

CHAPTER

3

**Hospital inpatient and
outpatient services**

R E C O M M E N D A T I O N S

3-1 For fiscal year 2024, the Congress should update the 2023 Medicare base payment rates for general acute care hospitals by the amount specified in current law plus 1 percent.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

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3-2 In fiscal year 2024, the Congress should:

- begin a transition to redistribute disproportionate share hospital and uncompensated care payments through the Medicare Safety-Net Index (MSNI);
- add \$2 billion to the MSNI pool;
- scale fee-for-service MSNI payments in proportion to each hospital's MSNI and distribute the funds through a percentage add-on to payments under the inpatient and outpatient prospective payment systems; and
- pay commensurate MSNI amounts for services furnished to Medicare Advantage (MA) enrollees directly to hospitals and exclude them from MA benchmarks.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

Hospital inpatient and outpatient services

Chapter summary

General acute care hospitals (ACHs) primarily provide inpatient care and various outpatient services. To pay these hospitals for their facility costs, 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 2021, the FFS Medicare program and its beneficiaries paid general acute care hospitals \$182.5 billion for inpatient and outpatient services under the IPPS and OPPS, including \$8.3 billion in uncompensated care payments made under the IPPS.

Assessment of payment adequacy

In 2021, most indicators of hospital payment adequacy remained positive or improved. However, indicators continued to vary substantially across hospitals, and some indicators remained below prepandemic levels. In 2022, input cost increases for hospitals were higher and more volatile than they have been in recent years.

Beneficiaries' access to care—In 2021 and 2022, the number of general ACHs that closed was the same as the number that opened, hospitals continued to have excess capacity in aggregate, and those with excess capacity continued to have a financial incentive to serve FFS Medicare

In this chapter

- Are Medicare payments adequate in 2023?
- How should Medicare payments change in 2024?
- Supporting Medicare safety-net hospitals
- Appendix: Supplemental information on the Medicare Safety-Net Index

beneficiaries. However, some hospitals faced occupancy and staffing constraints at times. In 2021, IPPS hospitals' marginal profit on IPPS and OPSS services (a measure of whether providers have a financial incentive to expand the number of Medicare beneficiaries they serve) was about 8 percent, which is similar to prepandemic levels.

Quality of care—In 2021, FFS beneficiaries' risk-adjusted hospital readmission rate improved relative to 2019. However, the risk-adjusted hospital mortality rate remained higher than in 2019, and most patient experience measures declined.

Providers' access to capital—Hospitals' access to capital strengthened in 2021, as IPPS hospitals' all-payer operating margin reached a record high of 8.7 percent. However, there was substantial variation in margins across hospitals. Preliminary data indicate that 2022 all-payer operating margins declined relative to 2021 and were mixed relative to prepandemic levels, but most hospitals continued to have strong access to bond markets.

Medicare payments and providers' costs—In 2021, Medicare's payments to hospitals continued to be below hospitals' costs in aggregate but near costs among relatively efficient hospitals and higher than in 2020. IPPS hospitals' Medicare margin increased in 2021 to -6.2 percent when including a share of federal relief funds (-8.3 percent exclusive of these funds), and the median Medicare margin for relatively efficient hospitals increased to 1 percent (near break-even exclusive of federal relief funds). However, we project that hospitals' Medicare margins in 2023 will be lower than in 2021, driven in part by growth in hospitals' input costs, which exceeded the forecasts CMS used to set Medicare payment rate updates, and in part by the expected expiration of federal relief funds and temporary Medicare payment increases related to the public health emergency. These federal relief funds and Medicare payment increases exceeded hospitals' additional costs related to coronavirus disease 2019 (COVID-19). We anticipate that reductions in net revenue will be partially offset by other factors, including (1) reductions in hospitals' costs related to COVID-19, as cases decline and hospitals become better at managing the disease; and (2) the statutory 0.5 percent increase to inpatient operating payments to remove prior temporary reductions for past documentation and coding changes. We estimate that IPPS hospitals' Medicare margin will decrease in 2023 to about -10 percent (similar to the level in 2017) and that the median Medicare margin for relatively efficient hospitals will decrease to modestly below break-even—similar to prepandemic levels.

How should Medicare payments change in 2024?

The current-law updates to payment rates for 2024 will not be finalized until summer 2023, but CMS's third-quarter 2022 forecasts would result in the IPPS operating base payment rate and OPPS base payment rate increasing by 2.9 percent and the IPPS capital base payment rate increasing by 2.4 percent.

The Commission anticipates that a 2024 update to hospital payment rates of current law plus 1 percent would generally be adequate to maintain FFS beneficiaries' access to hospital inpatient and outpatient care and keep IPPS and OPPS payment rates close to the cost of delivering high-quality care efficiently. The Commission's payment update recommendation for 2024 reflects the most recent inflation and other data from 2021, preliminary data from 2022, and projections for 2023. If current projections of input inflation and hospital costs turn out to be inaccurate, these discrepancies will be accounted for in our assessment of payment adequacy in our next recommendation cycle.

Supporting Medicare safety-net hospitals

The recommended update to IPPS and OPPS payment rates of current law plus 1 percent may not be sufficient to ensure the financial viability of some Medicare safety-net hospitals with a poor payer mix. As the Medicare program strives to ensure access to care for all beneficiaries and adequately pay providers for that access, additional Medicare payments to Medicare safety-net providers are warranted. Medicare already provides substantial safety-net funding to hospitals, but there are several problems with the way Medicare distributes these funds, including omitting a hospital's Medicare share from its funding formulas in favor of subsidizing Medicaid payments, making supplemental payments only for inpatient services, and having an uncompensated care payment formula that favors hospitals with few FFS Medicare patients. The Commission's view is that Medicare safety-net payments should be used primarily to support Medicare safety-net hospitals—those that provide care to large shares of low-income Medicare beneficiaries. We note that this definition of “safety-net hospital” is Medicare-centric by design; safety-net definitions used by Medicaid and other payers would likely differ.

The Commission recommends redistributing the current Medicare safety-net payments (disproportionate share hospital and uncompensated care payments) using the Commission-developed Medicare Safety-Net Index (MSNI) for hospitals. Implementation of this index would better target scarce Medicare resources to support hospitals that are key sources of care for low-

income Medicare beneficiaries and may be at risk of closure. In addition to the redistribution, the Commission recommends adding \$2 billion to this MSNI pool of funds to help maintain the financial viability of Medicare safety-net hospitals. The FFS portion of the MSNI pool of funds should be distributed to hospitals as add-on payments to Medicare's IPPS and OPPS payments, with commensurate add-on amounts made to hospitals treating Medicare Advantage enrollees.

While most hospitals will see increases in Medicare revenue due to the \$2 billion in additional Medicare safety-net spending, there are some hospitals that will see reductions. Material reductions in Medicare revenue could occur for hospitals that currently receive high Medicare uncompensated care payments but serve relatively few FFS Medicare patients. In light of these effects, the Congress could phase in the policy for all hospitals over a set period of time (i.e., transition to the MSNI policy over three to five years). Alternatively, a transition could be managed through a stop-loss policy so that no hospital would experience changes (positive or negative) in Medicare payments of more than 5 percent in any one year due to the transition to the MSNI. Both approaches would also allow time for the hospitals facing the most substantial revenue reductions to try to augment revenues from existing sources and request additional financial support from state and local governments, as warranted. To the extent that these hospitals have high cost structures, a transition also would allow time to improve efficiencies. ■

Background

General acute care hospitals (ACHs) primarily provide inpatient care and various outpatient services. To pay these hospitals for their facility costs, fee-for-service (FFS) Medicare generally sets prospective payment rates under the inpatient prospective payment systems (IPPS) and outpatient prospective payment system (OPPS).¹ (Clinicians who provide services at hospitals are paid separately under the physician fee schedule; Medicare also pays separately for certain hospital units and costs.²) In setting these prospective rates per inpatient stay or primary outpatient service, CMS adjusts IPPS and OPSS national base payment rates for factors outside of hospitals' control, such as regional wage rates and patient characteristics. Both the IPPS and OPSS also include separate payments not tied to the base payment rates. The IPPS includes uncompensated care payments to help support hospitals' costs of treating the uninsured. The OPSS sets payments for drugs that exceed a cost threshold based on the manufacturer's average sales price. In 2021, the FFS Medicare program and its beneficiaries paid general ACHs \$182.5 billion for inpatient and

outpatient services under the IPPS and OPSS, including \$8.3 billion in uncompensated care payments and \$16.4 billion for separately payable drugs (Table 3-1).^{3,4}

Medicare uses different payment methodologies to reimburse certain other general ACHs for their facility costs of providing inpatient and outpatient services to FFS beneficiaries. Most notably, Medicare has designated about 1,350 small rural hospitals as critical access hospitals (CAHs) and pays these hospitals based on their costs.⁵ There are also about 50 general ACHs in Maryland that Medicare pays based on an all-payer global budget. These payment methodologies are beyond the scope of this chapter.

The IPPS and OPSS payment rates affect more than FFS Medicare payments for general ACHs. Within the FFS Medicare program, the OPSS is used to pay for outpatient services at certain specialty hospitals and other facilities.⁶ But more importantly, most Medicare Advantage plans pay IPPS hospitals using rates benchmarked to FFS Medicare rates (Berenson et al. 2015, Maeda and Nelson 2017). In addition, other payers—such as the Department of Veterans Affairs, certain state employee health plans, and some state

**TABLE
3-1**

Medicare pays for most acute care hospital services provided to FFS beneficiaries under the IPPS and OPSS, 2021

Medicare payment system	Number of hospitals	Number of FFS users (in millions)	Number of FFS inpatient stays or outpatient services (in millions)	Payments (in billions)
IPPS—Inpatient stays	3,170	4.6	7.1	\$107.9
IPPS—Uncompensated care	2,640	N/A	N/A	8.3
OPSS—Outpatient services	3,370	17.1	135.7	49.9
OPSS—Separately payable drugs				16.4
Total				182.5

Note: FFS (fee-for-service), IPPS (inpatient prospective payment systems), OPSS (outpatient prospective payment system), N/A (not applicable). The number of general acute care hospitals that provided OPSS services is higher than the number that provided IPPS services primarily because about 200 facilities gained hospital provider numbers during the public health emergency but did not provide any inpatient services to FFS beneficiaries. Number of hospitals rounded to the nearest 10. "OPSS—Separately payable drugs" includes drugs, devices, blood products, and brachytherapy sources. Payments include applicable beneficiary cost-sharing responsibilities. "Year" refers to fiscal year for inpatient services and calendar year for outpatient services.

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

public option plans—also set hospitals’ rates based on FFS Medicare payments (Government Accountability Office 2013, Schramm and Aters 2021, Scott 2021). Given the widespread use of FFS Medicare payment rates as a benchmark, any update to the Medicare base payment amount will affect many other payers (White et al. 2013).

Are Medicare payments adequate in 2023?

In 2021—the most recent year of data for most of our measures—most hospital payment adequacy indicators remained positive or improved, despite the continued coronavirus pandemic. In particular, the number of general ACHs that closed was the same as the number that opened; IPPS hospitals’ all-payer operating margin increased to a record high of 8.7 percent; and the median Medicare margin for relatively efficient hospitals increased to near break-even, exclusive of Medicare’s share of federal relief funds, and remained at 1 percent when including these funds.

However, hospital payment adequacy indicators continued to vary substantially across hospitals, and some indicators remained below prepandemic levels. For example, some hospitals faced capacity and staffing constraints at times. In addition, FFS beneficiaries’ risk-adjusted hospital mortality rate remained higher than the rate in 2019.

