CHAPTER 3

Hospital inpatient and outpatient services

RECOMMENDATION

3 The Congress should:

- for 2026, update the 2025 Medicare base payment rates for general acute care hospitals by the amount specified in current law plus 1 percent; and
- redistribute existing disproportionate-share-hospital and uncompensated-care payments through the Medicare Safety-Net Index (MSNI)—using the mechanism described in our March 2023 report—and add $4 billion to the MSNI pool.

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

CHAPTER 3

Hospital inpatient and outpatient services

Chapter summary

General acute care hospitals primarily provide inpatient medical and surgical care to patients needing an overnight stay and outpatient services, including procedures, tests, evaluation and management services, and emergency care. To pay hospitals for the facility share of providing these 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 2023, the FFS Medicare program and its beneficiaries spent nearly $180 billion on services paid under the IPPS and OPPS, including $6.7 billion in uncompensated-care payments made under the IPPS.

Assessment of payment adequacy

In 2023, FFS Medicare payment-adequacy indicators for general acute care hospitals were mixed. Beneficiary access to care remained good overall, and hospitals' all-payer margin was positive and improved. However, quality indicators were mixed, and FFS Medicare payments remained well below hospitals' costs.

Beneficiaries' access to care—Indicators of beneficiaries' access to hospital inpatient and outpatient services suggest that FFS Medicare beneficiaries maintained good access.

In this chapter

- ***Capacity and supply of providers*—**From fiscal year (FY) 2022 to FY 2023, hospital employment increased 3 percent to 4.7 million and the number of hospitals' inpatient beds increased 1 percent to 674,000. In addition, hospitals' occupancy rate remained at about 69 percent, and the median percentage of emergency department patients who left without being seen remained near 2 percent. The supply of hospitals was relatively steady, though about 10 more hospitals closed than opened in both 2023 and 2024, and others converted to rural emergency hospitals.
- ***Volume of services*—**From FY 2022 to FY 2023, the number of inpatient stays per beneficiary increased over 1 percent, to 205.3 stays per 1,000 FFS Medicare beneficiaries. In addition, from calendar year (CY) 2022 to CY 2023, the number of hospital outpatient services per beneficiary increased over 2 percent, up to 5.2 services per FFS beneficiary.
- ***FFS Medicare marginal profit*—**We estimate that hospitals' marginal profit on inpatient and outpatient services provided to FFS Medicare beneficiaries remained positive in FY 2023. This finding suggests that most hospitals continued to have a financial incentive to serve FFS Medicare beneficiaries.

***Quality of care*—**In FY 2023, FFS Medicare beneficiaries' risk-adjusted hospital mortality rate was 7.6 percent, an improvement relative to the 2019 and 2022 level of 7.9 percent. FFS Medicare beneficiaries' risk-adjusted readmission rate was 15.0 percent in 2023, worse than the previous year but an improvement compared with the prepandemic rate of 15.5 percent. Most patient-experience measures improved in 2023 but continued to be at least 1 percentage point below prepandemic levels.

***Providers' access to capital*—**From FY 2022 to FY 2023, hospitals' all-payer operating margin increased from 2.7 percent to 5.1 percent, despite a decline in coronavirus relief funds. However, within this aggregate, there continued to be substantial variation: A quarter of hospitals had an all-payer operating margin greater than 10 percent, and a quarter had an all-payer operating margin less than −4 percent. In addition, the all-payer operating margin continued to be lower among hospitals with higher values of the Commission-developed Medicare Safety-Net Index (MSNI). Other measures of hospitals' access to capital were positive in 2023: Hospitals' all-payer total margin increased over 4 percentage points, hospitals' borrowing costs increased by less than the general market, and mergers and acquisitions continued. Preliminary data suggest further improvement in hospitals' access to capital in FY 2024.

FFS Medicare payments and providers' costs—FFS Medicare payments for inpatient and outpatient services continued to be below hospitals' costs in FY 2023. From 2022 to 2023, exclusive of coronavirus relief funds, hospitals' FFS Medicare margin was stable (from –13.1 percent to –13.0 percent). Nonetheless, some hospitals—which we refer to as "relatively efficient"—consistently achieved lower costs while still performing relatively well on a specified set of quality metrics. The 2023 median FFS Medicare margin among these relatively efficient hospitals was –2 percent, exclusive of coronavirus relief funds. For 2025, we project that hospitals' FFS Medicare margin will remain stable at about –13 percent. Similarly, we project that the median FFS Medicare margin among relatively efficient hospitals will remain stable at about –2 percent.

How should FFS Medicare payments change in 2026?

The current-law updates to payment rates for 2026 will not be finalized until summer 2025, but CMS's current forecasts and other required updates are projected to increase the IPPS and OPPS base rates by over 2 percent.

Based on our assessment of the payment-adequacy indicators listed above, the Commission recommends that the Congress (1) for 2026, update the 2025 Medicare base payment rates for general acute care hospitals by the amount reflected in current law plus 1 percent and (2) redistribute existing disproportionate-share-hospital and uncompensated-care payments to hospitals through the MSNI—using the mechanism described in our March 2023 report—and increase the MSNI pool by $4 billion. The MSNI funds would be distributed to hospitals across their FFS and Medicare Advantage 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 financial challenges.

Mandated report: Rural emergency hospitals

The Consolidated Appropriations Act (CAA), 2021, created a new rural emergency hospital (REH) designation, effective January 2023. The CAA requires the Commission to report annually on payments to REHs, beginning in March 2024.

During CY 2023, 21 hospitals converted to REHs. FFS Medicare paid about $10 million for outpatient hospital services at these REHs and about $30 million in fixed monthly payments to cover standby costs. FFS Medicare's monthly fixed payments were three times as high as claims-based payments, which underscores the importance of fixed payments for the viability of REHs. ■

Background

General acute care hospitals primarily provide inpatient medical and surgical care to patients needing an overnight stay and outpatient services, including procedures, tests, evaluation and management services, and emergency care. To pay hospitals for the facility share of inpatient and hospital 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] This chapter uses the term "general acute care hospital" or just "hospital" to refer to hospitals paid under the IPPS and OPPS.[2]

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, and the OPPS sets payments for separately payable drugs based on the manufacturer's average sales price.[3]

In 2023, the FFS Medicare program and its beneficiaries spent nearly $180 billion on services paid for under the IPPS and OPPS, including $6.7 billion in uncompensated-care payments made under the IPPS and $20.4 billion for separately payable items, mainly drugs, made under the OPPS (Table 3-1).[4] FFS beneficiaries' cost-sharing liability totaled 7 percent of IPPS payments and 17 percent of OPPS payments.

Services paid under the IPPS and OPPS were a sizable share of hospital services and accounted for a sizable share of hospital revenue

While hospitals provide a wide range of services to both FFS Medicare beneficiaries and other patients, services paid under the IPPS and OPPS continued to be a sizable share of hospital services. In FY 2023, 23 percent of all acute inpatient stays were FFS Medicare

TABLE 3–1

In 2023, FFS Medicare spent nearly $180 billion on hospital services paid for under the IPPS and OPPS

	Medicare payment system	
	IPPS	OPPS
Number of hospitals	3,145	3,110
Number of users (in millions)	4.2	15.9
Volume of services (in millions)	6.6	123.8
Total Medicare payments (in billions)	$109.3	$70.0
Payments for base-rate-covered services (in billions)	$102.6	$49.6
Other payments (in billions)	$6.7	$20.4
Beneficiary cost-sharing liability as share of total Medicare payments	7%	17%

Note: FFS (fee-for-service), IPPS (inpatient prospective payment systems), OPPS (outpatient prospective payment system). The number of hospitals that provided IPPS services is higher than the number that provided OPPS services primarily because Indian Health Services hospitals are paid under the IPPS but not OPPS and data are limited to Subsection (d) hospitals. (OPPS data on other hospitals, such as post-acute care hospitals, are not included.) "Total Medicare payments" includes the FFS Medicare program amount and beneficiary cost-sharing liability (which may be paid by the beneficiary or the beneficiary's supplemental insurance, or it may become hospital bad debt). "Other payments" refers to uncompensated-care payments (in the case of the IPPS) and to payments for separately payable drugs, devices, blood products, and brachytherapy sources (in the case of the OPPS). The given year (2023) refers to fiscal year for inpatient services and calendar year for outpatient services, consistent with when CMS updates these payment systems.

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

TABLE 3–2

Hospital employment and inpatient beds increased in 2023

	Fiscal year					Percent change	
Capacity measure	**2019**	**2020**	**2021**	**2022**	**2023**	**2019–2023**	**2022–2023**
Employment (millions)	4.5	4.4	4.5	4.5	4.7	4.1%	3.0%
Beds (thousands)	663	669	670	667	674	1.5	1.0

Note: Data include all Subsection (d) and critical access hospitals that provided inpatient services to at least one fee-for-service Medicare beneficiary. Employment figures and numbers of beds differ from those published in prior years because this year we limited employment to Subsection (d) and critical access hospitals and included all inpatient beds, regardless of what share of time the beds were used for swing-bed or observation services. Data were imputed for hospitals that had not yet submitted 2023 cost reports at the time of our analysis. Percentage changes were calculated on unrounded data.

Source: MedPAC analysis of hospital cost reports.

stays paid under the IPPS. In addition, 18 percent of all outpatient services (as measured by charges) were FFS Medicare services paid under the OPPS.

Similarly, services paid under the IPPS and OPPS accounted for a sizable share of hospitals' revenue. Of the over $1.2 trillion in hospitals' operating revenue in FY 2023, about 14 percent came from services provided to FFS Medicare beneficiaries paid under the IPPS or OPPS. (The share of hospitals' operating revenue from FFS Medicare across all service lines, such as physician services, is higher.)

Furthermore, like other FFS Medicare payment rates, IPPS and OPPS payments have implications beyond FFS Medicare because both Medicare Advantage and other payers use FFS payment rates in setting their rates (see Chapter 2).

Are FFS Medicare payments adequate in 2025?

Based on the most recently available data, indicators of the adequacy of IPPS and OPPS payments have been mixed. In FY 2023, FFS Medicare beneficiaries' access to hospital inpatient and outpatient services remained adequate: Hospitals continued to have the capacity to care for FFS Medicare beneficiaries and a financial incentive to provide inpatient and outpatient services. In addition, hospitals' access to capital improved: Hospitals' all-payer operating margin increased in 2023, and preliminary data suggest further improvement in 2024. However, FFS Medicare payments continued to be lower than hospitals' costs in 2023: Excluding relief funds, hospitals' FFS Medicare margin was –13 percent, and the median FFS Medicare margin was –2 percent for relatively efficient hospitals. For FY 2025, we project stable FFS Medicare margins.

