rate was 24 percent and the Hospice CAHPS response rate was 29 percent).

10 IPPS hospitals' all-payer total margin in 2022 was lower than the operating margin (1.5 percent when excluding relief funds), reflecting investment losses. In contrast, the all-payer total margin in 2021 was higher than the operating margin (9.2 percent when excluding relief funds), reflecting investment gains.

11 We reviewed financial statements for six large hospital systems: three nonprofit systems and three for-profit systems (Ascension 2023, Ascension 2022, CommonSpirit 2023, CommonSpirit 2022, Community Health Systems 2023, Community Health Systems 2022, HCA Healthcare 2023, HCA Healthcare 2022 Tenet Health 2023, Tenet Health 2022, Trinity Health 2023, Trinity Health 2022). Together, these six systems represent over 20 percent of all IPPS hospitals.

12 Because distinct units within hospitals can affect the margin of inpatient and outpatient service lines based on where they treat patients (e.g., having a skilled nursing facility in the hospital can allow earlier discharges from the inpatient unit), our FFS Medicare margin includes multiple hospital service lines (including inpatient, outpatient, swing bed, skilled nursing, rehabilitation, psychiatric, and home health services) as well as direct graduate medical education and uncompensated care payments. It does not include payments the Medicare program makes directly to teaching hospitals for their care of MA beneficiaries. In addition, because federal coronavirus relief funds were intended to help cover lost revenue and payroll costs—including lost revenue from FFS Medicare patients and the cost of staff who helped treat these patients—we report a FFS Medicare margin including a portion of these relief funds (based on FFS Medicare's share of 2019 all-payer operating revenue).

13 Hospitals' cost reporting periods vary. In calculating IPPS hospitals' 2022 FFS Medicare margin, we use cost reports with a midpoint in 2022, of which about 30 percent began in July 2021 and 40 percent began in January 2022. However, in the discussion that follows, we primarily focus on changes during FY 2022 because that is the period for which CMS sets IPPS payments.

14 There is an automatic forecast error correction in the inpatient capital PPS. When setting rates for FY 2022, CMS also underestimated the inpatient hospital capital market basket, which was further reduced by an automatic forecast error correction to remove CMS's overestimate in FY 2020.

15 We categorized hospitals as under "high fiscal pressure" if they had a median non-Medicare margin of 1 percent or less over five years and a net worth (assets minus liabilities) that would have grown by less than 1 percent per year over that period if the hospital's Medicare profits had been zero.

16 We do not adjust our costs per inpatient unit for economies of scale. However, we excluded all hospitals with fewer than 300 Medicare inpatient stays and fewer than 900 Medicare outpatient services from our analysis. Teaching hospitals tend to have higher costs per unit, but we standardize costs per unit by adjusting for the effect of case mix, outlier cases, and the cost of training residents. After these adjustments, teaching hospital costs, on average, are similar to nonteaching hospital costs.

17 We adjust costs per unit for the share of Medicare patients that are low income (patients that receive the Part D low-income subsidy or are dually eligible for Medicare and Medicaid in the year). However, we do not adjust readmission or mortality metrics for patient income, in keeping with our policy of not adjusting quality metrics for income.

18 We separate years of data used to assign providers to the relatively efficient group and the performance year metrics to prevent random variation in a single year from affecting both assignment to the efficient group and the efficient group's median margin.

19 The characteristics include (1) average patient severity; (2) relative labor costs (as measured by the Commission's recommended alternative wage index); (3) low-income status; (4) teaching intensity; and (5) outlier index (measured as the Medicare outlier payments' share of base payments). For each hospital, we standardized Medicare costs per unit by removing the effect of expected costs, given their characteristics, on actual costs. Since high outlier costs can indicate either unmeasured differences in illness severity or high-cost structures, we standardize only for a portion of the estimated effect of outliers on costs.

20 We standardized outpatient cost per service using the same set of hospital characteristics as used for standardizing inpatient costs per stay.

21 We require hospitals to have at least 300 inpatient stays and 900 outpatient services in each year of the baseline. In prior years, we required 500 inpatient stays and had no requirement for outpatient volume. We continued to require that Medicaid patients compose a minimum share of hospital days.

22 The 0.5 percent reduction to the OPPS conversion factor will begin in calendar year 2026.

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