In addition, in 2022, input cost increases for hospitals were higher and more volatile than they have been in recent years. Preliminary data from 2022 suggest that hospital margins were lower in 2022 than in 2021, driven in part by higher-than-expected input costs.

For 2023, we project IPPS hospitals’ Medicare margin will decrease to about -10 percent (similar to the level in 2017), and the median Medicare margin for relatively efficient hospitals will decline to modestly below break-even, similar to prepandemic levels.

Beneficiaries maintained good access to hospital inpatient and outpatient services, but some hospitals faced constraints at times

FFS Medicare beneficiaries maintained good access to inpatient and outpatient services at general ACHs:

The number of general ACHs that closed was the same as the number that opened in both 2021 and 2022, hospitals continued to have excess capacity in aggregate, and those with excess capacity continued to have a financial incentive to serve FFS beneficiaries.⁷ However, some hospitals faced occupancy and staffing constraints at times.

Hospital care also accelerated its shift from inpatient to outpatient settings. In 2021, inpatient stays per FFS beneficiary declined, remaining below the prepandemic trend, while the number of hospital outpatient services per FFS beneficiary increased, reaching prepandemic levels.

Supply of hospitals has been steady

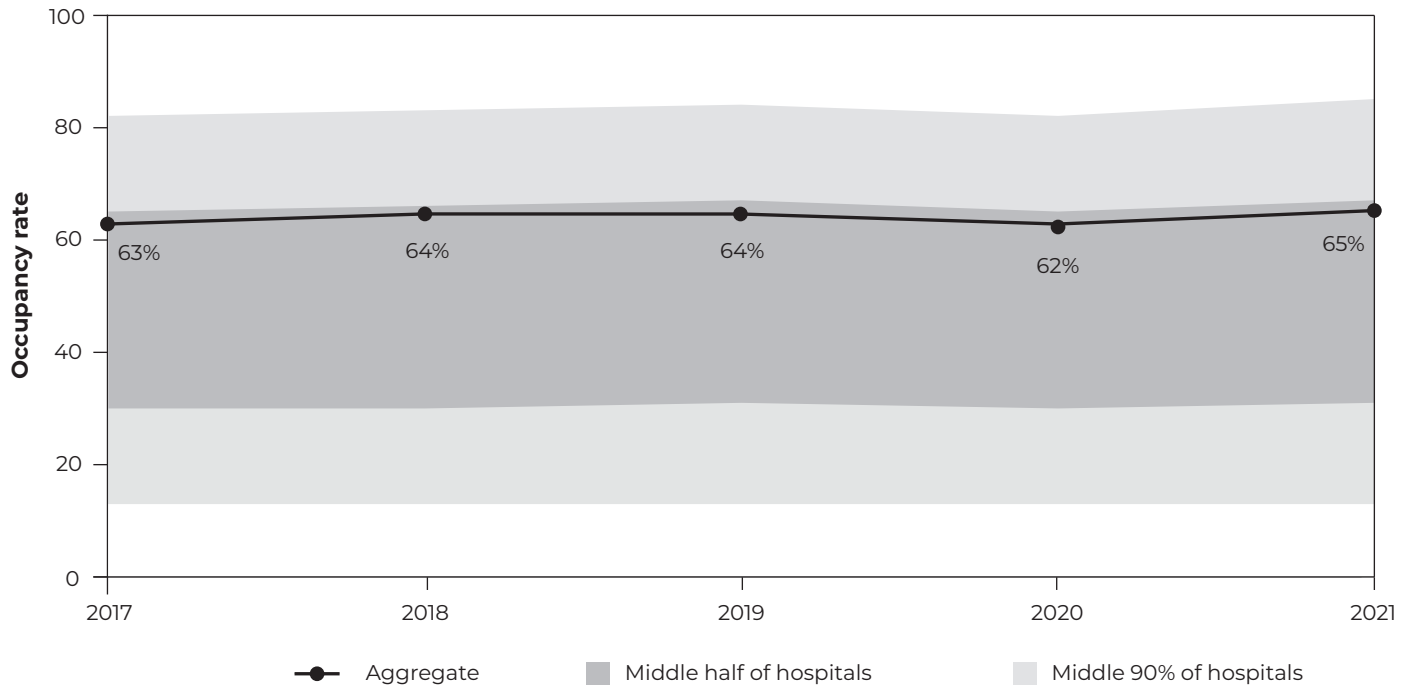
In both fiscal years 2021 and 2022, the number of general ACHs that closed was the same as the number that opened: 11 in 2021 and 16 in 2022.⁸ The number of closures was substantially below the levels in 2019 (46) and 2020 (25) and comparable with the number in 2017 and 2018. In contrast, from 2017 through 2022, the number of hospital openings was steadier, ranging from 8 to 18 openings.

Of the 16 hospitals that closed and the 16 that opened in fiscal year 2022, most shared several characteristics.⁹ All were IPPS hospitals, most were in metropolitan areas (12 of 16 closures and 13 of 16 openings), and the majority had 100 or fewer beds (9 of 16 closures and 11 of 16 openings). In addition, almost all the closures (14 of 16) were within 25 miles of the next nearest hospital, suggesting that most beneficiaries continued to have access to inpatient and emergency services in their region, but some may have faced moderately longer travel times.

Medicare’s payment policies were not a main contributor to the financial difficulties of the hospitals that closed. Rather, many hospitals that closed in 2022 cited other financial reasons, such as failing to secure a buyer or low patient volume, as a driving factor for the closure. Rural hospitals often face the greatest challenges with declining admissions, in part due to rural beneficiaries increasingly bypassing their local hospitals to seek care at urban hospitals. However, as the Rural Emergency Hospital (REH) designation began on January 1, 2023, some rural hospitals in financial distress may choose to convert to REHs rather than cease providing all services.¹⁰

FIGURE 3-1

In 2021, general acute care hospitals continued to have excess inpatient capacity in aggregate, but some hospitals reached near capacity



Note: Data are for general acute care hospitals that had a cost report with a midpoint in the fiscal year and the report was complete as of our analysis.

Source: MedPAC analysis of hospital cost report data.

Hospitals had excess inpatient capacity in aggregate and increased staff in 2021, but some hospitals faced capacity and staffing constraints at times

General ACHs continued to have excess inpatient capacity in aggregate, with about 65 percent of all bed-days occupied during fiscal year 2021, slightly higher than in prior years (Figure 3-1). This increased occupancy resulted from an increase in inpatient days and a decrease in staffed inpatient beds.

However, inpatient capacity continued to vary substantially across hospitals (Figure 3-1). For example, in 2021, 5 percent of hospitals had occupancy rates of over 85 percent, which was slightly higher than prior years. Moreover, as hospitals' occupancy rates varied throughout the year, many of these hospitals likely neared or exceeded their capacity at times, and preliminary data suggest that more hospitals exceeded

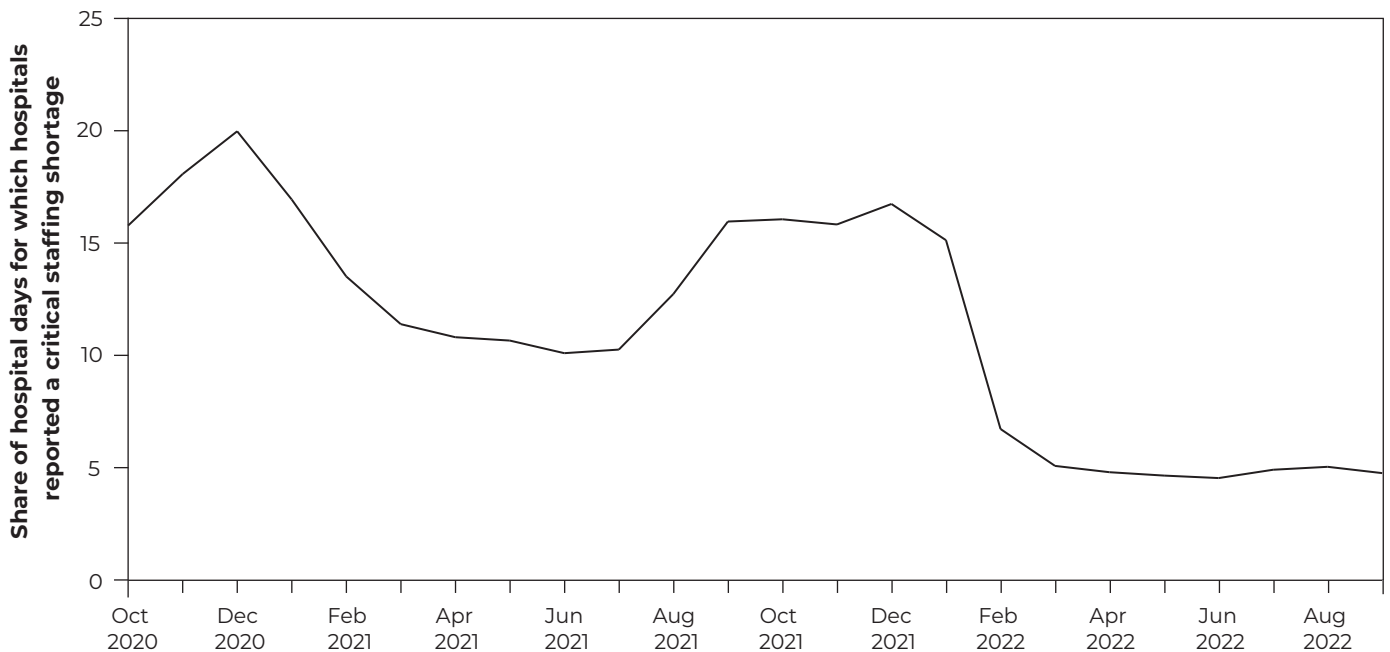
their capacity at times during 2022.¹¹ At the other extreme, a quarter of hospitals had an occupancy rate of less than 30 percent, and 5 percent had occupancy rates below 15 percent, consistent with prior years. Some of these hospitals, which tended to be small and rural, may not have sufficient inpatient volume to maintain inpatient services, suggesting that they could be good candidates for the new Medicare REH designation.

Another component of hospitals' capacity is their staffing level, which increased slightly in 2021 but was still below prepandemic trends. Prior to the pandemic, hospital employment had been increasing by about 1 percent a year; employment then declined by over 1 percent in fiscal year 2020 and recovered about half of this reduced employment in 2021.

Despite this modest increase in hospital employment, some hospitals reported critical staffing shortages at

**FIGURE
3-2**

Some hospitals reported critical staffing shortages at times in fiscal year 2021 and, to a lesser extent, in 2022



Note: Hospitals report critical staffing shortages to the Department of Health and Human Services based on their own individual facility needs and staffing ratio policies. The use of temporary staff does not automatically count as having a staffing shortage. Data include all general acute care hospitals and certain specialty hospitals and units.

Source: MedPAC analysis of healthdata.gov hospital capacity data.