Beneficiaries maintained good access to hospital inpatient and outpatient services in 2023

Indicators of hospital capacity and supply and FFS Medicare beneficiaries' use of services all suggest that FFS Medicare beneficiaries maintained good access to hospital inpatient and outpatient services in FY 2023. Hospital employment and the number of hospital beds both increased, and hospitals' occupancy rate remained steady at 69 percent. The supply of hospitals was also relatively steady. Looking more specifically at FFS Medicare beneficiaries, the number of inpatient stays and outpatient services per beneficiary increased. In addition, hospitals' FFS Medicare marginal profit remained positive—that is, FFS Medicare payments for inpatient and outpatient services continued to exceed estimates of hospitals' costs of providing an additional inpatient or outpatient service to FFS Medicare beneficiaries.

TABLE 3–3

Hospitals maintained available inpatient and emergency department capacity in 2023, but considerable variation remained

						Percentage point change	
Available capacity measure	**2019**	**2020**	**2021**	**2022**	**2023**	**2019–2023**	**2022–2023**
Occupancy rate							
Aggregate	67%	64%	68%	69%	69%	2	0
5th percentile	13	13	13	13	12	–1	–1
95th percentile	87	83	88	89	89	2	–1
Left ED without being seen							
Median	1%	1%	2%	2%	TBD	TBD	TBD
5th percentile	1	1	2	2	TBD	TBD	TBD
95th percentile	4	4	6	7	TBD	TBD	TBD

Note: ED (emergency department), TBD (to be determined). "Occupancy rate" refers to the share of bed days that were occupied by a patient (regardless of whether the patient was receiving inpatient, observation, or swing-bed services); bed days may be higher than staffed bed days. Data include all Subsection (d) and critical access hospitals that had a complete cost report with a midpoint in the fiscal year and had non-outlier data as of our analysis. Results differ from those published last year because of newer data and methodological updates, such as identification of statistical outliers. Years are fiscal except for ED data, which are reported on a calendar-year basis. ED data for 2023 were not available at the time of our analysis. Percentage point differences were calculated on unrounded data.

Source: MedPAC analysis of hospital cost reports and CMS timely and effective care data.

Hospital capacity increased, relative to both 2022 and 2019

From FY 2022 to FY 2023, two measures of hospital capacity increased: hospital employment and the number of inpatient beds (Table 3-2). Hospital employment increased 3 percent to 4.7 million full-time-equivalent staff. The number of inpatient beds increased 1 percent, to 674,000. Both measures of capacity were higher than they were in the immediate prepandemic period.

Hospitals maintained available capacity

In FY 2023, hospitals continued to have available inpatient and emergency department (ED) capacity (Table 3-3). Hospitals' occupancy rate was 69 percent in FY 2023, similar to the level in 2022. While the occupancy rate was 2 percentage points higher than in the immediate prepandemic period, it was still indicative of available capacity. Hospitals also continued to have adequate ED capacity: At the median hospital, about 2 percent of ED patients left without being seen in CY 2022 (the most recent year of data currently available).

However, as in past years, there was significant variation within these aggregates, with some hospitals having substantially higher available capacity while others faced capacity constraints. In FY 2023, 5 percent of hospitals had an occupancy rate under 12 percent, while another 5 percent had an occupancy rate over 89 percent. Similarly, in CY 2022, 5 percent of hospitals had over 7 percent of ED patients leave without being seen. Hospital EDs that have a high share of patients who leave without being seen may not have the staff or resources to provide timely and effective ED care.

Supply of hospitals held relatively steady in 2023, though slightly more hospitals closed than opened

In FY 2023, the supply of hospitals as measured by provider numbers was relatively steady, declining 0.2 percent to 4,556 (Table 3-4, p. 70). However, changes in the count of hospital provider numbers do not necessarily reflect changes in access; for example, they can also reflect mergers and acquisitions. Of the 4,556 hospitals that provided at least one inpatient service

TABLE 3–4

In 2023, the number of hospitals held relatively stable, though slightly more closed than opened, and others converted to rural emergency hospitals

	Fiscal year					Percent change	
Supply measure	**2019**	**2020**	**2021**	**2022**	**2023**	**2019–2023**	**2022–2023**
Unique provider numbers	4,645	4,603	4,572	4,563	4,556	–1.9%	–0.2%
Openings	12	18	11	17	7	N/A	N/A
Metropolitan	12	15	10	13	5	N/A	N/A
Rural micropolitan	0	1	0	2	0	N/A	N/A
Other	0	2	1	2	2	N/A	N/A
Closures	46	25	11	17	19	N/A	N/A
Metropolitan	28	14	7	12	11	N/A	N/A
Rural micropolitan	4	6	1	5	5	N/A	N/A
Other	14	5	3	0	3	N/A	N/A
Conversions to rural emergency hospital	N/A	N/A	N/A	N/A	17	N/A	N/A

Note: N/A (not applicable). Data include all Subsection (d) and critical access hospitals that provided inpatient services to at least one fee-for-service Medicare beneficiary. "Unique provider numbers" are those that provided at least one inpatient service to a fee-for-service Medicare beneficiary. A change in unique provider numbers does not necessarily reflect a change in access; for example, it can reflect mergers and acquisitions. "Openings" refers to a new location for inpatient services, while "closures" refers to a hospital that ceased inpatient services and did not convert to a rural emergency hospital. The counts of openings and closures do not include the relocation of inpatient services from one hospital to another under common ownership within 10 miles, nor do they include hospitals that both opened and closed within a five-year period. The number of hospital closures and openings in a given year can change from prior publications as hospitals reopen and newer data become available. Percentage changes were calculated on unrounded data. "Metropolitan" refers to counties that contain an urban cluster of 50,000 or more people; "rural micropolitan" refers to counties that contain a cluster of 10,000 to 50,000 people; all other counties are classified as "other."

Source: MedPAC analysis of Medicare Provider Analysis and Review file, Provider of Services files, census data on metropolitan and micropolitan areas, and internet searches.

to FFS Medicare beneficiaries in FY 2023, 7 opened at some point in the year, while 19 ceased to offer inpatient services. In addition, 17 hospitals converted to REHs in FY 2023 (see text box on rural emergency hospitals, pp. 72–73).

In FY 2024, an additional 4 hospitals opened, 15 closed, and 17 converted to REHs (data not shown). Of the four hospitals that opened, all were in metropolitan areas, one is reopening as a critical access hospital, and the distance to the nearest hospital ranged from less than 2 miles to about 26 miles. Of the 15 hospitals that closed, 10 were located in metropolitan areas, 8 had fewer than 50 beds, and 5 were critical access hospitals. In addition, four of the closures were in two hospital systems. The average distance to the next-nearest hospital was 16 miles; four rural closures were more than 25 miles from the next hospital. According to hospital press releases and news reports, FFS Medicare payment rates did not appear to be the main contributor to the financial difficulties of the hospitals that closed in 2024. Rather, many hospitals that closed in 2024 cited other financial reasons; low patient volume was the most common.[5]

FFS Medicare beneficiaries' use of inpatient services per capita increased but remained substantially below prepandemic level

In FY 2023, inpatient stays per FFS Medicare beneficiary increased 1.5 percent, up to 205 stays per 1,000 FFS Medicare beneficiaries (Table 3-5). The increase in stays per capita primarily resulted from increases in inpatient stays for circulatory conditions, infectious diseases, and musculoskeletal conditions, which collectively more than offset a decrease in respiratory conditions; together these shifts

TABLE 3–5

FFS Medicare beneficiaries' inpatient stays per capita increased in 2023 but remained substantially below prepandemic level

	Fiscal year					Percent change	
Inpatient volume measure	**2019**	**2020**	**2021**	**2022**	**2023**	**2019–2023**	**2022–2023**
Inpatient stays per 1,000 beneficiaries	244.5	213.6	207.7	202.3	205.3	–16.0%	1.5%
Inpatient stays (millions)	9.2	7.9	7.4	7.0	6.9	–25.0	–1.3
Average length of stay (days)	4.9	5.1	5.5	5.6	5.3	7.9	–4.1

Note: FFS (fee-for-service). Data include all Subsection (d) and critical access hospitals. FFS Medicare beneficiary enrollment is limited to those who resided in the U.S. and had Part A. Percentage changes were calculated on unrounded data.

Source: MedPAC analysis of Medicare Provider Analysis and Review file and Common Medicare Environment files.

contributed to a 4.1 percent decrease in the average length of stay. (Overall, inpatient stays by FFS Medicare beneficiaries declined 1.3 percent in 2023 because the decrease in FFS Medicare beneficiaries was larger than the increase in stays per beneficiary.)

Despite the increase in 2023, the number of inpatient stays per capita remained 16 percent below that of the immediate prepandemic period, and the length of stay remained nearly 8 percent longer. These findings could reflect a continuation of the prepandemic decline in stays per capita, driven by the shift of some types of care (such as joint replacements) from inpatient to outpatient settings.

FFS Medicare beneficiaries' use of hospital outpatient services per capita increased but remained below prepandemic level

In CY 2023, hospital outpatient services per FFS Medicare beneficiary increased 2.4 percent, up to 5.2 services per FFS Medicare beneficiary (Table 3-6). The increase in outpatient services per capita primarily resulted from small volume increases in a broad range of evaluation and management, imaging, and procedure services that collectively more than offset a large drop in the number of COVID-19 specimen collection services. (Overall, outpatient services provided to FFS Medicare beneficiaries declined 1.3 percent in 2023, to 145 million, because the decrease in FFS Medicare

TABLE 3–6

FFS Medicare beneficiaries' hospital outpatient services per capita increased in 2023 but remained below prepandemic level

	Calendar year					Percent change	
Outpatient volume measure	**2019**	**2020**	**2021**	**2022**	**2023**	**2019–2023**	**2022–2023**
Outpatient services per beneficiary	5.3	4.3	5.2	5.1	5.2	–2.8%	2.4%
Outpatient services (millions)	173.3	136.6	157.6	146.9	145.0	–16.3	–1.3

Note: FFS (fee-for-service). Data include all Subsection (d) and critical access hospitals. FFS Medicare beneficiary enrollment is limited to those who resided in the U.S. and had Part B. Outpatient results differ from the results previously published because we modified the way we capture changes in policies for packaging ancillary items under the outpatient prospective payment system and because of the effects of expanded uses of comprehensive ambulatory payment classifications that occur over time. Percentage changes were calculated on unrounded data.