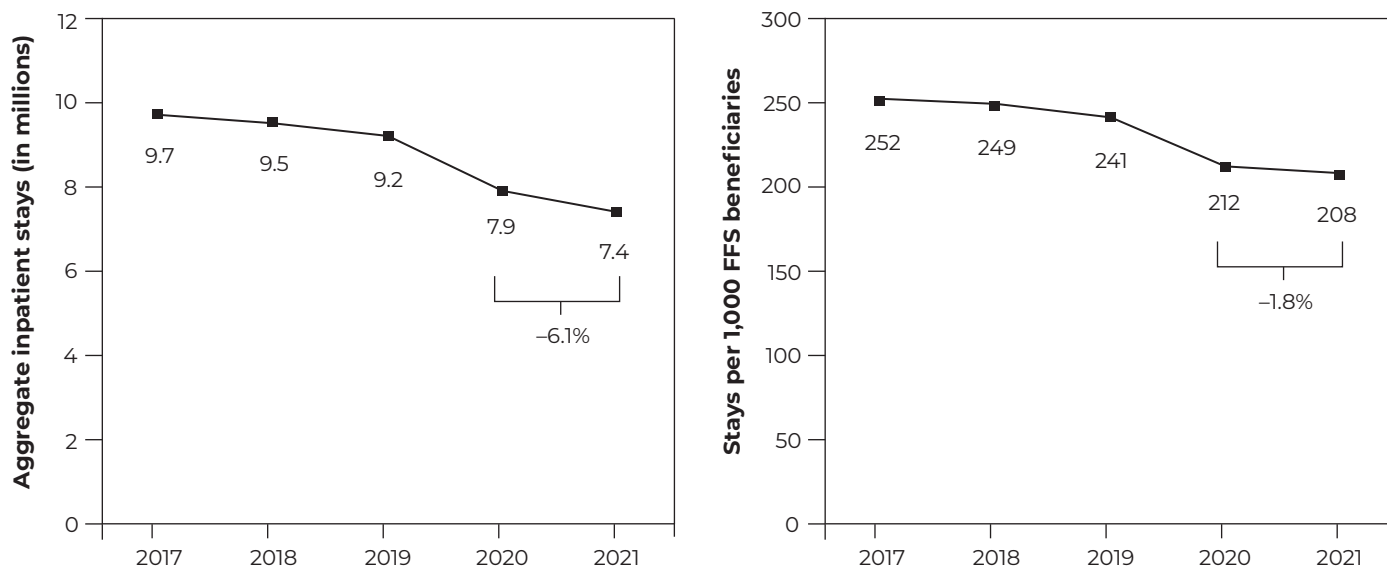
times during fiscal year 2021 and, to a lesser extent, in 2022 (Figure 3-2). Throughout fiscal year 2021, hospitals reported a critical staffing shortage for over 10 percent of all hospital days. The share of hospital days with a critical staffing shortage was higher at the start and end of 2021, exceeding 15 percent in aggregate and over 30 percent in some states. Anecdotal reports suggest that these staffing shortages caused some hospitals to temporarily close their emergency departments or intensive care units and to postpone or delay certain services such as surgeries. To address these staffing shortages, many hospitals have increased their use of travel nurses (Adegbesan 2022). However, in fiscal year 2022, reported critical staffing shortages declined; hospitals reported a critical staffing shortage for around 5 percent of all hospital days since March 2022.

Hospitals with excess capacity continued to have a financial incentive to provide inpatient and outpatient services to FFS beneficiaries

In 2021, IPPS hospitals' marginal profit on IPPS and OPSS services was about 8 percent—similar to prepandemic levels. We calculate hospitals' Medicare marginal profit by comparing Medicare's IPPS and OPSS payments with the variable cost of treating an additional FFS Medicare patient. To make a conservative estimate of hospitals' Medicare marginal profit, we use a broad definition of variable costs that is consistent with our prior estimates of the share of costs that varied over a one-year period. We have found that roughly 80 percent of costs are variable, including in 2021; to the extent that a higher share of hospitals' costs are fixed, the marginal profit would be higher.

**FIGURE
3-3**

In 2021, FFS beneficiaries' inpatient stays at general acute care hospitals declined, remaining well below the prepandemic trend



Note: FFS (fee-for-service). Analysis includes FFS Medicare beneficiaries' stays at hospitals paid under the inpatient prospective payment systems, critical access hospitals, and acute care hospitals in Maryland and U.S. territories.

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

As we noted last year, the rapid response to the coronavirus pandemic has demonstrated that—in response to lower volumes—many hospitals can substantially lower their costs over a matter of months. We expect that hospitals will have an even greater ability to adjust costs to patient volume when they have a longer period to adjust to environmental changes and the resulting long-term changes in volume that can be anticipated.

In 2021, FFS beneficiaries' inpatient stays declined, though their average length of stay increased

From 2020 to 2021, the number of inpatient stays by FFS Medicare beneficiaries at general ACHs declined by 6.1 percent to 7.4 million stays (Figure 3-3, left panel). Controlling for the number of FFS beneficiaries, the number of inpatient stays declined by 1.8 percent, to 208 stays per 1,000 FFS beneficiaries (Figure 3-3, right panel).¹² Inpatient stays per beneficiary were relatively

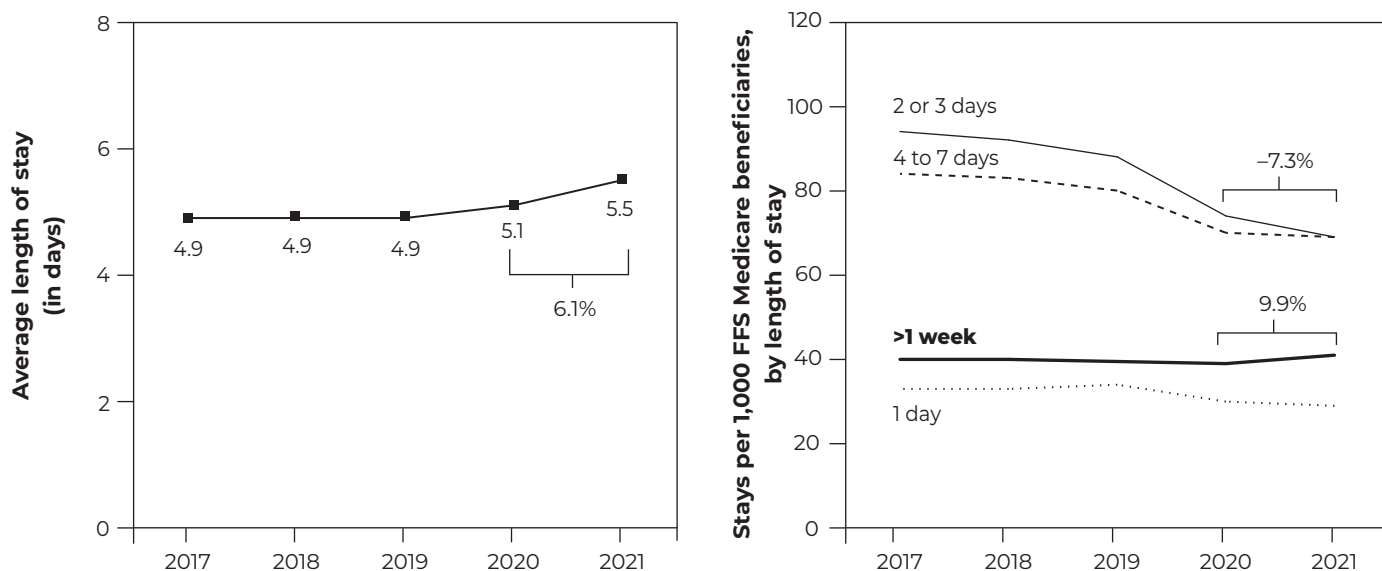
steady throughout 2021, at a level similar to the end of fiscal year 2020 (data not shown).

In contrast to the decline in the number of inpatient stays per FFS beneficiary, in 2021, FFS beneficiaries' average length of stay increased by 6.1 percent to 5.5 days (Figure 3-4, p. 64, left panel). The increase in the average length of stay was driven by a 7.3 percent decrease in stays of 2 to 3 days and a 9.9 percent increase in stays of longer than one week (Figure 3-4, p. 64, right panel). The increase in length of stay was even larger in stays of over two weeks (17.7 percent) and over two months (19.9 percent) (data not shown). Collectively, the decline in inpatient stays per beneficiary and the increase in average length of stay resulted in the total number of days per beneficiary rebounding to near the prepandemic trend.

From 2020 to 2021, the combination of the accelerated drop in inpatient stays per FFS beneficiary and the rise

**FIGURE
3-4**

In 2021, FFS beneficiaries' average length of stay at general acute care hospitals increased, driven by increase in stays of over 1 week



Note: FFS (fee-for-service). Data include FFS Medicare beneficiaries' stays at hospitals paid under the inpatient prospective payment systems, critical access hospitals, and acute care hospitals in Maryland and U.S. territories.

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

in average length of stay was driven by the acceleration of two trends related to the shift of certain care from inpatient to outpatient settings:

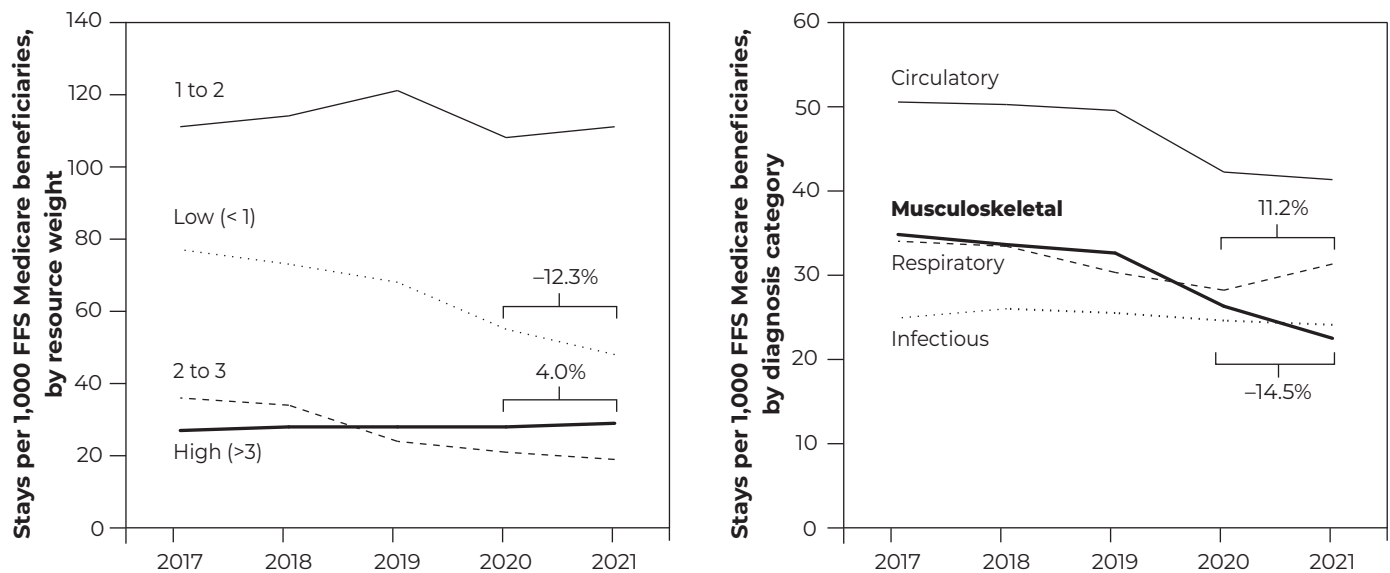
- Accelerated decline in less resource-intensive inpatient stays and increase in more resource-intensive inpatient stays.** From 2020 to 2021, the number of inpatient stays per FFS beneficiary with a Medicare severity–diagnosis related group (MS–DRG) weight of less than 1 declined by 12.3 percent, about twice as fast as prepandemic trends (Figure 3-5, left panel). (The MS–DRG weight reflects CMS's estimate of the relative average resource intensity of a type of stay. In 2021, the most common FFS Medicare inpatient stays with a weight of less than 1 were those for gastrointestinal hemorrhage, esophagitis without major complications or comorbidities (MCCs), and kidney and urinary tract infections without MCCs.) These less resource-intensive conditions can increasingly be treated in hospital outpatient

settings. In contrast, from 2020 to 2021, the number of inpatient stays per beneficiary with a resource weight of greater than 3 increased by 4 percent. (In 2021, the most common FFS inpatient stays with a weight of greater than 3 were stays for infectious diseases with operating room procedures and MCCs, septicemia or severe sepsis with mechanical ventilation for more than 96 hours, and percutaneous cardiovascular procedures with drug-eluting stents and MCCs.)

- Accelerated decline in short inpatient stays for musculoskeletal conditions and an increase in long stays for respiratory conditions.** From 2020 to 2021, the number of inpatient stays per FFS beneficiary for musculoskeletal conditions, such as joint replacements, declined 14.5 percent, about four times faster than before the pandemic (Figure 3-5, right panel). The decline was over three times larger (–50.5 percent) among the most common type of musculoskeletal stay—major hip or knee

**FIGURE
3-5**

Increasingly, fewer FFS beneficiaries' inpatient stays are for low resource-intensive and musculoskeletal conditions



Note: FFS (fee-for-service). Data include FFS Medicare beneficiaries' stays at hospitals paid under the inpatient prospective payment systems (IPPS), critical access hospitals, and acute care hospitals in Maryland and U.S. territories. Resource weight refers to the diagnosis-related group weight used in the IPPS. Right panel shows the four most common major diagnostic categories in 2021.

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

joint replacement without MCCs—which had an average length of stay of two days. Increasingly, these procedures can be safely provided in outpatient settings. In contrast, the number of inpatient stays per beneficiary for respiratory conditions, including COVID-19, increased 11.2 percent. The increase was nearly 14 times larger (156 percent) among the most common type of respiratory stay, respiratory infections and inflammations with MCC, which had an average length of stay of 7 days.

Some of the increase in average length of stay may also stem from staffing constraints at skilled nursing facilities that limited hospitals' ability to discharge patients to post-acute care facilities.

Preliminary data for 2022 suggest that the number of inpatient stays per FFS beneficiary declined at a faster rate than in 2021 and that growth in average length of stay slowed.

In 2021, FFS beneficiaries' hospital outpatient services increased, with services per beneficiary reaching prepandemic levels

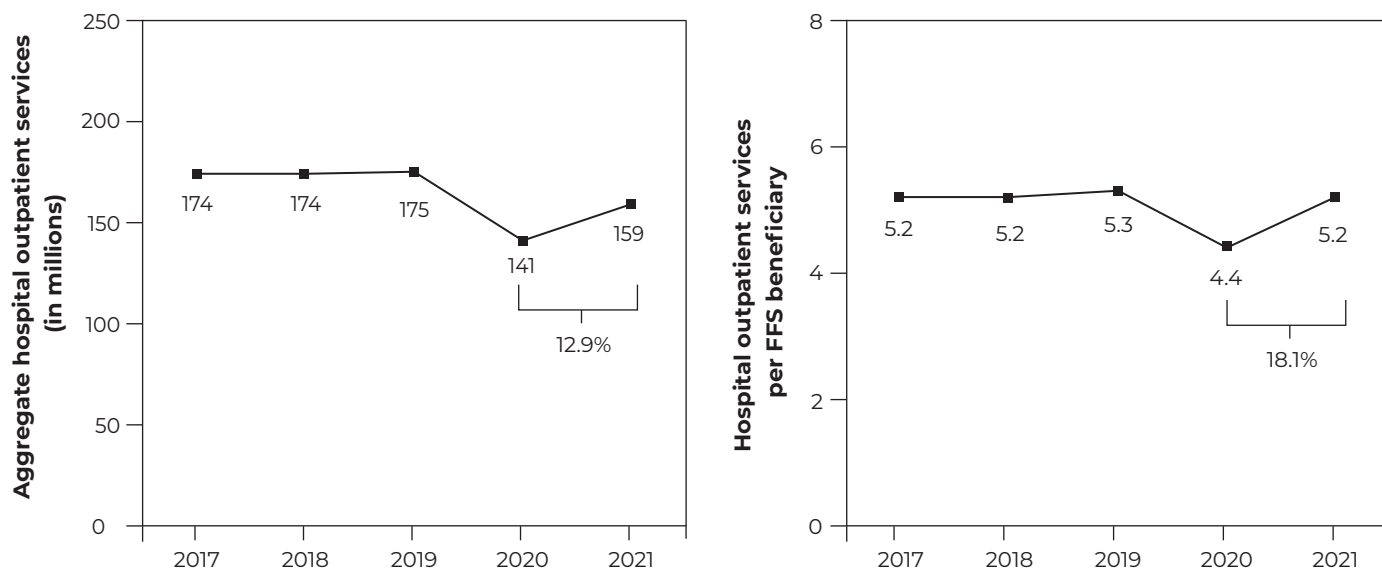
From 2020 to 2021, the number of FFS beneficiaries' hospital outpatient services at hospitals covered under the OPSS, CAHs, and Maryland hospitals increased by 12.9 percent to 159 million (Figure 3-6, p. 66, left panel). Controlling for the number of FFS beneficiaries, the number of hospital outpatient services climbed 18.1 percent to 5.2 services per beneficiary (Figure 3-6, p. 66, right panel). The volume of outpatient services was lower in January 2021 and February 2021 relative to the rest of the calendar year. From March 2021 through December 2021, outpatient volume was steady.

This increase in FFS Medicare beneficiaries' outpatient hospital services per beneficiary was primarily driven by increases in:

- **COVID-19-related services.** In 2021, there were 9.7 million services, or 0.3 per beneficiary, for COVID-19-related care, including vaccine administration,

**FIGURE
3-6**

In 2021, FFS beneficiaries' hospital outpatient services and services per beneficiary increased, the latter nearing prepandemic levels



Note: FFS (fee-for-service). Data include FFS Medicare beneficiaries' outpatient services at hospitals paid under the outpatient prospective payment system, critical access hospitals, and acute care hospitals in Maryland.

Source: MedPAC analysis of outpatient claims data and the Medicare Trustees report.

specimen collection, and chest X-rays. Since many of these services were new, arising from the coronavirus pandemic, the levels were above 2019 levels.

- **Clinic services.** In 2021, there was a 3.4 million increase in clinic services, or 0.9 increase per beneficiary (19.6 percent increase over 2020). Despite this large increase, the level remained below the 2019 level.

Preliminary data for 2022 suggest that outpatient services per FFS beneficiary continued to increase as hospital care continued to shift from inpatient to outpatient settings and hospitals continued to acquire physician practices. The shift of services away from inpatient care is particularly noteworthy because it coincided with a reduction in observation care. From 2019 to 2021, the number of outpatient observation visits per 1,000 Part B FFS beneficiaries

paid under the OPSS declined from 43 to 32 per 1,000 beneficiaries.

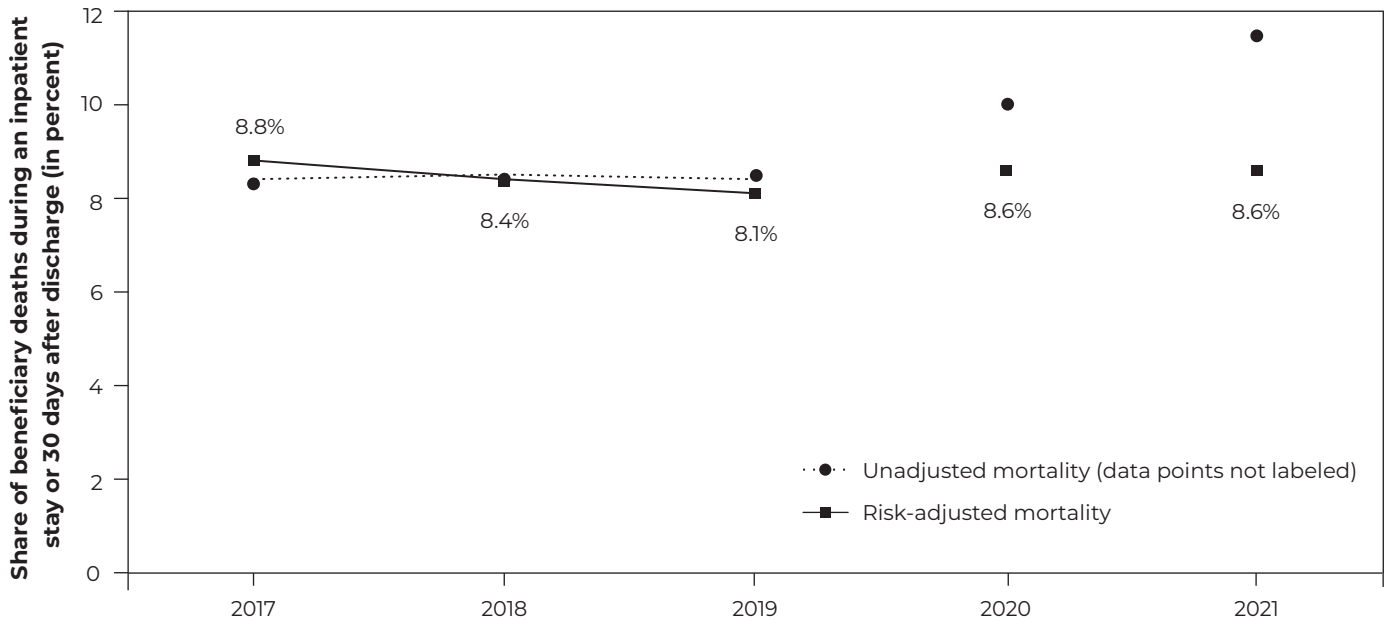
Quality of care in 2021 was mixed relative to 2019

Changes in our hospital quality indicators from 2019 to 2021 were mixed. FFS beneficiaries' risk-adjusted hospital mortality rate increased slightly, while the risk-adjusted hospital readmission rate improved. Patient experience indicators declined.

Quality of care in 2020 was difficult to assess due to effects of the coronavirus pandemic on beneficiaries and providers. The results reflect temporary changes in the delivery of care and data limitations unique to the public health emergency (PHE), so we did not use these results to inform our conclusions about trends in the quality of care provided to Medicare beneficiaries or their relationship to Medicare payment adequacy.

FIGURE
3-7

From 2019 to 2021, FFS beneficiaries' risk-adjusted all-condition mortality rate during an inpatient stay or 30 days after discharge increased



Note: FFS (fee-for-service). Data include hospitals paid under the inpatient prospective payment systems, critical access hospitals, and acute care hospitals in Maryland and U.S. territories. The 2017–2020 risk-adjusted values differ slightly from what was presented in the March 2022 report to the Congress because of a change in the baseline years and version of the 3M™ all-patient refined–diagnosis related group software for calculating expected results. The 2019–2021 values are not connected because we cannot draw conclusions on the quality of care in 2020 due to the effects of the coronavirus pandemic.

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

This year we have updated the mortality and readmission risk-adjustment models to include the COVID-19 diagnosis, which improves our ability to represent the acuity and mix of patients receiving hospital care in 2021. The 2021 patient experience results include a full year of survey results instead of a partial year.