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

Mandated report: Rural emergency hospitals

Since 1983, when Medicare moved from paying hospitals on the basis of their costs to prospectively determined rates, policymakers have sought ways to support rural beneficiaries' access to hospital services. Historically, this support focused on making inpatient hospital services more profitable. However, inpatient volume has declined dramatically over the past 40 years, especially at rural hospitals, reducing the impact of Medicare's inpatient-centric support of hospitals and contributing to an increase in rural hospital closures. This situation led the Commission, in 2018, to recommend that Medicare create a new category of hospital: an outpatient-only facility with a 24/7 emergency department (ED). Rather than being paid on a purely fee-for-service (FFS) basis, the new outpatient-only hospitals would receive a fixed monthly payment to help support the standby costs of maintaining an ED in addition to outpatient prospective payment system (OPPS) rates for each outpatient service. Consistent with the Commission's recommendation, the Congress enacted the new rural emergency hospital (REH) designation in the Consolidated Appropriations Act (CAA), 2021. As an REH, a hospital will:

- not furnish inpatient care,
- have an emergency department that is staffed 24/7,
- receive fixed monthly payments from Medicare,
- be paid 105 percent of standard OPPS rates for emergency and outpatient services, and
- meet other criteria (e.g., have a transfer agreement with a Level I or II trauma center).

Becoming an REH is voluntary, meaning that hospitals can choose whether they want to transition to an REH. Hospitals eligible to transition to an REH are those that, as of December 27, 2020, were critical access hospitals or Subsection (d) hospitals with 50 or fewer beds in a rural county. Hospitals began to transition to REHs starting in 2023.

The CAA requires the Commission to report annually on payments to REHs. In its March 2024 report to the Congress, the Commission described the historical context that led to the creation of REHs and the characteristics of the first cohort of REHs (Medicare Payment Advisory Commission 2024). In this report, we provide updated information on the number of REHs and payments made from FFS Medicare to REHs in the first full year that the designation was available.

(continued next page)

beneficiaries was larger than the increase in services per beneficiary.)

Despite the increase in 2023, the number of outpatient services per capita in 2023 remained 2.8 percent lower than in the immediate prepandemic period (Table 3-6, p. 71). While the volume of many types of hospital outpatient services rebounded to near prepandemic levels, other types of services remained well below the level in 2019. In particular, ED visits per FFS Medicare beneficiary remained about 13 percent below the level in 2019 (data not shown). This shift could reflect FFS Medicare beneficiaries seeking certain types of care in other settings, such as urgent care centers.

Hospitals continued to have a financial incentive to provide services to FFS Medicare beneficiaries

We estimate that, on average, FFS Medicare payments exceeded hospitals' marginal costs of treating an additional FFS Medicare beneficiary in 2023, indicating that hospitals continued to have a financial incentive to provide services to FFS Medicare beneficiaries. It is difficult to use hospital cost reports' cost-center accounting to precisely estimate the share of

Mandated report: Rural emergency hospitals (cont.)

In calendar year (CY) 2023, 21 hospitals converted to REHs. In 2024, the number of active REHs increased to 36.[6] Because complete CY 2024 claims data were not available at the time of our analysis, we analyzed 2023 claims data for the 21 REHs in 2023.

In CY 2023, FFS Medicare paid about $10 million for outpatient hospital services at REHs.[7] Over $8 million was paid through the OPPS. Because REHs get paid 105 percent of standard OPPS rates, in aggregate, these payments were about $400,000 higher than they would have been using standard OPPS rates. The OPPS services that accounted for the highest share of spending at REHs were ED visits, drug-administration services, intraocular procedures (e.g., cataract surgery), and imaging services.

The remaining payments to REHs were for non-OPPS services, such as physical therapy and clinical laboratory fee schedule services. Non-OPPS services are not paid enhanced rates at REHs but are instead paid standard rates (e.g., physical therapy services are paid at the standard physician fee schedule rate).

In addition to claims-based payments, REHs also receive fixed monthly payments from Medicare. In CY 2023, fixed payments were about $267,000 per month per REH after incorporating the effects of the sequester. In CY 2023, we estimate that, in aggregate, REHs received about $30 million in monthly fixed payments. Monthly fixed payments were three times as high as FFS Medicare's claims-based payments, which underscores the importance of fixed payments for the viability of REHs.

The Commission continues to monitor the implementation and uptake of the new REH designation. In the summer of 2024, the Commission conducted site visits at REHs and other rural hospitals to discuss the new REH designation and other payment issues. As in our site visits in 2023, we heard from rural hospitals that Medicare Advantage (MA) plans tend to match FFS's claims-based payment rates for REHs but do not pay REHs fixed monthly payments. However, Medicare's fixed monthly payments to REHs are included in MA benchmarks. In the March 2024 report to the Congress, the Commission noted that excluding REH fixed payments from MA benchmarks would promote equity between FFS and MA because plans would not be paid (through higher benchmarks) for doing something they are not expected to do (i.e., match the fixed payments to REHs) (Medicare Payment Advisory Commission 2024). ■

hospitals' costs that increase with each additional patient. For example, the share of administrative costs that are fixed can vary substantially by hospital and the planning horizon. We therefore looked at how hospitals' aggregate costs varied from year to year and estimated that between about 75 percent and 85 percent of costs varied as volume changed.[8] Since IPPS and OPPS payments amounted to about 85 percent of hospitals' costs, we estimate that hospitals' FFS Medicare marginal profit continued to be positive in 2023.[9] (See the text box in Chapter 2 on the different margin measures MedPAC uses to assess provider profitability.)

Direct financial incentives are not the only factors that affect hospital decision-making on whether to provide services to FFS Medicare beneficiaries. For example, hospitals may also choose to serve FFS Medicare patients to maintain their nonprofit status and support hospitals' missions.

Quality of hospital care in 2023 was mixed

In 2023, the quality of hospital care was mixed, relative to both 2022 and 2019. FFS Medicare beneficiaries' risk-adjusted hospital mortality rate improved 0.3 percentage points in 2023, and it improved relative

TABLE 3–7

FFS Medicare beneficiaries' risk-adjusted hospital mortality rate improved in 2023 and relative to prepandemic level

	Fiscal year					Percentage point change	
Mortality rate	**2019**	**2020**	**2021**	**2022**	**2023**	**2019–2023**	**2022–2023**
Risk adjusted	7.9%	8.4%	8.4%	7.9%	7.6%	–0.3	–0.3
Unadjusted	8.2	9.8	11.3	10.6	9.4	1.2	–1.2

Note: FFS (fee-for-service). "Mortality rate" refers to the share of inpatient stays that result in death during or within 30 days after the inpatient stay. Results differ from those published in prior years because of methodological updates, including removing critical access hospital stays.

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

to the prepandemic level. FFS beneficiaries' risk-adjusted readmission rate was slightly worse in 2023 than in 2022 but about 0.5 percentage points better than the immediate prepandemic period. Most patient-experience measures improved in 2023 but continued to be at least 1 percentage point lower than prepandemic levels.

Hospital mortality rate improved in 2023 and relative to prepandemic level

In FY 2023, FFS Medicare beneficiaries' risk-adjusted hospital mortality rate—defined as the share of inpatient stays that result in death during or within 30 days after the inpatient stay—improved to 7.6 percent, 0.3 percentage points lower than the level in 2022 and in 2019 (Table 3-7). Since the start of the pandemic in 2020, 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. However, from 2021 to 2023, FFS Medicare beneficiaries' hospital mortality rate improved on both an unadjusted and risk-adjusted basis.

In 2023, hospitals in rural nonmicropolitan areas had a higher risk-adjusted mortality rate (9.2 percent) compared with hospitals in rural micropolitan (8.3 percent) and hospitals in urban areas (7.5 percent) (data not shown).[10] From 2021 to 2023, hospitals in rural nonmicropolitan areas had the most improvement in risk-adjusted mortality rates (1.7 percentage points). In

TABLE 3–8

FFS Medicare beneficiaries' risk-adjusted hospital readmission rate worsened in 2023 but improved relative to prepandemic level

	Fiscal year					Percentage point change	
Readmission rate	**2019**	**2020**	**2021**	**2022**	**2023**	**2019–2023**	**2022–2023**
Risk adjusted	15.5%	15.0%	14.8%	14.6%	15.0%	–0.5	0.4
Unadjusted	15.7	15.6	15.9	15.6	15.7	0.0	0.1

Note: FFS (fee-for-service). "Readmission rate" refers to the share of inpatient stays that result in a readmission for any condition within 30 days after the initial inpatient stay. Results differ from those published in prior years because of methodological updates, including removing critical access hospital stays.

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

TABLE 3–9

Most hospital patient-experience measures improved in 2023 but remained below prepandemic levels

	Calendar year					Percentage point change	
H–CAHPS measure	2019	2020	2021	2022	2023	2019–2023	2022–2023
Share of patients rating the hospital a 9 or 10 out of 10	73%	72%	72%	70%	72%	–1	2
Share of patients who would definitely recommend the hospital	72	71	70	69	70	–2	1
Share of patients giving top ratings for:							
Communication with nurses	81	80	80	79	80	–1	1
Communication with doctors	82	81	80	79	80	–2	1
Responsiveness of hospital staff	70	67	66	65	66	–4	1
Communication about medicines	66	63	62	62	62	–4	0
Cleanliness of hospital environment	76	73	73	72	73	–3	1
Quietness of hospital environment	62	63	62	62	62	0	0
Understanding their care when they left the hospital (care transitions)	54	52	52	51	52	–2	1
Share of patients who received discharge information	87	86	86	86	86	–1	0

Note: H–CAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems). H–CAHPS is a standardized 29-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. These results encompass all hospitals that received H–CAHPS scores. National H–CAHPS response rates from 2019 to 2023 ranged from 23 percent to 25 percent.

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

2023, for-profit hospitals had higher mortality rates (7.8 percent) than nonprofit hospitals (7.5 percent).

Hospital-readmission rate worsened in 2023 but remained better than the prepandemic level

In FY 2023, FFS Medicare beneficiaries' risk-adjusted hospital-readmission rate worsened (higher is worse) by 0.4 percentage points to 15.0 percent; however, it remained better than the 15.5 percent rate in 2019 (Table 3-8). Although unadjusted readmission rates were stable from 2019 to 2023, risk-adjusted readmission rates decreased because beneficiaries admitted to hospitals in recent years tend to have more comorbidities and thus a higher expected rate of readmission.