FFS beneficiaries' risk-adjusted hospital mortality rate increased

In 2021, the overall mortality rate continued to rise nationwide due to deaths from COVID-19. From 2019 to 2021, FFS beneficiaries' unadjusted hospital mortality rate (death during a hospital stay or 30 days after discharge) increased from 8.4 percent to 11.5 percent (data points are not labeled). During that time, the

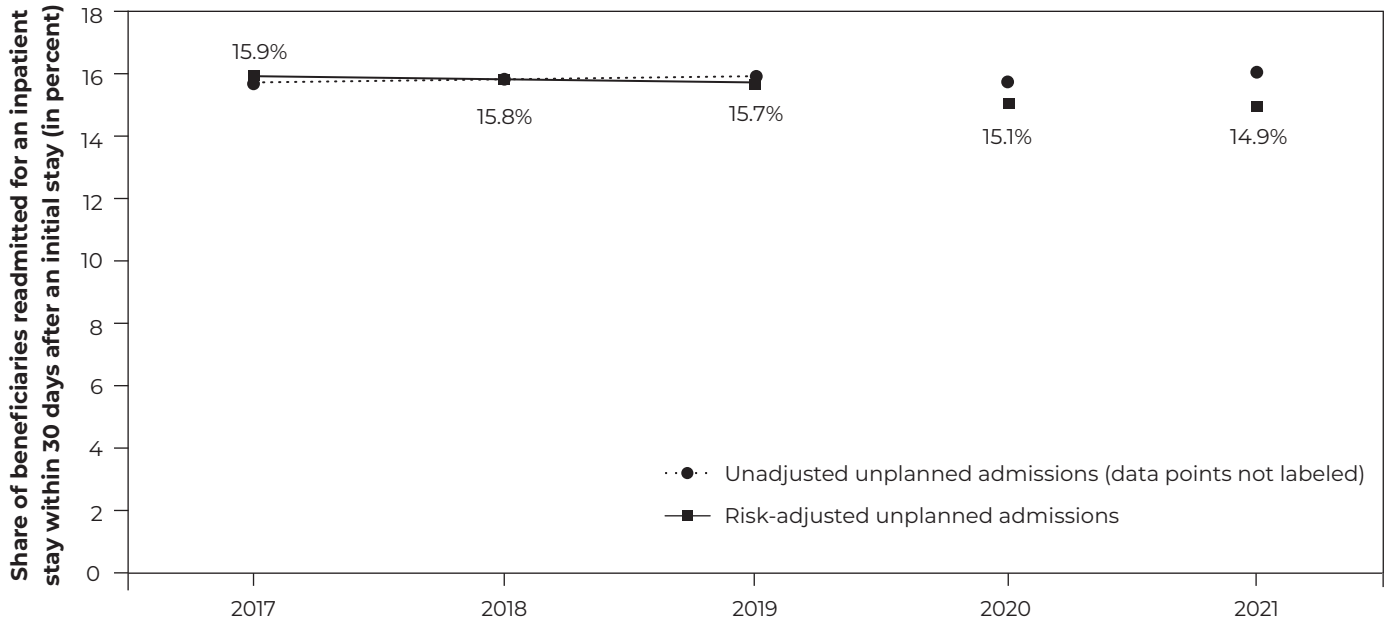
2021 risk-adjusted mortality rate increased (that is, worsened) from 8.1 percent to 8.6 percent (Figure 3-7). From 2017 to 2019, the risk-adjusted mortality rate had improved (that is, declined) by 0.7 percentage point. Over the three-year period, unadjusted mortality rates were relatively stable, but expected mortality increased because beneficiaries admitted to hospitals in recent years tended to have more comorbidities and thus a higher risk of mortality.

FFS beneficiaries' risk-adjusted hospital readmission rate improved

Many factors related to the coronavirus pandemic affected hospitalization rates, including both greater demand for beds for patients diagnosed with COVID-19 and lower demand for beds because some patients

**FIGURE
3-8**

From 2019 to 2021, FFS Medicare beneficiaries' all-condition risk-adjusted hospital readmission rate improved



Note: FFS (fee-for-service). Data include FFS Medicare beneficiaries ages 65 or older and hospitals paid under the inpatient prospective payment systems, critical access hospitals, and acute care hospitals in Maryland and U.S. territories. The 2017–2020 unadjusted values differ slightly from values presented in the March 2022 report to the Congress because of minor changes to the measure calculation. The 2017–2020 risk-adjusted values differ because of a change in the baseline years and version of the 3M™ all-patient refined–diagnosis related group software for calculating expected results. The 2019–2021 values are not connected because we cannot draw conclusions on the quality of care in 2020 due to the effects of the coronavirus pandemic.

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

avoided hospitals due to fears of infection. Between 2019 and 2021, the unadjusted rate of readmissions (FFS Medicare beneficiaries over age 65 readmitted within 30 days after discharge) increased by 0.1 percentage point (data not labeled) (Figure 3-8). The rate of risk-adjusted readmissions decreased (that is, improved) by 0.8 percentage point to 14.9 percent because beneficiaries admitted to hospitals in recent years tended to have more comorbidities and thus a higher expected rate of readmission.

Patient experience results declined

Between 2019 and 2021, hospital patient experience measures remained high but most declined by 1 percentage point to 4 percentage points (Table 3-2).

Hospitals collect Hospital Consumer Assessment of Healthcare Providers and Systems® (H-CAHPS®) surveys from a sample of admitted patients, which CMS uses to calculate results for 10 measures of patient experience included in hospitals' overall ratings.¹³ 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 2021, 72 percent of surveyed patients rated their overall hospital experience a 9 or 10 on a 10-point scale, which is a 1 percentage point decrease from 2019. Communication with nurses, communication with doctors, and receipt of discharge information had the highest scores, with at least 80 percent of surveyed patients answering

**TABLE
3-2**

Hospital patient experience measures declined from 2019–2021

H-CAHPS® measure	2017	2018	2019	2020	2021	Percentage point change, 2019–2021
Share of patients rating the hospital a 9 or 10 out of 10	73%	73%	73%	72%	72%	-1
Share of patients who would definitely recommend the hospital	72	72	72	71	70	-2
Share of patients giving top ratings for:						
Communication with nurses	80	81	81	80	80	-1
Communication with doctors	82	81	82	81	80	-2
Responsiveness of hospital staff	70	70	70	67	66	-4
Communication about medicines	66	66	66	63	62	-4
Cleanliness of hospital environment	75	75	76	73	73	-3
Quietness of hospital environment	62	62	62	63	62	0
Understanding their care when they left the hospital (care transitions)	53	53	54	52	52	-2
Share of patients who received discharge information	87	87	87	86	86	-1

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

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

with the most positive response. From 2019 to 2021, responsiveness of hospital staff and communication about medicines dropped by 4 percentage points, and cleanliness of hospital environment dropped by 3 percentage points. In 2021, the care-transition measure continued to get the lowest score, with only 52 percent of surveyed patients responding with "Strongly Agree" that they understood their care plan when they left the hospital.

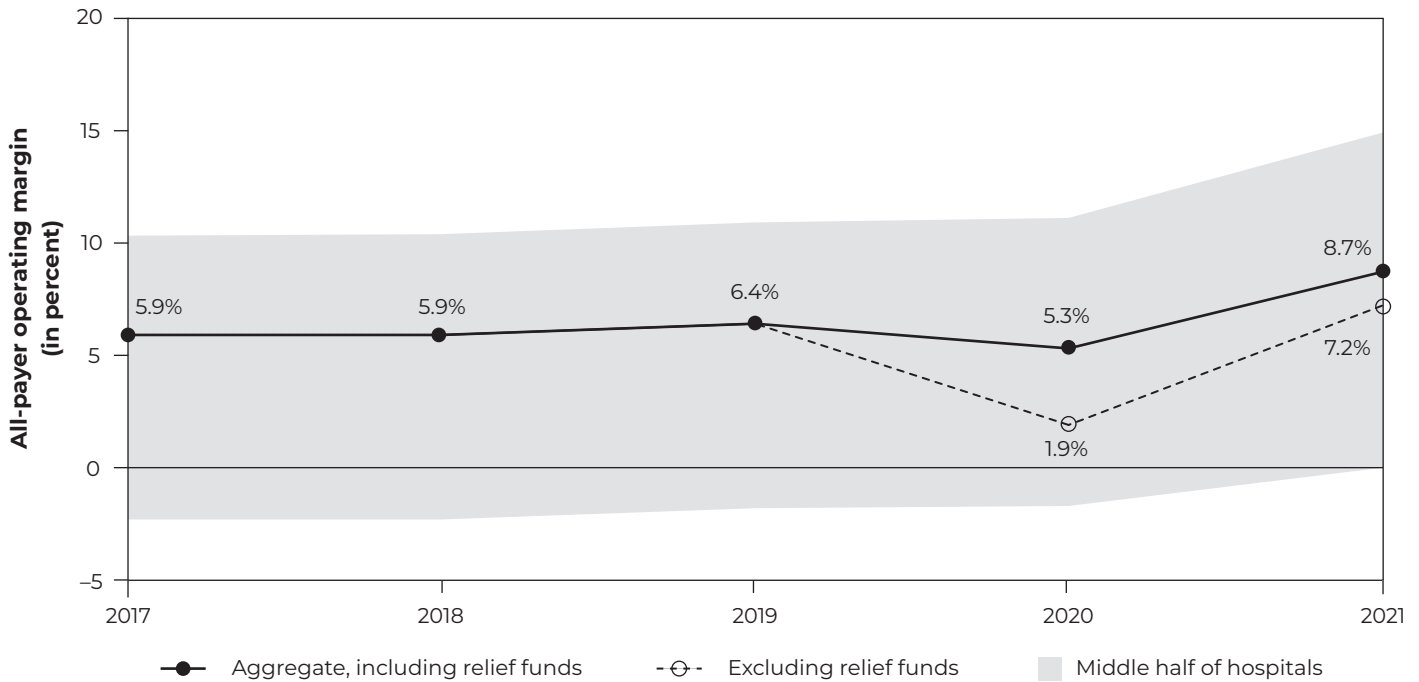
Need for a redesign of hospital quality payment programs

In March 2019, the Commission recommended that the Congress replace Medicare's current hospital quality programs (including the penalty-only programs) with a single, outcome-focused quality-based payment program for hospitals—a hospital value incentive

program (HVIP)—that balances rewards and penalties and has the potential to drive further improvement in hospital quality (Medicare Payment Advisory Commission 2019). Initially, the HVIP could incorporate existing quality measure domains such as readmissions, mortality, spending, patient experience, and hospital-acquired conditions (or infection rates). A key feature of the Commission's HVIP design is that it accounts for differences in providers' patient populations by incorporating a peer-grouping methodology. Quality-based payments would be distributed to hospitals separated into peer groups, defined by their share of beneficiaries who have full dual eligibility for Medicare and Medicaid (as a proxy for income). The grouping of hospitals into peer groups that serve similar populations would make payment adjustments more equitable than existing quality payment programs.

**FIGURE
3-9**

IPPS hospitals' all-payer operating margin reached a record high in 2021, despite declines in federal relief funds



Note: IPPS (inpatient prospective payment systems). Hospitals' margins are calculated as aggregate payments minus aggregate costs, divided by aggregate payments. "All-payer" margin includes payments from all payers. The "operating" margin is limited to patient care and other operating revenue, and in 2020 and 2021 these margins are reported with and without federal relief funds (Provider Relief Fund payments and forgiven loans from the Paycheck Protection Program). Data are for IPPS hospitals that had a cost report with a midpoint in the fiscal year and that was complete as of our analysis.

Source: MedPAC analysis of hospital cost reports.

Hospitals' access to capital strengthened in 2021 but was mixed in 2022

Hospitals' access to capital strengthened in 2021, with IPPS hospitals' all-payer operating margin reaching a record high despite declining federal relief funds. However, margins continued to vary substantially across hospitals.

Preliminary 2022 all-payer operating margin data were mixed relative to pre-pandemic levels, but hospitals continued to have strong access to bond markets.