In 2023, hospitals in urban areas had a higher risk-adjusted readmission rate (15.1 percent) compared with hospitals in rural micropolitan and nonmicropolitan areas (14.2 percent) (data not shown). From 2021 to 2023, hospitals in rural nonmicropolitan areas had the most improvement in risk-adjusted readmission rates (1.3 percentage points). In 2023, for-profit hospitals had higher readmission rates (15.7 percent) than nonprofit hospitals (15.0 percent).

Most patient-experience measures improved in 2023 but remained below prepandemic levels

Most hospital patient-experience measures improved from 2022 to 2023, but performance remained at least 1 percentage point below prepandemic levels for almost all measures (Table 3-9). 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. 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 2023, 72 percent of surveyed patients rated their overall hospital experience a 9 or 10 on a 10-point scale, an improvement of 2 percentage points from 2022 but still a percentage point below 2019.[11] 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 52 percent of surveyed patients "strongly agreeing" that they understood their care plan when they left the hospital.

Hospitals in rural areas have higher H–CAHPS results than hospitals in urban areas (Centers for Medicare & Medicaid Services 2024). For example, 74 percent of surveyed patients who received care in a rural hospital rated their overall hospital experience a 9 or 10, while 69 percent of surveyed patients who received care in an urban hospital rated their overall hospital experience highly (data not shown). Nonprofit hospitals have higher H–CAHPS results than for-profit hospitals on all but the measure of quietness in the hospital. Larger hospitals (by number of beds) have higher H–CAHPS results than smaller hospitals.

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.

Hospitals' access to capital improved in 2023

The main way that hospitals access capital to maintain, modernize, and expand their facilities is through operating profits, and these improved in FY 2023. Hospitals' all-payer operating margin increased to 5.1 percent in 2023, and the majority of hospitals had a positive operating margin, indicating that hospitals had net operating profits that could be used for hospital capital projects. Other measures of hospitals' access to capital were positive in 2023, with a larger increase in hospitals' all-payer total margin but also higher borrowing costs. Preliminary data suggest further improvement in hospitals' access to capital in 2024.

Hospitals' all-payer margin increased in 2023

Hospitals' primary source of access to capital—operating profits—increased in FY 2023. Hospitals' all-payer operating margin increased to 5.1 percent in 2023, up from 2.7 percent in 2022 (Table 3-10). (See the text box in Chapter 2 on the different margin measures MedPAC uses to assess provider profitability.) The 2.4 percentage point increase in hospitals' all-payer operating margin occurred despite a decrease in coronavirus relief funds. In 2023, hospitals reported about $3 billion in coronavirus relief funds, down from $9 billion in 2022 (data not shown). Nonetheless, hospitals' operating revenue increased about 8 percent in 2023—the second-highest growth rate in the past 10 years. In comparison, their costs increased about 5 percent—similar to the levels in the immediate prepandemic period.

As in prior years, there was significant variation within this aggregate. A quarter of hospitals had an all-payer operating margin below –4 percent, while another quarter had a margin above 10 percent. The majority of hospitals had a positive operating margin. While there was variation within each group of hospitals, the 2023 all-payer operating margin continued to be much higher for hospitals located in urban areas than for hospitals located in rural nonmicropolitan areas. In addition, the all-payer margin remained lower among hospitals that had higher values on the Commission-developed Medicare Safety-Net Index (MSNI) (see text box, p. 78), and the MSNI continued to be a better predictor of hospitals' all-payer operating margin than the current disproportionate-share-hospital (DSH) metric.[12]

Other indicators of access to capital were positive

Hospitals' other sources of capital were positive in FY 2023 relative to FY 2022:

- ***Hospitals' all-payer total margin increased.*** In FY 2023, hospitals' all-payer total margin was 6.4 percent, up from 2.3 percent in 2022. (See the text box in Chapter 2 on the different margin measures MedPAC uses to assess provider profitability.) The total margin includes operating income as well as investment and donation income. The total margin increased more than the operating margin because hospitals received about $13 billion in

TABLE 3–10

Hospitals' all-payer operating margin increased in 2023, and significant variation across hospitals persisted

Group	Fiscal year 2019	2020	2021	2022	2023
Including relief funds					
All					
Aggregate	6.7%	5.5%	8.8%	2.7%	5.1%
25th percentile	–1.5	–1.2	0.9	–5.5	–4.0
Median	4.3	4.6	7.2	1.6	2.8
75th percentile	11.0	11.3	14.9	9.8	10.4
Ownership					
For profit	12.5	13.0	15.4	12.9	12.9
Nonprofit	6.2	4.8	8.3	1.0	4.4
Geography*					
Metropolitan	6.9	5.5	8.8	2.8	5.3
Micropolitan	5.1	5.7	9.0	1.2	3.2
Other rural	0.9	3.9	7.7	0.9	–0.5
MSNI					
Lowest quartile	NS	NS	11.6	5.9	7.6
2nd quartile	NS	NS	9.7	3.4	7.1
3rd quartile	NS	NS	8.7	4.3	5.7
Highest quartile	NS	NS	4.9	3.1	3.7
Excluding relief funds					
All					
Aggregate	6.7	2.1	7.4	2.0	4.9
25th percentile	–1.5	–6.6	–1.8	–7.1	–4.5
Median	4.3	0.8	4.6	0.5	2.5
75th percentile	11.0	8.4	13.0	8.8	10.1
Ownership					
For profit	12.5	10.7	14.3	12.5	12.7
Nonprofit	6.2	1.2	7.0	0.2	4.1
Geography*					
Metropolitan	6.9	2.1	7.5	2.2	5.0
Micropolitan	5.1	1.2	6.5	–0.7	2.9
Other rural	0.9	–1.7	2.7	–2.5	–1.0
MSNI					
Lowest quartile	NS	NS	10.5	5.4	7.4
2nd quartile	NS	NS	8.5	2.8	7.0
3rd quartile	NS	NS	7.3	3.4	5.3
Highest quartile	NS	NS	2.7	2.2	3.3

Note: MSNI (Medicare Safety–Net Index), NS (not shown). Data are for hospitals paid under the inpatient prospective payment systems that had a complete cost report with a midpoint in the fiscal year and had non-outlier data as of our analysis. The all-payer operating margin excludes investment and donation income. "Relief funds" refers to federal or other coronavirus relief funds. Results differ from those published last year because of newer data and methodological updates, such as identification of statistical outliers and inclusion of other coronavirus relief funds.
* 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."

Source: MedPAC analysis of hospital cost reports, census geographic files, and MSNI data sources.

The Commission-developed Medicare Safety-Net Index

The Commission developed the Medicare Safety-Net Index (MSNI) to identify financially vulnerable hospitals that serve large shares of low-income Medicare beneficiaries. Our conceptual framework for the development of the MSNI is detailed in our June 2022 report to the Congress (Medicare Payment Advisory Commission 2022). These hospitals are particularly vulnerable to unforeseen circumstances (such as misestimates of input price inflation) (Medicare Payment Advisory Commission 2023b, Medicare Payment Advisory Commission 2022).

We found that the MSNI was an important predictor of hospitals' all-payer margins and risk of closure—and a better predictor than the metric used in current disproportionate-share-hospital (DSH) payments.

Calculating each hospital's MSNI

Each hospital's MSNI is calculated as the sum of three components:

- low-income share of Medicare volume,
- uncompensated-care costs as share of all-payer revenue, and
- Medicare share of all-payer volume (divided by 2).

For more details on the principles for each component, see our March 2023 report to the Congress, Chapter 3, Table 3A-1.

This year we incorporated additional data sources so that, where possible, the MSNI calculation is based on both inpatient and outpatient data and on fee-for-service (FFS) and Medicare Advantage (MA) beneficiaries.[13]

Using the MSNI to reform Medicare's support of Medicare safety-net hospitals

The Commission's view is that Medicare safety-net payments should be used primarily to support Medicare safety-net hospitals, which are hospitals that provide care to large shares of low-income Medicare beneficiaries. This measure of "safety-net" status is Medicare-centric by design; safety-net definitions used by Medicaid and other payers would likely differ.

In contrast to current Medicare payments to support safety-net hospitals (DSH and uncompensated-care payments), the Commission's proposed new MSNI payments would be:

- targeted to hospitals with higher Medicare dependency, measured on a sliding scale;
- calculated as a percentage add-on for both Medicare inpatient and outpatient services; and
- made to hospitals for both their FFS and MA beneficiaries and carved out of MA benchmarks.

The current DSH and uncompensated-care payments would be replaced with payments distributed using the MSNI, and, if needed, new funds could be added using the MSNI to target hospitals most in need (Medicare Payment Advisory Commission 2024). In our simulations of replacing DSH and uncompensated-care payments with payments based on the MSNI, some hospitals would receive more payments and others would receive less. Phasing in changes (and adding additional MSNI funds) would help ease the transition for hospitals that would receive lower safety-net payments under the MSNI. ■

investment income in 2023, compared with $7 billion in investment losses in 2022. Donation income was steadier at between $2 billion and $3 billion in both years.

- ***Hospitals' borrowing costs increased but by less than in the general market.*** In FY 2023, hospitals' borrowing costs increased. The yield on hospital municipal bonds increased from about 3.6 percent in 2022 on average to 4.4 percent in 2023

(S&P Global 2024). However, the spread between hospitals' borrowing costs and borrowing costs in the general market declined. The yield on hospital bonds fell from 1.2 percentage points above the yield of 10-year treasury bonds in 2022 to 0.6 percentage points in 2023, suggesting that bond investors see little risk of hospital defaults on their bonds.

Hospital mergers and acquisitions also continued, indicating that investors continue to be willing to put capital into acquiring hospitals. Our analysis of Levin Pro HC data for hospitals paid under the IPPS and the OPPS found that about 110 hospitals were acquired in FY 2022, and an additional 90 hospitals were acquired in FY 2023.