Hospitals' all-payer operating margin reached a record high in 2021

In 2021, IPPS hospitals' all-payer operating margin increased to 8.7 percent with federal relief funds

and to 7.2 percent without federal relief funds, both of which were higher than the prior all-time high in 2019 (Figure 3-9).¹⁴ The increase in IPPS hospitals' all-payer operating margin occurred despite a decrease in federal relief funds: In their fiscal year 2021 cost-reporting period, hospitals reported receiving about \$18 billion in these funds, down from \$35 billion in 2020.¹⁵ In other words, the federal relief funds that hospitals received in 2021 more than offset the additional coronavirus pandemic-related expenses that were not covered by the higher patient revenues associated with COVID-19. Rather, the increase in the operating margin of over 3 percentage points resulted from hospitals' operating revenues growing more than their costs: Operating revenue increased

**TABLE
3-3**

In 2021, IPPS hospitals' all-payer operating margins continued to vary across hospital groups, including an all-time high among for-profit hospitals

Hospital group				2020		2021	
	2017	2018	2019	With relief funds	Without relief funds	With relief funds	Without relief funds
All IPPS	5.9%	5.9%	6.4%	5.3%	1.9%	8.7%	7.2%
Ownership							
For profit	10.5	11.4	12.2	12.6	10.4	15.1	13.9
Nonprofit	5.9	5.5	6.1	4.7	1.2	8.2	6.8
Location							
Metropolitan (urban)	6.0	6.1	6.6	5.3	2.0	8.6	7.3
Rural micropolitan	4.9	3.9	5.2	6.2	1.9	9.2	6.8
Other rural	2.1	0.2	0.7	3.4	-1.5	7.6	3.0
Teaching and DSH							
Both	5.7	5.8	6.2	4.8	1.4	8.4	6.9
DSH only	5.5	5.6	6.3	6.2	2.8	8.9	7.3
Teaching only	8.8	8.7	7.7	6.0	4.1	7.7	6.7
Neither	9.0	9.1	10.1	8.4	6.0	13.5	11.8

Note: IPPS (inpatient prospective payment systems), DSH (disproportionate share hospital). Hospitals' margin is calculated as aggregate payments minus aggregate costs, divided by aggregate payments. "All-payer operating margin" includes patient care and other operating revenue from all payers, and, for 2020 and 2021, is reported with and without reported federal relief funds (Provider Relief Fund payments and Paycheck Protection Program forgiven loans). Metropolitan (urban) counties contain an urban cluster of 50,000 or more people; rural micropolitan counties contain a cluster of 10,000 to 50,000 people; all other counties are classified as "other rural." Data are for IPPS hospitals that had a cost report with a midpoint in the specified fiscal year and that were complete as of our analysis.

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

over 11 percent, while costs increased by only about 7 percent.¹⁶ Several large hospital systems highlighted the growth in inpatient acuity as contributing to their improved operating margin.

Within hospitals' aggregate all-payer operating margin, there continued to be significant variation: The 2021 operating margin ranged from 0.8 percent to 14.9 percent among the middle half of IPPS hospitals (Figure 3-9, data not labeled). While there was variation within each group of hospitals, in aggregate, the operating margin continued to be higher among for-profit hospitals and those that were neither teaching nor receiving disproportionate share payments (the

latter known as disproportionate share hospitals (DSHs)) (Table 3-3). In contrast, the operating margin continued to be lower among hospitals in rural nonmicropolitan areas. However, rural hospitals received targeted federal relief funds, so the difference in the all-payer operating margin between rural and urban hospitals was smaller than prepandemic levels.

Preliminary 2022 all-payer operating margin data are mixed relative to prepandemic levels

Preliminary data from several large hospital systems suggest hospitals' all-payer operating margin declined during the first half of 2022 relative to the record high

margins in 2021. Because 2021 was atypical, we also compare these large systems' 2022 all-payer margins with their prepandemic (2019) operating margins. Our sample of partial year data for 2022 is limited to five large systems that represent about 17 percent of all IPPS hospitals. From the fiscal year ending in June 2019 to the fiscal year ending in June 2022, two of the largest nonprofit systems reported a decline in operating margins of 2 percentage points to 4 percentage points (Ascension 2022a, Ascension 2020, Trinity Health 2022a, Trinity Health 2020). In contrast, during the first nine months of 2022 compared with the first nine months of 2019, two of the three largest for-profit systems reported an increase in operating margins of 2 percentage points to 4 percentage points (HCA Healthcare 2022, HCA Healthcare 2020, Tenet Health 2022, Tenet Health 2020); the third reported a 2022 operating margin similar to its 2019 margin (Community Health Systems 2022, Community Health Systems 2020). Aggregating the data from these five systems, all-payer operating margins remained positive and about equal to 2019 levels.¹⁷ There is still a material level of uncertainty regarding labor costs and overall profitability in the fourth quarter of 2022.

A few factors influenced these large hospital systems' lower operating margins in 2022 relative to those in 2021. Inflation was higher than expected and led to higher operating expenses. Hospital systems also cited a combination of ongoing workforce shortages, high labor costs, a reduction of provider relief funds, and declining patient acuity as some reasons for the downward fiscal pressure on margins. The decline in patient acuity in 2022 was attributed to declining COVID-19 volume, reversing a prior trend of higher acuity due to high COVID-19 volume.¹⁸ However, several hospital systems reported improvements in financial performance for the second and third quarters of 2022. Those improvements were attributed to near-term favorable trends in patient volume, fewer COVID-19 disruptions, and a decline in the use of contract labor (Ascension 2022b, CommonSpirit 2022, Community Health Systems 2022, Trinity Health 2022b).

Hospitals continued to have strong access to bond markets

In both fiscal years 2021 and 2022, hospitals have continued to pay a relatively low risk premium to

access the bond market. During the start of the coronavirus pandemic in spring 2020, investors demanded a larger premium to hold hospital bonds, reaching a peak of 3.5 percentage points above the yield on treasury bonds. This peak was well above the premium over the past 10 years, which generally ranged from 1 percentage point to 2.5 percentage points above the yield on treasury bonds. By the start of fiscal year 2021, hospitals' risk premium to access bonds had declined to 2.5 percentage points above the yield on treasury bonds. Throughout most of 2021 and 2022, hospitals' risk premium to access bonds continued to decline, falling to 1 percentage point above the yield on treasury bonds by the end of fiscal year 2022 (S&P Global 2022).

While investor interest in bonds remained strong, by the end of 2022 S&P Global Ratings downgraded about 10 percent of nonprofit hospital bonds (S&P Global Ratings 2022). At the start of fiscal year 2023, the ratings agencies reported a stable outlook for about 80 percent of nonprofit hospitals, a negative outlook for about 15 percent of nonprofit hospitals, and a positive outlook for about 5 percent of nonprofit hospitals (Moody's Investors Service 2022, S&P Global Ratings 2022).

IPPS hospitals' Medicare margin improved in 2021 and was near break-even for relatively efficient hospitals

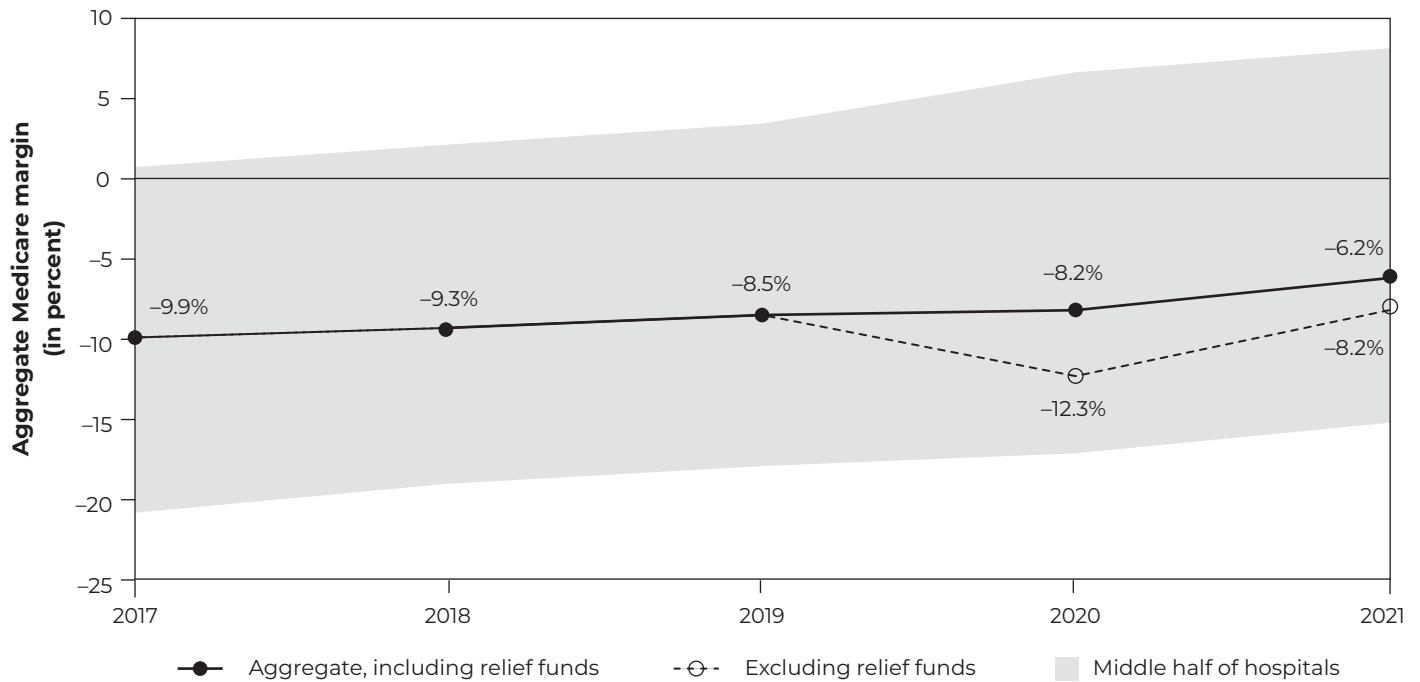
From 2020 to 2021, IPPS hospitals' Medicare margin increased, with the median Medicare margin among relatively efficient hospitals becoming positive when including Medicare's share of federal relief funds and increasing from negative to break-even when excluding these funds.

IPPS hospitals' Medicare margin remained negative in 2021 but increased above prepandemic levels

In 2021, IPPS hospitals' aggregate Medicare margin across hospital service lines remained negative but increased above prepandemic levels, even before including any federal relief funds (Figure 3-10).¹⁹ Specifically, IPPS hospitals' Medicare margin increased to -6.2 percent in 2021 when including Medicare's share of federal relief funds—a recent high.²⁰ Exclusive of these funds, the Medicare margin was -8.2 percent, which was still higher than prepandemic levels. The

**FIGURE
3-10**

IPPS hospitals' Medicare margin remained negative in 2021 but increased to above prepandemic levels



Note: IPPS (inpatient prospective payment systems). "Relief funds" refers to Provider Relief Fund payments and forgiven loans from the Paycheck Protection Program, as recorded on hospitals' cost reports; Medicare's share of these funds was calculated using fee-for-service Medicare's share of 2019 all-payer operating revenue. Hospitals' "Medicare margin" is calculated as aggregate Medicare payments minus aggregate allowable Medicare costs, divided by aggregate Medicare payments. Payments and costs include multiple hospital service lines (including inpatient, outpatient, swing bed, skilled nursing, rehabilitation, psychiatric, and home health services) as well as direct graduate medical education and uncompensated care payments. Data are for IPPS hospitals that had a cost report with a midpoint in the fiscal year and that was complete as of our analysis.

Source: MedPAC analysis of hospital cost reports.

increase in IPPS hospitals' Medicare margin from 2020 to 2021 of 2 percentage points (about 4 percentage points before including relief funds) resulted from hospitals' Medicare revenues growing while their costs held relatively steady. In other words, in aggregate, the Medicare payment increases during the PHE more than offset hospitals' additional pandemic-related costs and increased the share of hospitals that had a positive Medicare margin. (For a description of the Medicare payment increases, see the text box in our March 2022 report to the Congress, p. 89.)