Preliminary data suggest that hospitals' access to capital continued to improve in 2024

Preliminary data from selected hospitals and rating agencies suggest that hospitals' all-payer operating margin continued to increase in 2024, and for-profit hospitals continued to have higher operating margins than nonprofit hospitals. The all-payer operating margin among six large hospital systems increased about 1 percentage point in 2024.[14] Among the three largest for-profit health systems, the all-payer operating margin increased by about 0.9 percentage points from the quarter ending September 30, 2023, to the quarter ending September 30, 2024, though the individual all-payer operating margins varied widely, from 6.0 percent to 13.8 percent (Community Health Systems 2024, HCA Healthcare 2024, Tenet Health 2024). To explain what drove their improved margin, these systems cited reasons such as increased admissions and revenue per admission (from 2024 contract negotiations and Medicaid supplemental revenue, among other reasons) and decreased contract-labor costs. Among the three selected large nonprofit hospital systems, the all-payer operating margin increased by about 1 percentage point from the year ending July 30, 2023, to the year ending July 30, 2024, ranging from −5.3 percent to 0.3 percent (Ascension 2024, CommonSpirit 2024, Trinity Health 2024). This gradual improvement in these three nonprofit hospitals' all-payer operating margin is consistent with rating agencies' findings for 2024. The agencies attribute some of the increase in nonprofit hospitals' all-payer operating margin in 2024 to easing labor costs and to one-time payments, such as those to offset lower payments for drugs acquired through the 340B Drug Pricing Program from 2018 to 2021 (Fitch Ratings 2024, Moody's Investors Service 2024, S&P Global Ratings 2024).[15]

Hospitals' borrowing costs through the bond markets were steady between 2023 and 2024. However, the spread between hospitals' borrowing costs and borrowing costs in the general market declined, with the yield on hospital bonds falling to 0.2 points above that of 10-year treasury bonds in 2024 (S&P Global 2024).

Looking forward to 2025, rating agencies project a continued slow and sustained recovery for nonprofit hospitals' access to capital, including a projected gradual improvement in nonprofit hospitals' all-payer operating margin and more favorable than unfavorable outlooks (Fitch Ratings 2024, Moody's Investors Service 2024, S&P Global Ratings 2024).

FFS Medicare payments to hospitals were lower than hospitals' costs in 2023

In FY 2023, hospitals' FFS Medicare margin remained negative but with substantial variation. (See the text box in Chapter 2 on the different margin measures MedPAC uses to assess provider profitability.) The FFS Medicare margin remained stable from 2022 to 2023 when coronavirus relief funds were excluded. Among the subset of hospitals we identified as relatively efficient, the median FFS Medicare margin was higher than among other hospitals but still negative. Like last year, we project that hospitals' FFS Medicare margin in 2025 will remain negative and near the level in 2023.

The FFS Medicare margins we present this year reflect updates from our most recent periodic methodology reviews. The results under the updated methodology were generally similar to the prior methodology: For each of the past 10 years (2014 to 2023), hospitals' FFS Medicare margin was always within 0.8 percentage points of results using the prior methodology and mostly within 0.3 percentage points. The largest change stemmed from limiting our margin analysis to payments and costs for services paid under the IPPS and OPPS.[16] Hospitals' FFS Medicare margin on other service lines affects the overall financial effect on hospitals of providing services to FFS Medicare beneficiaries and could affect hospitals' margin on inpatient and outpatient services. However, we concluded that the most relevant margin for this

TABLE 3–11

Hospitals' FFS Medicare margin excluding relief funds remained stable between 2022 and 2023, but significant variation persisted (cont. next page)

	Fiscal year				
Group	**2019**	**2020**	**2021**	**2022**	**2023**
Including relief funds					
All					
Aggregate	–8.0%	–8.2%	–6.3%	–11.9%	–12.6%
25th percentile	–17.1	–17.2	–15.2	–21.5	–22.0
Median	–5.7	–4.4	–2.7	–8.7	–9.7
75th percentile	4.8	7.7	9.2	3.8	2.8
Ownership					
For profit	1.4	4.3	5.6	1.1	0.4
Nonprofit	–9.4	–10.2	–8.1	–13.6	–13.8
Geography*					
Metropolitan	–8.4	–8.8	–6.9	–12.3	–12.8
Micropolitan	–4.6	–2.7	–1.5	–8.7	–9.8
Other rural	0.4	5.1	8.1	0.1	–3.2
Fiscal pressure**					
Low pressure	–10.6	–10.8	–8.9	–13.9	–14.6
High pressure	4.0	7.5	5.8	–2.6	–4.3
MSNI					
Lowest quartile	NS	NS	–10.0	–16.1	–16.8
2nd quartile	NS	NS	–9.5	–14.3	–14.7
3rd quartile	NS	NS	–4.2	–8.7	–10.1
Highest quartile	NS	NS	3.2	–3.6	–4.8

chapter on assessing the adequacy of FFS Medicare payments for services paid under the IPPS and OPPS is a margin limited to those services. If FFS Medicare's payments for other service lines are too high or too low, the adequacy of payments for those services is best addressed through updates to FFS Medicare payments for those service lines. We made other minor changes, including updating our method of trimming data for statistical outliers and identifying swing-bed costs.

Hospitals' FFS Medicare margin exclusive of coronavirus relief funds remained stable but lower than prepandemic level

In FY 2023, hospitals' FFS Medicare margin including coronavirus relief funds fell to –12.6 percent, but exclusive of these funds it remained steady at about –13 percent (Table 3-11).[17] The 0.7 percentage point decline in hospitals' FFS Medicare margin from 2022 to 2023 when including coronavirus relief funds was exclusively due to a decline in relief funds. The steady FFS Medicare margin exclusive of relief funds reflects offsetting pressures. For example, both the reinstatement of sequestration on Medicare payments and higher-than-expected inflation decreased hospitals' FFS Medicare margin.[18] On the other hand, the continued growth in profitable, separately payable drugs increased hospitals' FFS Medicare margin.[19] While there are analytic challenges to calculating FFS Medicare margins separately for services paid under the IPPS and OPPS, we approximate that, after excluding uncompensated-care payments, hospitals' FFS Medicare margin in 2023 was roughly similar for FFS Medicare patients across inpatient and outpatient settings.[20]

TABLE 3–11

Hospitals' FFS Medicare margin excluding relief funds remained stable between 2022 and 2023, but significant variation persisted (cont.)

	Fiscal year				
Group	**2019**	**2020**	**2021**	**2022**	**2023**
Excluding relief funds					
All					
Aggregate	–8.0%	–12.3%	–8.3%	–13.1%	–13.0%
25th percentile	–17.1	–22.2	–17.2	–22.7	–22.5
Median	–5.7	–8.6	–5.2	–10.2	–10.1
75th percentile	4.8	3.3	6.4	2.0	2.3
Ownership					
For profit	1.4	1.7	4.1	0.5	0.1
Nonprofit	–9.4	–14.6	–10.1	–14.7	–14.3
Geography*					
Metropolitan	–8.4	–12.8	–8.7	–13.3	–13.2
Micropolitan	–4.6	–7.8	–4.7	–11.3	–10.4
Other rural	0.4	–1.1	2.8	–4.1	–3.9
Fiscal pressure**					
Low pressure	–10.6	–14.4	–10.6	–14.9	–15.0
High pressure	4.0	1.4	2.5	–4.2	–5.1
MSNI					
Lowest quartile	NS	NS	–11.7	–16.9	–17.2
2nd quartile	NS	NS	–11.3	–15.2	–15.0
3rd quartile	NS	NS	–6.1	–9.9	–10.7
Highest quartile	NS	NS	0.4	–5.2	–5.4

Note: FFS (fee-for-service), MSNI (Medicare Safety-Net Index), NS (not shown). Data are for hospitals paid under the inpatient prospective payment systems (IPPS) that had a complete cost report with a midpoint in the fiscal year and had non-outlier data as of our analysis. The "FFS Medicare margin" is limited to revenue and costs for services included under the IPPS or outpatient prospective payment system (OPPS), including uncompensated-care payments and revenue and costs of separately payable drugs, including any reported discounts to drug costs under the 340B Drug Pricing Program. "Relief funds" refers to FFS Medicare's share of federal and other coronavirus relief funds. Results differ from those published last year because of newer data and methodological updates, such as limiting the set of included services to IPPS and OPPS services.
* 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–FFS 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 FFS Medicare profits had been zero. "High [fiscal] pressure" hospitals are defined as those with a median non–FFS 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.

Source: MedPAC analysis of hospital cost reports, census geographic files, and MSNI data sources.

Hospitals' FFS Medicare margin remained about 5 percentage points lower than in 2019 (Table 3-11). This finding reflects in part a decline in Medicare's uncompensated-care payments from over $8 billion in 2019 to about $7 billion in 2023, as well as substantially higher-than-expected input price inflation in 2022 (data not shown).

As in prior years, there was significant variation within this aggregate: A quarter of hospitals had a FFS Medicare margin below –22 percent, while a quarter had a margin above 2 percent (Table 3-11). While there was variation within each group of hospitals, in aggregate:

- ***For-profit hospitals' FFS Medicare margin remained positive and much higher than nonprofit hospitals' margin but fell in 2023.*** For-profit hospitals' FFS Medicare margin remained positive and over 10 percentage points higher than nonprofit hospitals' margin, primarily because they have been able to constrain costs. This relationship held despite for-profit hospitals' margin declining in 2023.[21]

- ***Rural hospitals' FFS Medicare margin remained higher than urban hospitals' margin but became negative in 2023.*** Hospitals in rural nonmicropolitan areas continued to have a FFS Medicare margin higher than urban or rural micropolitan hospitals' margin primarily because most of these hospitals benefit from one or more special designations that provide additional FFS Medicare payments above standard IPPS and/or OPPS payments. However, rural hospitals also received targeted coronavirus relief funds; as these payments continued to decrease, so did rural hospitals' margin, which fell from 0.1 percent in 2022 to –3.2 percent in 2023.[22]

- ***FFS Medicare margin remained higher at hospitals under high fiscal pressure.*** The FFS Medicare margin continued to be higher at hospitals consistently under higher fiscal pressure, though the spread between the margin at high– and low–fiscal pressure hospitals has been declining. By definition, hospitals under higher fiscal pressure—that is, with a median non–FFS 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 if the hospital's FFS Medicare profits had been zero—have more constraints on their costs.[23]

- ***FFS Medicare margin remained higher at hospitals with higher MSNI values.*** The FFS Medicare margin also continued to be higher among hospitals with higher values on the Commission-developed MSNI. This finding primarily reflects how, in general, these hospitals receive some additional FFS Medicare payments from existing Medicare safety-net payments (DSH and uncompensated-care payments). However, as we noted previously, the MSNI would better target scarce Medicare resources to hospitals that treat large shares of low-income Medicare beneficiaries (Medicare Payment Advisory Commission 2024, Medicare Payment Advisory Commission 2023b, Medicare Payment Advisory Commission 2022).

Medicare should move toward site-neutral payments

The FFS Medicare payment rates for services provided in hospital outpatient departments (HOPDs) are generally higher than the payment rates for the same services provided in other ambulatory settings (ambulatory surgical centers and freestanding physician offices). These payment differences encourage arrangements among providers—such as consolidation of physician practices with hospitals—that result in care being billed from settings with the highest payment rates, which increases total Medicare spending and beneficiary cost sharing without material improvements in patient outcomes. The Commission contends that 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 and when doing so does not pose a risk to access (Medicare Payment Advisory Commission 2023a). For example, the Commission recommended aligning FFS Medicare payment rates across ambulatory settings for certain services that CMS deems safe and appropriate to provide outside of a hospital setting. To illustrate this concept, the Commission modeled the effect of aligning payment rates across ambulatory settings in a budget-neutral manner for 66 ambulatory payment classifications (APCs) (Medicare Payment Advisory Commission 2023a).

In the Bipartisan Budget Act (BBA) of 2015, the Congress took an approach to site-neutral payments between freestanding offices and hospitals that differs from the method recommended by the Commission. The approach in the BBA of 2015 has had a modest effect because it is largely limited to off-campus provider-based departments (PBDs) owned by hospitals that were not open when the Congress passed the BBA of 2015. We evaluated the effects of expanding this method to all off-campus PBDs (see text box on expanding the site-neutral payment policy, pp. 84–85).

Relatively efficient hospitals continued to have higher quality, lower costs, and higher margins in 2023

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 better on selected measures of quality and cost for inclusion than other hospitals. We define "efficiency" as the level of resources needed to provide a certain quality and quantity of services. However, our method does not seek to identify all hospitals that efficiently deliver hospital care. For example, we exclude from our analysis 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 (see text box on method to identify relatively efficient hospitals, p. 87).

This year, we used 2019, 2021, and 2022 historical performance to identify relatively efficient hospitals and found that about 6 percent met our criteria for costs and quality (Table 3-13, p. 86). One reason for the small number of hospitals meeting the criteria is related to the requirement of achieving relatively high performance (higher quality and lower standardized costs) across all three years of the baseline period. In this year's analysis, the baseline period covered 2019, 2021, and 2022, which was a more difficult time for hospitals to perform consistently well because of the exclusion of 2020 when the coronavirus pandemic started and the pandemic's continuing impacts in 2021 and 2022. Loosening the requirements (such as by requiring less consistency over three years or broadening the quality or cost thresholds) would increase the share of hospitals meeting the criteria but would include hospitals with worse quality outcomes and/or higher standardized costs in the baseline years. The baseline period will continue to shift forward by a year in future analyses, and we will continue to monitor the number and characteristics of the relatively efficient hospitals identified.

The hospitals we identified as historically relatively efficient continued to have lower costs and higher quality in 2023. In terms of quality, the relatively efficient hospitals had lower mortality and readmission rates (90 percent of the national median and 93 percent, respectively) and higher patient satisfaction scores (104 percent of the national median). They also had lower standardized FFS Medicare costs per unit, at 91 percent of the national median. These lower standardized costs allowed them to generate higher FFS Medicare margins than the comparison group.

When including relief funds, in 2023 the median relatively efficient hospital had an all-payer operating margin of 7 percent and a FFS Medicare margin of –1 percent (–2 percent when excluding relief funds).[24] Both of these margins were improvements relative to 2022.

As in past years, relatively efficient hospitals were spread across the country and included different categories of hospitals. For example, among for-profit and nonprofit hospitals, the shares of hospitals categorized as relatively efficient were similar. Although for-profit hospitals tend to have lower costs, nonprofit hospitals tend to have higher quality metrics.

FFS Medicare margin is projected to remain near 2023 level in 2025

We project that hospitals' FFS Medicare margin in 2025 will be about –13 percent, similar to the level in 2023 exclusive of coronavirus relief payments. Similarly, we project the median FFS Medicare margin among relatively efficient hospitals to remain about –2 percent. These projections are based on actual payments and costs in the most recent year of complete data (2023), FFS Medicare payment policies for 2024 and 2025, and environmental changes that took place in 2024 and are anticipated in 2025.

Our projected margin reflects roughly offsetting pressures, the largest of which are:

- ***Declines in coronavirus relief support.*** While hospitals continued to record some federal and other coronavirus relief funds in their 2023 cost reports, the overall amounts—and therefore FFS Medicare's share—declined in 2023, as expected. We do not project any federal or other coronavirus relief funds in 2025.

Effects of expanding the Bipartisan Budget Act of 2015's site-neutral payment policy

For over a decade, the Commission has observed that Medicare's payment rates often differ for the same service across different ambulatory settings (hospital outpatient departments, ambulatory surgical centers, and freestanding physician offices). These payment differences encourage arrangements among providers—such as consolidation of physician practices with hospitals—that result in care being billed from settings with the highest payment rates, which increases total Medicare spending and beneficiary cost sharing without material improvements in patient outcomes. To address this issue, the Commission has twice recommended aligning Medicare payment rates for selected services that are safe and appropriate to provide in all settings when doing so does not pose a risk to beneficiary access to care (Medicare Payment Advisory Commission 2023b, Medicare Payment Advisory Commission 2014).

In Section 603 of the Bipartisan Budget Act (BBA) of 2015, the Congress took a different approach to aligning Medicare payment rates (referred to as "site-neutral payments"). The BBA of 2015 focused on outpatient prospective payment system (OPPS)-covered services provided in off-campus provider-based departments (PBDs) of hospitals, which are departments of a hospital that are not located on the campus of the hospital or within 250 yards of a remote location of the hospital facility. Under this statute, OPPS payment rates for all services provided to Medicare beneficiaries in certain off-campus PBDs must be aligned with payment rates in the Medicare physician fee schedule (PFS) for services provided in freestanding physician offices. The locations that are subject to this statute are generally those that became off-campus PBDs of hospitals after the date that the BBA of 2015 was passed by the Congress, November 2, 2015. Off-campus PBDs that were established before November 2, 2015, are exempt from this statute and are allowed to bill at standard OPPS payment rates. While the Commission recommended aligning payments for specific services provided in any hospital outpatient department (HOPD) that is covered under the OPPS, the BBA of 2015 requires that all services provided in certain hospital outpatient departments (that is, specified off-campus PBDs) are subject to site-neutral payments. In addition, where the Commission recommended that site-neutral payments be coupled with a budget-neutral adjustment that would increase the OPPS payment rates for the services that are not subject to the site-neutral payments, which results in no change in Medicare FFS spending under the OPPS, the BBA of 2015 has no accompanying budget-neutrality adjustment, which results in lower overall Medicare FFS spending.

To satisfy the requirements in the BBA of 2015, CMS set payment rates for the OPPS-covered services provided in the off-campus PBDs that are subject to the rules of the BBA of 2015 to 40 percent of the standard OPPS payment rates. Under Sections 1833(t)(1)(B)(v) and 1833(t)(21) of the Social Security Act, the affected services are no longer considered HOPD services for the purpose of payment under the OPPS and are instead paid under the PFS. Initially, these lower payment rates resulted in a small reduction in total spending in the OPPS of $170 million because most off-campus PBDs were exempt from the site-neutral requirements in the BBA of 2015. In 2023, total spending in the OPPS was reduced by $500 million as the number of services provided in these off-campus PBDs increased.

In 2019, CMS substantially increased the breadth of services that are subject to the site-neutral payment rates resulting from the BBA of 2015 by specifying that all clinic visits (specified by Healthcare Common Procedure Coding System (HCPCS) code G0463) provided in any exempt off-campus PBD must be subject to site-neutral payments. Because clinic visits specified by HCPCS G0463 are by far the most common service provided in off-campus PBDs, this policy change substantially increased the effects of the site-neutral payments.

(continued next page)

Effects of expanding the Bipartisan Budget Act of 2015's site-neutral payment policy (cont.)

CMS did not extend site-neutral payments to all services in the exempt PBDs, but the Commission evaluated the effects of doing so. The Commission found that, without a budget-neutrality adjustment, expanding this site-neutral policy to all OPPS-covered services (excluding separately payable drugs but including drug administration services) would reduce payments to hospitals for OPPS services by 3.2 percent. Therefore, applying a budget-neutral adjustment would require a uniform increase of 3.2 percent to the payment rates for all OPPS-covered services that would not be affected by the site-neutral policy.

We found that applying this policy to services furnished in 2023 without a budget-neutrality adjustment would have lowered combined inpatient and outpatient FFS Medicare revenue by 0.9 percent, Medicare spending under the OPPS would have been $1.3 billion lower, and beneficiary cost-sharing obligations would have been $0.3 billion lower.

After applying a budget-neutrality adjustment, there would be no change in aggregate inpatient and outpatient revenue, but there would be distributional effects such as urban hospitals losing a small amount of revenue and rural hospitals gaining a small amount (Table 3-12). ■

TABLE 3–12

Expanding existing site-neutral payment policy to all OPPS-covered services provided in off-campus provider-based departments would have varying effects, 2023

	Change in combined inpatient and outpatient revenue, with budget neutrality	
Hospital category	**Dollar change (in millions)**	**Percent change**
All hospitals	$0	0.0%
Urban	–50	<–0.1
Rural	50	0.4
For profit	80	0.4
Nonprofit	–50	<–0.1
Government	–30	–0.1

Note: OPPS (outpatient prospective payment system). "Inpatient and outpatient revenue" includes payments under the relevant inpatient and outpatient prospective payment systems. Data are for hospitals that had a complete cost report with a midpoint in the fiscal year as of our analysis.

Source: MedPAC analysis of outpatient standard analytic claims files, hospital cost reports, and census geographic files.