Within hospitals' aggregate Medicare margin, there continued to be significant variation: The 2021 Medicare margin ranged from -15.2 percent to +8.1

percent among the middle half of IPPS hospitals (Figure 3-10, data not labeled). While there was variation within each group of hospitals, in aggregate, the Medicare margin continued to be higher—and positive—at for-profit hospitals and hospitals in small rural communities (Table 3-4, p. 74). In contrast, the Medicare margin continued to be lower among hospitals that were not disproportionate share hospitals.

In 2021, aggregate IPPS payments increased while hospitals' aggregate inpatient costs decreased slightly

In 2021, aggregate IPPS payments to hospitals for FFS Medicare beneficiaries' inpatient stays increased 3.4 percent to \$107.9 billion (Figure 3-11, p. 75, left panel).

**TABLE
3-4**

In 2021, IPPS hospitals' Medicare margin continued to vary across hospital groups, including higher margins at for-profit and rural hospitals

Hospital group	2017	2018	2019	2020		2021	
				With relief funds	Without relief funds	With relief funds	Without relief funds
All IPPS	-9.9%	-9.3%	-8.5%	-8.2%	-12.3%	-6.2%	-8.2%
Ownership							
For profit	-2.2	-0.3	1.3	4.3	1.6	5.3	3.7
Nonprofit	-11.1	-10.6	-10.0	-10.3	-14.8	-8.2	-10.2
Location							
Metropolitan (urban)	-10.1	-9.5	-8.8	-8.7	-12.8	-6.6	-8.5
Rural micropolitan	-8.3	-7.1	-6.1	-3.7	-8.5	-2.6	-5.8
Other rural	-5.6	-5.2	-2.5	1.6	-4.0	4.9	-0.8
Teaching and DSH							
Both	-8.7	-8.4	-7.8	-7.7	-11.8	-5.8	-7.8
DSH only	-11.2	-10.3	-9.1	-7.9	-12.2	-5.7	-8.0
Teaching only	-14.3	-12.0	-11.7	-14.4	-16.9	-11.0	-12.5
Neither	-17.2	-15.3	-14.3	-13.9	-17.0	-10.8	-13.3

Note: IPPS (inpatient prospective payment systems). Hospitals' margin is calculated as aggregate payments minus aggregate allowable costs, divided by aggregate payments. Hospitals' "Medicare margin" is calculated as aggregate Medicare payments minus aggregate allowable Medicare costs, divided by aggregate Medicare payments. Payments and costs include multiple hospital service lines (including inpatient, outpatient, swing bed, skilled nursing, rehabilitation, psychiatric, and home health services) as well as direct graduate medical education and uncompensated care payments. For 2020 and 2021, the margin is reported with and without reported federal relief funds (Provider Relief Fund payments and Paycheck Protection Program forgiven loans). Metropolitan (urban) counties contain an urban cluster of 50,000 or more people; rural micropolitan counties contain a cluster of 10,000 to 50,000 people; all other counties are classified as "other rural." Data are for IPPS hospitals that had a cost report with a midpoint in the specified fiscal year and that were complete as of our analysis.

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

This increase in payments occurred despite a decrease in FFS beneficiaries because there was a larger growth in Medicare payments per stay, which rose 10.3 percent to about \$15,600 (Figure 3-11, right panel).

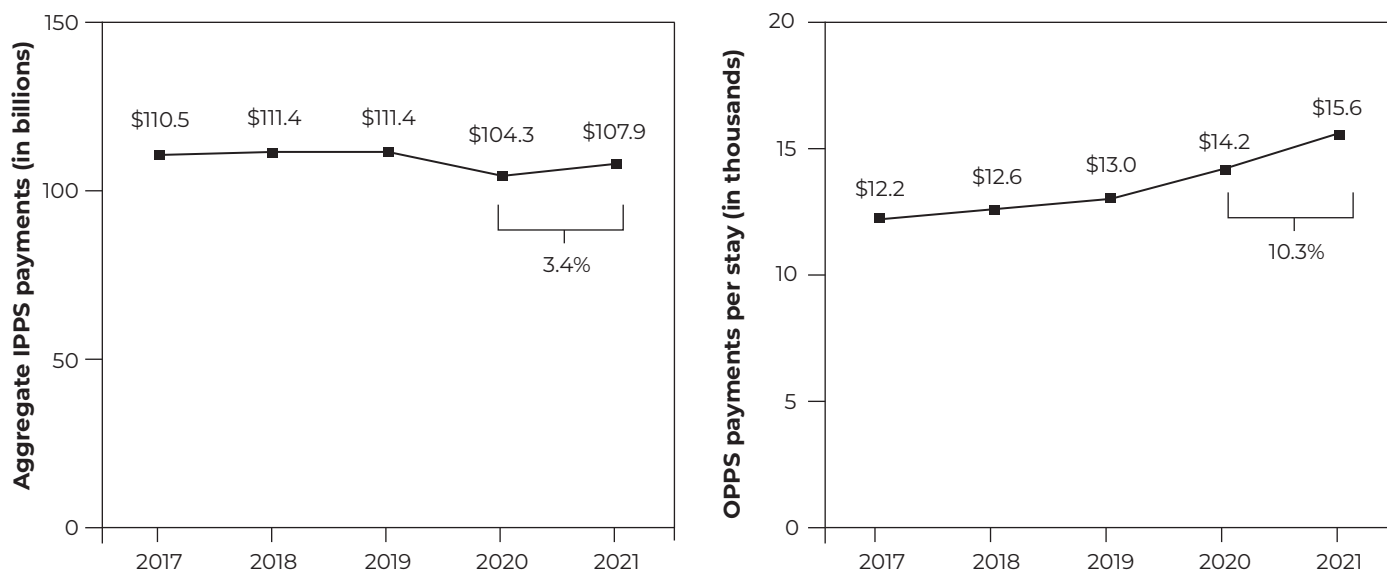
The 10.3 percent growth in IPPS payments per stay in 2021 resulted primarily from:

- **Annual update to the IPPS base payment rates and statutory increase.** In 2021, the net annual update to IPPS base payment rates—including a statutory increase—was 2.8 percent. This increase

resulted from: (1) a 2.4 percent annual update to the inpatient operating base payment rate; (2) a 0.5 percent statutory increase to the inpatient operating base rate (from phasing out adjustments that were put in place in 2018 to recoup prior coding-induced overpayments); and (3) a 1.1 percent update to the inpatient capital base rate. Because the inpatient operating rate is about 97 percent of total IPPS base rates, the net update was 2.8 percent ((93 percent × 2.9 percent) + (7 percent × 1.1 percent)).

FIGURE 3-11

In 2021, aggregate IPPS payments for FFS beneficiaries' inpatient stays remained below the prepandemic level while payments per stay continued to rise rapidly



Note: IPPS (inpatient prospective payment systems), FFS (fee-for-service). IPPS payments exclude payments for uncompensated care because these are not payments for FFS Medicare beneficiaries' inpatient stays. Payments per stay are per transfer-adjusted stay.

Source: MedPAC analysis of Medicare Provider Analysis and Review data for fiscal years 2017 to 2021.

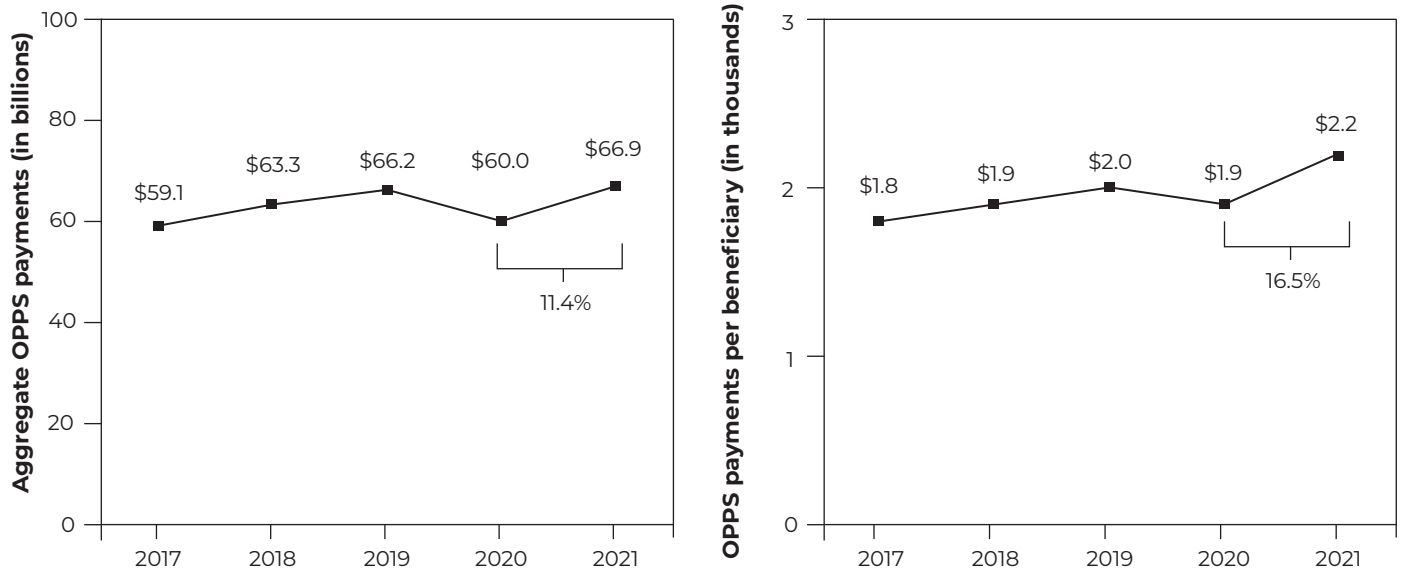
- **Growth in case mix.** In 2021, there was a 3.4 percent increase of reported inpatient case mix, net of changes from annual updates to relative weights. These weights do not consider patients' COVID-19 status.
- **Increases in Medicare payments during the PHE.** We estimate that the suspension of the 2 percent sequestration in the Medicare program's share of FFS payments, which began on May 1, 2020, and extended through April 2022, raised IPPS payments per stay by 1.1 percent in 2021.²¹ In addition, we estimate that the mandated 20 percent increase in the resource weight for inpatient stays when patients have a COVID-19 diagnosis increased 2021 IPPS payments per stay by an additional 1.2 percent. We also estimate that add-on payments for new COVID-19 technologies increased 2021 IPPS payments per stay by an additional 1 percent.

Meanwhile, between 2020 and 2021, IPPS hospitals' aggregate costs for inpatient services fell slightly. This decrease was the combination of two factors. First, the number of FFS Medicare inpatient stays declined. Second, IPPS hospitals were able to constrain the growth in costs per inpatient stay to slightly below the increase in input prices and average case mix. This constraint in cost growth is similar to prior years, except for 2020, and indicates that hospitals coded patients more extensively, improved productivity, or both. As the increase in costs per inpatient stay was slightly lower than the decline in the number of FFS Medicare inpatient stays, IPPS hospitals' aggregate inpatient costs declined slightly.

In 2021, uncompensated care payments held steady In 2021, uncompensated care payments—payments that the Medicare program makes to help cover hospitals' costs of bad debt and charity care—held steady at near

**FIGURE
3-12**

In 2021, OPSS aggregate payments for outpatient services and payments per FFS beneficiary rose above pre-pandemic levels



Note: OPSS (outpatient prospective payment system). The data include all OPSS payments (including, but not limited to, general acute care hospitals). Data reported by calendar year.

Source: MedPAC analysis of Medicare outpatient claims data and the Medicare Trustees report.