- ***Declines in uncompensated-care payments.*** FFS Medicare's uncompensated-care pool (and supplemental payments to hospitals located in Puerto Rico and Indian Health Services hospitals) was $7.0 billion in 2023 and will decline to $5.8 billion in 2025. These decreases are largely due to the decline in the national uninsured rate, which CMS projects will fall from 9.2 percent in 2023 to 7.6 percent in 2025.
- ***Hospitals' input costs grew slightly faster than expected.*** Based on actual market basket data through the second quarter of 2024, hospitals' input costs increased 3.7 percent in FY 2024; however, FFS Medicare payments for FY 2024

TABLE 3–13

Relatively efficient hospitals performed better than other hospitals but still had a negative median FFS Medicare margin in FY 2023

Metric	Relatively efficient hospitals	Other hospitals
Number of hospitals	123	1,852
Share of hospitals in our study sample	6%	94%
Historical performance, average over 2019, 2020, 2022 (percentage of national median)		
FFS Medicare mortality rate	87%	101%
FFS Medicare readmission rate	92	101
Standardized FFS Medicare costs per unit	92	101
Current-year performance, 2023 (percentage of national median)		
FFS Medicare mortality rate	90%	101%
FFS Medicare readmission rate	93	100
Share of patients rating the hospital a 9 or 10 (out of 10)	104	99
Standardized FFS Medicare costs per unit	91	101
Current-year margins, 2023 (median percentage)		
All-payer operating margin, including coronavirus relief funds	7%	3%
All-payer operating margin, excluding coronavirus relief funds	7	2
FFS Medicare margin, including coronavirus relief funds*	–1	–9
FFS Medicare margin, excluding coronavirus relief funds*	–2	–10

Note: FFS (fee-for-service), FY (fiscal year). Data are for hospitals paid under the inpatient prospective payment systems (IPPS) that had a complete cost report with a midpoint in the fiscal year and had non-outlier data as of our analysis. "Relatively efficient" and "other" hospitals were identified based on their performance during 2019, 2021, and 2022. (For more details, see text box on our identification methodology.)
* The "FFS Medicare margin" is limited to revenue and costs for services included under the IPPS or outpatient prospective payment system, including uncompensated-care payments and revenue and costs of separately payable drugs, and is reported with and without FFS Medicare's share of federal or other coronavirus relief funds.

Source: MedPAC analysis of hospital cost reports, claims data, data to standardize costs, and CMS's summary of H–CAHPS survey results tables.

included only a 3.3 percent increase for hospitals' input costs. Actual inflation for the rest of 2024 and 2025 is not yet known; we use CMS's current estimates of input price inflation because they represent the best estimates available at this time.

- ***Continued increase in profitable, separately payable drugs.*** Consistent with historical trends, we project continued growth in aggregate FFS Medicare payments for separately payable drugs and their share of hospitals' FFS Medicare inpatient and outpatient revenue. Because FFS Medicare payments for separately payable drugs are set at the average sales price plus 6 percent, which is higher than hospitals' aggregate costs of acquiring these drugs, growth in separately payable drugs increases hospitals' FFS Medicare margin.

Like all projections, ours are subject to uncertainty. For example, the inflation figure in 2025 is uncertain. Uncertainty unique to this time period exists about how hospitals will spend the $9 billion in one-time remedy payments they received in 2024 to offset the reduced payment rates for drugs obtained through the 340B Drug Pricing Program from CY 2018 to CY 2021. To the extent that hospitals spend those funds in ways

Identifying relatively efficient hospitals

The Commission follows two principles when identifying a set of relatively efficient hospitals:

- hospitals must perform relatively well on both quality and cost metrics, and
- the performance has to be consistent.

Our assessment of efficiency is not in absolute terms but, rather, relative to a comparison group of other hospitals.

Categorizing hospitals as relatively efficient

We categorize a hospital as relatively efficient if, over the previous three years, it consistently performed at a relatively high level on either fee-for-service (FFS) Medicare mortality rates or standardized inpatient and outpatient costs, and it never performed at a relatively low level on mortality rates, readmission rates, or costs.[25] Specifically, we categorized a hospital as relatively efficient if it met the following criteria:

- Either FFS Medicare risk-adjusted mortality rates or standardized inpatient and outpatient cost per unit was among the best one-third of hospitals in each of the prior three years.
- FFS Medicare risk-adjusted mortality rates, risk-adjusted readmission rates, and standardized costs per unit were never in the bottom third of all hospitals in any of the prior three years.
- At least half of the hospitals' patients rated it a 9 or 10 on the 10-point scale in the previous year (per the Hospital Consumer Assessment of Healthcare Providers and Systems survey).
- FFS Medicare and Medicaid volume metrics met required minimums.[26]

Implications

There is no single way to identify hospitals that are operating efficiently, and we do not seek to identify all efficient hospitals, nor do we conclude that all hospitals that did not meet our criteria are inefficient. For example, lower-volume hospitals have more variation in their costs, volume, and mix of patients and are therefore less likely to have consistent performance over three years. Still, the median FFS Medicare margin among the set of hospitals we identified as relatively efficient provides some insight about whether FFS Medicare payments to hospitals are adequate to cover the cost of providing inpatient and outpatient hospital care efficiently. This analysis is a complement to other metrics we use to assess the adequacy of FFS payments. ■

that increase hospital costs (more than revenue) in 2025, our projected margin would be lower.

Looking forward to 2026, there are additional uncertainties as well as known policy changes. We do not yet know what the uncompensated-care pool will be in 2026. As finalized by CMS in rulemaking, in 2026 CMS will begin implementing an annual 0.5 percentage point decrease to the OPPS conversion factor to offset the increased payments for nondrug items and services from CY 2018 through CY 2022. This 0.5 percent reduction in outpatient revenue would reduce the overall Medicare margin by less than 0.2 percent. While factors such as the outpatient adjustment will cause small shifts in hospitals' FFS Medicare margin, we expect hospitals' 2026 FFS Medicare margin to be similar to the projected 2025 Medicare margin of –13 percent if current law holds.

We will update 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 cycles.

How should FFS Medicare payments change in 2026?

Under current law, CMS sets the percentage update to IPPS and OPPS payment rates based on its 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 2026 will not be set until summer 2025. However, based on current CMS forecasts through the third quarter of 2024, the 2026 updates would include:

- a 2.5 percent increase in the IPPS operating rate (resulting from 3.1 percent growth in the market basket less 0.6 percentage points in productivity);
- a 2.5 percent increase in the IPPS capital base rate, plus a forecast-error adjustment; and
- a 2.0 percent increase in the OPPS base rate (the same estimated 3.1 percent market basket less 0.6 percentage point productivity adjustment as the inpatient operating rate, less the first year of 0.5 percentage point reductions to offset increased payments for nondrug items and services from 2018 to 2021, following a Supreme Court decision).

Since 2006, the Commission has made a single update recommendation for FFS Medicare's payment rates for services provided under the IPPS and OPPS. Primarily we do so because we cannot adequately apply some of the Commission's payment-adequacy indicators separately for hospital inpatient and outpatient services since hospitals typically provide both types of services. Allocating costs to inpatient and outpatient services is conceptually challenging and subject to data limitations and variation in hospitals' accounting practices. Access to capital is also fundamentally a hospital-specific, not service line–specific, measure. Moreover, at this time we do not see evidence of significant differences between inpatient and outpatient settings in FFS Medicare beneficiaries' access to care or hospitals' FFS Medicare margins.[27]

That said, the Commission has long recognized that Medicare's payments in any sector should reflect the potential to deliver the service in other settings, suggesting the importance of considering the relationship of prices across sectors. That work, such as the Commission's recommendation for site-neutral payments (see text box on site-neutral payments, pp. 84–85), raises complex issues beyond the scope of our update criteria. For that reason, we address such issues in separate workstreams.

Our hospital payment-adequacy indicators were mixed and suggest that combined FFS Medicare payments across inpatient and outpatient services were below costs for most hospitals, including the median "relatively efficient" hospital. We also project that this gap between payments and costs will persist under current-law updates.

In considering how hospital base payment rates should change in 2026, 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; and
- limit the need for large across-the-board payment-rate increases by directing a portion of the increase in Medicare funds to safety-net hospitals that treat large shares of vulnerable Medicare patients.

Balancing these objectives continues to be difficult.

RECOMMENDATION 3

The Congress should:

- **for 2026, update the 2025 Medicare base payment rates for general acute care hospitals by the amount specified in current law plus 1 percent; and**
- **redistribute existing disproportionate-share-hospital and uncompensated-care payments through the Medicare Safety-Net Index (MSNI)—using the mechanism described in our March 2023 report—and add $4 billion to the MSNI pool.**

RATIONALE 3

Our indicators of the adequacy of FFS Medicare payments to hospitals continued to be mixed, though a subset improved relative to last year. Beneficiaries maintained good access to hospital care, and hospitals' access to capital improved in 2023. However, indicators of the quality of care experienced by patients continued to be mixed, FFS Medicare payments were below hospitals' costs—even among the small subset of relatively efficient hospitals—and we project that the median FFS Medicare margin among relatively efficient hospitals will remain slightly negative into 2025 and 2026 under current law. Therefore, for 2026, the Commission recommends increasing payments by more than current law.

Hospitals that treat larger shares of low-income Medicare patients continue to face larger financial challenges. Therefore, this recommendation reiterates last year's recommendation that the Congress redistribute existing safety-net payments to the MSNI and add $4 billion to the MSNI pool. As specified in more detail last year, this action would involve:

- a transition from DSH and uncompensated-care payments to payments through the MSNI;
- scaling FFS MSNI payments in proportion to each hospital's MSNI and distributing the funds through a percentage add-on to payments under the inpatient and outpatient prospective payment systems;
- paying commensurate MSNI amounts for services furnished to MA enrollees directly to hospitals and excluding them from MA benchmarks; and
- expanding the MSNI pool in future years. For example, the pool could be expanded by the same rate as Medicare's base payment rates to hospitals.

The MSNI would better target limited Medicare resources toward those hospitals that are key sources of care for low-income Medicare beneficiaries and are facing financial challenges. However, even with an additional roughly $2 billion in FFS MSNI payments in 2026 (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), aggregate Medicare FFS safety-net payments would still be below the 2019 level because, from 2019 to 2025, there was a roughly $3 billion decline in FFS uncompensated-care and DSH payments.

Combined, we estimate that the 1 percentage point increase above current law and the approximately $2 billion in additional FFS MSNI payments would increase FFS Medicare base payment rates to hospitals by about 2.2 percentage points above current law. However, while the 1 percentage point increase above current law to hospital base rates would affect all hospitals equally, the shift from the current DSH and uncompensated-care payment model to the MSNI model—and the addition of $4 billion dollars to the MSNI pool—would have distributional impacts. The hospitals that would benefit most from the new MSNI approach are hospitals with large shares of Medicare patients—in particular, large shares of low-income Medicare patients. We estimate that all major categories of hospitals (e.g., teaching, nonteaching, rural, urban, for profit, nonprofit, government, small, large) would have some hospitals that see lower and some that see higher Medicare payments under our recommendation compared with current law, but in aggregate, most categories of hospitals would see increased Medicare payments under our recommendation. The largest gains would be for rural hospitals because they tend to have larger Medicare shares and larger shares of low-income Medicare patients. We expect that the recommendation would increase rural hospitals' FFS Medicare margin by nearly 7 percentage points over current law, almost three times the percentage point increase across all hospitals. In contrast, we expect that the recommendation would decrease government hospitals' FFS Medicare margin by about 1 percentage point relative to current law because some large government hospitals have relatively few Medicare patients and currently very high uncompensated-care payments.

We anticipate that a 2025 update to hospital payment rates of current law plus 1 percent and roughly $2 billion in FFS MSNI funds would generally be adequate to maintain FFS beneficiaries' access to hospital inpatient and outpatient care. These funds would raise hospital payment rates close to the cost of delivering high-quality care efficiently.

IMPLICATIONS 3

Spending

- Current law is expected to increase IPPS operating, IPPS capital, and OPPS payment rates by over 2 percent. This recommendation would increase spending relative to current law by $5 billion to $10 billion in one year and by $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 Clinicians who provide inpatient and outpatient services at hospitals are paid separately under the physician fee schedule. FFS Medicare uses other payment systems for certain types of hospitals, such as critical access hospitals, hospitals participating in demonstrations, and hospitals that provide care to a specific population (e.g., children's hospitals) or, for inpatient services, a limited set of diagnoses (e.g., psychiatric hospitals, rehabilitation hospitals, and long-term care hospitals). An assessment of the adequacy of these payment systems is beyond the scope of this chapter.

2 However, when discussing indicators of beneficiaries' access to care, we use the term "hospital" to also include other Subsection (d) hospitals that FFS Medicare pays for inpatient and outpatient services under alternative methodologies (such as demonstrations), as well as critical access hospitals. These hospitals can provide care similar to care received at hospitals paid under the IPPS and OPPS.

3 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/.

4 Unless otherwise noted, all years referring to inpatient services are fiscal years, while those referring to outpatient services are calendar years, consistent with when CMS updates these payment systems.

5 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.

6 Not included in this count are two hospitals that converted to REHs but subsequently closed or had their REH status revoked. The count of active REHs was determined as of January 28, 2025, and is subject to change.

7 This figure does not include services beyond outpatient hospital services billed by REHs or affiliated entities, such as services billed under the physician fee schedule or services provided by rural health clinics or distinct-part skilled nursing facilities.

8 This range was derived from the confidence interval of our regression estimates.

9 In calculating the FFS Medicare marginal profit on services paid under the IPPS and OPPS, we exclude FFS Medicare uncompensated-care payments since each hospital's annual amount does not vary with volume.

10 The hospital mortality- and readmission-measure results include only hospitals paid under the IPPS because that is the focus of the Commission's work on payment adequacy in this chapter. CAHs are not included for this reason. Also, CAHs (which are paid on costs) have less incentive to code comorbidities because they do not affect payment, which affects the risk adjustment of measure results.

11 The H–CAHPS national response rate for 2023 was 23 percent. The response rate for other provider-focused CAHPS surveys is similar (e.g., the Home Health Care CAHPS response rate was 24 percent, and the Hospice CAHPS response rate was 29 percent).

12 In 2023, the all-payer operating margin among the hospitals in the highest quartile of the DSH metric was 4.7 percent (1 percentage point higher than the 3.7 percent among those in the highest quartile of MSNI). In addition, the spread in all-payer operating margin between the highest and lowest quartile was wider for the MSNI than the DSH metric.

13 The low-income share of Medicare volume was previously based on FFS Medicare inpatient and outpatient volume. This year, on the inpatient side, we calculated the percentage of FFS and MA Medicare inpatient stays that were for low-income beneficiaries using the Medicare Provider Analysis and Review and inpatient encounter data. On the outpatient side, we continued to use the percentage of Medicare FFS outpatient volume that was for low-income FFS beneficiaries, but we plan to incorporate MA outpatient data in the future. The Medicare share of all-payer volume now incorporates both FFS- and MA-covered inpatient and outpatient volume using data from the Medicare cost reports. This component of the MSNI was previously based only on FFS- and MA-covered inpatient volume.

14 We reviewed the most recent financial statements for six large hospital systems: three for-profit systems (Community Health Systems, HCA Health Care, and Tenet Health) and three nonprofit systems (Ascension, CommonSpirit, and Trinity Health). Together, these six systems represent about 20 percent of all hospitals. In calculating the all-payer operating margin, we define operating expenses such as salaries, supplies, lease and rent, depreciation and amortization, and other operating expenses that are not one-time expenses unrelated to same-store operations.

15 As described in the Commission's March 2024 report, Chapter 3, text box on p. 70, CMS changed payment policies in response to a 2022 Supreme Court ruling. CMS reprocessed CY 2022 claims for drugs that hospitals obtained through the 340B Drug Pricing Program and provided lump-sum payments for 340B drugs provided in 2018 to 2021.

16 The payments and costs for IPPS and OPPS services include those for services determined by IPPS and OPPS base rates as well as uncompensated-care payments made under the IPPS and payments and costs for separately payable drugs under the OPPS.

17 Like last year, we report a FFS Medicare margin including a portion of coronavirus relief funds (based on FFS Medicare's share of 2019 all-payer operating revenue) because coronavirus relief funds were intended to help cover lost revenue and higher costs—including lost revenue from FFS Medicare patients and costs to treat these patients. Under the prior methodology, hospitals' FFS Medicare margin in 2023 was –12.4 percent when including relief funds and –12.7 percent exclusive of relief funds.

18 The Congress suspended the 2 percent sequestration on Medicare payments from May 1, 2020, through March 31, 2022; applied 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. Therefore, a smaller sequester reduction to Medicare payments was in effect for part of hospitals' FY 2022 cost-reporting period, but the full sequester reduction applied to all (or virtually all) of their 2023 cost-reporting period.

19 The growth in FFS Medicare spending on separately payable drugs reflects both the continued historical trend of faster growth and a policy change. Effective CY 2022, CMS increased the payment rate for non–pass-through separately payable drugs acquired through the 340B Drug Pricing Program from average sales price minus 22.5 percent to average sales price plus 6 percent. Because the average sales price plus 6 percent is higher than hospitals' aggregate costs of acquiring these drugs, growth in separately payable drugs increases hospitals' FFS Medicare margin.

20 The FFS Medicare margin on inpatient services is bolstered by inpatient-centric add-on payments for hospitals with certain characteristics (i.e., teaching hospitals, DSH hospitals, and certain rural hospitals). Conversely, the FFS Medicare margin on outpatient services is bolstered by the inclusion of separately payable drugs, which are paid at the average sales price plus 6 percent, and of which a subset—drugs through the 340B Drug Pricing Program—can be obtained by hospitals at significantly reduced prices. However, cost reports only measure drug-acquisition costs jointly across inpatient and outpatient services. Therefore, we cannot precisely differentiate between inpatient and outpatient margins.

21 Using the prior methodology, in 2023 for-profit hospitals' FFS Medicare margin including relief funds was 0.8 percent (0.4 percentage points higher than under the new methodology) and nonprofit hospitals' FFS Medicare margin was –13.9. (0.1 percentage point lower than under the new methodology) (data not shown).

22 Using the prior methodology, in 2023 rural nonmicropolitan hospitals' FFS Medicare margin including relief funds was –7.4 percent (4.2 percentage points lower than under the new methodology), while urban hospitals' FFS Medicare margin was –12.5 percent (0.3 percentage points higher than under the new methodology) (data not shown). The higher rural nonmicropolitan FFS Medicare margin under the new method in part reflects how hospital-based post-acute care services—which generally have low FFS Medicare margins—are a larger share of FFS Medicare revenue for rural than urban hospitals. In addition, this higher FFS Medicare margin among rural nonmicropolitan hospitals reflects a change in how we allocated costs for routine bed days across inpatient, observation, and swing-bed services. This change in swing-bed cost allocation has a larger effect on rural hospitals since only hospitals in (or reclassified as) rural areas can have swing beds. Previously, we followed the method CMS uses to estimate and carve out swing-bed costs for PPS hospitals: to assume they are equal to regional Medicare skilled nursing facility rates and state Medicaid nursing facility rates. Under the new method, we allocate costs evenly across all routine bed days, regardless of how the bed was used, given that hospitals must staff and equip inpatient beds at inpatient-service levels. If we were to have included swing-bed services in the new methodology, rural hospitals' FFS Medicare margin excluding relief funds would have been over 2 percentage points lower.

23 In 2023, about 11 percent of hospitals in our FFS Medicare margin analysis met the definition of "high fiscal pressure" and about 49 percent met the criteria of "low fiscal pressure" (those with a median non–FFS 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 FFS Medicare profits had been zero).

24 Although we updated our margin methodology, the results would have been the same under the prior methodology.

25 We risk adjust our mortality and readmission rates but do not adjust for patient income, consistent with the Commission's prior recommendations. We do not adjust our costs per unit for economies of scale; however, we exclude from our analyses all hospitals with fewer than 300 FFS Medicare

inpatient stays or fewer than 900 outpatient services. We standardized inpatient and outpatient costs per unit by (1) average patient severity; (2) relative labor costs (as measured by the Commission's recommended alternative wage index); (3) low-income status (as measured by the share of FFS Medicare patients who received the Part D low-income subsidy or were eligible for Medicaid); (4) teaching intensity; and (5) a portion of a hospital's outlier index (as measured by FFS Medicare outlier payments' share of total FFS base payments) since high outlier costs can indicate either unmeasured differences in illness severity or high cost structures.

26 We exclude from our analyses all hospitals with fewer than 300 FFS Medicare inpatient stays or fewer than 900 outpatient services. We also exclude hospitals with low shares of Medicaid inpatient days (lower than 5 percent).

27 We approximate that, after attempting to allocate costs across inpatient and outpatient services, excluding uncompensated-care payments, hospitals' FFS Medicare margin in 2023 was roughly similar for FFS Medicare patients across inpatient and outpatient settings. The FFS Medicare margin on inpatient services is bolstered by inpatient-centric add-on payments for hospitals with certain characteristics (i.e., teaching hospitals, DSH hospitals, and certain rural hospitals). Conversely, the FFS Medicare margin on outpatient services is bolstered by the inclusion of separately payable drugs, which are paid at the average sales price plus 6 percent, and for which a subset—drugs purchased through the 340B Drug Pricing Program—can be obtained by hospitals at significantly reduced prices. However, cost reports measure drug-acquisition costs jointly across inpatient and outpatient services. Therefore, we cannot precisely differentiate between inpatient and outpatient margins.

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