\$8.3 billion and therefore did not materially contribute to the increase in hospitals' Medicare margin in 2021.²²

In 2021, OPSS aggregate payments and payments per beneficiary increased rapidly, outpacing growth in hospitals' outpatient costs In 2021, OPSS payments for FFS Medicare beneficiaries' outpatient services at general ACHs increased to \$66.9 billion, which was slightly above pre-pandemic levels despite a decrease in the number of FFS Medicare beneficiaries (Figure 3-12, left panel). Meanwhile, OPSS payments per Part B FFS beneficiary increased to about \$2,200, a sharp increase from the 2020 level and above the pre-pandemic 2019 level (Figure 3-12, right panel).

The 16.5 percent growth in OPSS payments per FFS Medicare beneficiary in 2021 resulted primarily from:

- **Annual update to OPSS conversion factor.** In 2021, the annual update to the OPSS conversion factor was 2.5 percent. However, the OPSS update does

not affect the payment rates of separately payable drugs and devices, which are based on average acquisition costs and represent 26 percent of OPSS payments.²³ Therefore, the average effect of the annual update on spending across OPSS services was 1.8 percent ((74 percent × 2.5 percent) + (26 percent × 0 percent)).

- **Growth in service volume.** In 2021, the volume of OPSS services per beneficiary raised OPSS payments per FFS beneficiary by 13.5 percent. This increase was driven by a general increase in all types of hospital outpatient department (HOPD) services and by the provision of 7.7 million COVID-19 vaccine administrations and testing for COVID-19.
- **Decline in complexity.** In 2021, OPSS payments per service fell 1.8 percent due to the mix of outpatient services, measured by the OPSS relative weights

of the services. This measure decreased because of a sharp increase in relatively low-complexity services, especially administration of the COVID-19 vaccines and testing for COVID-19.

- **Continued growth in spending on separately payable drugs.** Payments for separately payable drugs grew 9.8 percent per beneficiary. Separately paid drugs are about 26 percent of total OPSS spending, so this increase in drug spending boosted OPSS spending per beneficiary by 2.6 percent.
- **Increases in Medicare payments during the PHE.** We estimate that the suspension of the 2 percent sequestration in Medicare's share of FFS payments, which began on May 1, 2020, and extended through April 2022, raised OPSS payments per beneficiary by 0.6 percent in 2021.²⁴

Meanwhile, hospitals' outpatient aggregate costs and cost per beneficiary increased but at a slower rate. The increase in costs reflects the large increase in outpatient services per beneficiary, a small increase in input prices, a small increase in the cost of separately payable drugs and devices, and a decrease in the resource requirements per OPSS-covered service. One driver of the decreased resource requirements was the large volume of COVID-19 vaccine administrations and COVID-19 sample collections (7.7 million), which are low-complexity services. One reason why hospitals' Medicare outpatient costs grew more slowly than Medicare payments in 2021 is that the suspension of the 2 percent sequestration on Medicare program payments was in effect for all of calendar year 2021 compared with only a portion of 2020, which increased payments without affecting costs. A second possible explanation for why hospitals' outpatient costs grew more slowly than Medicare payments is that the costs incurred when providing COVID-19 vaccines and taking sample collections were smaller than the OPSS payments for those services.

In 2021, relatively efficient hospitals' median Medicare margin was positive after including Medicare's share of federal relief funds

In 2021, the median Medicare margin among the 15 percent of IPSS hospitals we identified as relatively efficient remained at 1 percent when including Medicare's share of federal relief funds and increased from -3 percent in 2020 to break-even excluding these

funds (Table 3-5, p. 78).²⁵ These findings are consistent with data over the last several years showing relatively efficient hospitals approximately breaking even on Medicare.²⁶ (As in prior years, we identified relatively efficient hospitals as those that were never in the worst third on any quality or cost metrics during the prior three years (we used 2017, 2018, and 2019 to limit the effect of the start of the pandemic) and consistently performed in the top third of either costs or mortality (see text box, p. 79); however, to limit the effect of the start of the pandemic on these measures and hospitals' different cost-reporting periods, we used 2017, 2018, and 2019 to identify relatively efficient hospitals and then looked at their performance in 2021.)

In 2021, the relatively efficient hospitals' lower costs per inpatient stay (91 percent of the national median) allowed them to generate better Medicare margins than the comparison group. The relatively efficient group also had better patient satisfaction, with 71 percent of H-CAHPS respondents rating the hospital a 9 or 10 in 2020, compared with 68 percent for other hospitals. The relatively efficient hospitals (those that had relatively good prepandemic quality metrics) continued to have lower risk-adjusted median mortality and readmission rates than other hospitals during the pandemic. Among our sample of 284 relatively efficient hospitals in 2021, mortality was 7 percentage points below the national median and readmission rates were 4 percentage points below the national median—consistent with comparisons in 2017 to 2019. These results suggest that relatively efficient and other hospitals' mortality and readmission metrics, on average, were equally affected by the pandemic.

As in past years, relatively efficient hospitals were spread across the country and represented diverse categories of hospitals, including teaching, nonteaching, rural, urban, for-profit, and nonprofit hospitals, as well as hospitals serving large shares of low-income patients. On average, the shares of Medicare and Medicaid patients are similar in both groups. While most types of hospitals were represented in the efficient group, a disproportionate share of relatively efficient hospitals had relatively high volumes of admissions. Volume primarily affects our efficiency measures in two ways. First, higher-volume hospitals tended to have lower risk-adjusted mortality. Second, we require some consistency of results over three years and remove from the efficient group any hospital that

**TABLE
3-5**

Performance of relatively efficient hospitals in 2021

Relative performance measure	Type of hospital	
	Relatively efficient	Other
Number of hospitals	284	1,672
Share of hospitals in our study sample	15%	85%
Historical performance, 2017–2019 (percent of national median)		
Mortality rate	89%	101%
Readmission rate	93	102
Standardized Medicare costs per stay	90	103
Performance metrics, 2021 (percent of national median)		
Mortality rate	93%	101%
Readmission rate	96	101
Standardized Medicare costs per stay	91	102
Share of patients rating the hospital a 9 or 10 (out of 10), 2021	71	68
Median Medicare margin, 2021		
Medicare margin excluding relief funds	0%	-7%
Medicare margin with relief funds	1	-4
Median all-payer total margin	11	9

Note: “Relatively efficient hospitals” and “other hospitals” were identified based on their mean performance during 2017–2019 relative to the median hospital’s performance during those years. We removed hospitals with a low share of Medicaid patient days reported on cost reports (the bottom 10 percent of hospitals) and hospitals in markets with high service use (top 10 percent of hospitals) due to concerns that socioeconomic conditions and aggressive treatment patterns can influence unit costs and risk-adjusted quality metrics. Data differ slightly from the data presented in our March 2022 report because we limit this set of data to providers that had 2021 cost report data. “Mortality rate” is the risk-adjusted rate of mortality within an inpatient stay through 30 days after the stay. “Readmission rate” is the risk-adjusted rate of readmission within 30 days of an inpatient stay. “Standardized Medicare costs per stay” is standardized for area wage rates, case-mix severity, prevalence of outlier and transfer cases, interest expense, low-income shares, and teaching intensity. “Share of patients rating the hospital a 9 or 10 (out of 10)” is based on Hospital Consumer Assessment of Healthcare Providers and Systems survey data collected from patients discharged July to December of 2021.

Source: MedPAC analysis of cost report and claims-based quality data from CMS.

performed in the bottom third on any metric in a single year.²⁷ Thus, random variation in smaller hospitals may make them more likely to be excluded from our efficient group. The efficient group also tends to have lower shares of low-income patients.²⁸

This year, as in past years, we have found that for-profit hospitals have been able to break even or generate small profits on Medicare patients (Medicare Payment Advisory Commission 2022a). Given that for-profit

hospitals tend to have lower costs, one might expect them to be in the efficient group. However, between 14 percent and 15 percent of both for-profit and nonprofit hospitals were deemed relatively efficient. The factor that separates the relatively efficient hospitals from other low-cost hospitals is that they perform relatively well on both quality and costs. While for-profit hospitals tended to have lower costs, nonprofit hospitals tended to perform slightly better on our quality metrics.

Identifying relatively efficient hospitals

The Commission follows two principles when identifying a set of efficient providers. First, the providers must do relatively well on cost and quality metrics. Second, the performance has to be consistent, meaning that the provider cannot have poor performance on any metric over the past three years. In the hospital sector, the variables we use to identify relatively efficient hospitals are hospital-level mortality rates (risk-adjusted, all-condition mortality during an inpatient stay through 30 days after discharge), readmission rates (risk-adjusted, all-condition readmission rates within 30 days after an initial stay), and standardized inpatient Medicare costs per case. Our assessment of efficiency is not in absolute terms but, rather, relative to a comparison group of other hospitals paid under Medicare's inpatient prospective payment systems (IPPS).²⁹

Categorizing hospitals as relatively efficient

We assigned IPPS hospitals to the relatively efficient group or the control group according to each hospital's performance relative to the national median on a set of risk-adjusted cost and quality metrics for the three years prior to the most recent cost report year. We then examined the performance of the two hospital groups in the most recent cost report year.

Hospitals were identified as relatively efficient if they met four criteria in each of the three prior years:

- Risk-adjusted mortality rates were not among the worst third in any year.
- Risk-adjusted readmission rates were not among the worst third in any year.
- Standardized costs per inpatient stay were not among the worst third in any year.
- Risk-adjusted mortality or standardized costs per stay were among the best one-third of all hospitals in all years.

The objective was to identify a sample of hospitals that consistently performed at an above-average level on at least one measure (cost or mortality) and that always performed reasonably well on all measures. Because we screen out hospitals that have few Medicaid patients or have poor performance in a single year, our methodology does not seek to identify all efficient hospitals, only a subsample of relatively efficient hospitals. The rationale for this methodology and the details of computing the various measures are discussed in our March 2011 report (Medicare Payment Advisory Commission 2011). As a secondary check on hospital quality, we use the Hospital Consumer Assessment of Healthcare Providers and Systems survey to require that at least 60 percent of the hospital's patients rated it a 9 or 10 on a 10-point scale (in the year prior to the performance period).³⁰ ■

Hospitals' Medicare margin for 2023 is projected to decline relative to 2021

We project that IPPS hospitals' aggregate Medicare margin for 2023 will decline relative to 2021. Specifically, we project that their Medicare margin in 2023 will be approximately -10 percent, similar to the level in 2017. Among relatively efficient IPPS hospitals, we project that the median Medicare margin in 2023 will be modestly below break-even, near prepandemic levels. These projections are based on actual payments

and costs from the most recent year of complete data (2021) and policy, inflation, and coronavirus pandemic-related changes that took place in 2022 and are anticipated in 2023.

The following are key drivers of our projected lower Medicare margin in 2023 relative to 2021:

- **Hospitals' input prices growing faster than CMS's forecast.** In 2022, CMS underestimated the growth in hospitals' input prices when it set the annual

update for IPPS and OPSS payment rates (Table 3-6). Using data available as of the time of the 2022 final rule (published in 2021), CMS forecast that general ACHs' input prices for a market basket of operating inputs would increase by 2.7 percent from 2021 to 2022. However, CMS's latest forecast (with historical data through the second quarter of calendar year 2022) suggests that input prices in fiscal year 2022 grew 5.7 percent (3.0 percentage points higher than initially forecast). There is even more uncertainty in what hospitals' actual input price inflation will be in 2023 relative to the forecast CMS used when setting the annual IPPS and OPSS updates for 2023, but CMS's latest forecast suggests that the agency may have underestimated 2023 input price inflation as well. The underestimated inflation in 2022 and 2023 contrasts with prior years: From 2012 to 2021, CMS overestimated input price inflation in all but one year, for a cumulative overestimate of 5.5 percent.

- Expected expiration of federal relief funds and Medicare PHE payment changes, which were higher than hospitals' additional costs.** In both 2020 and 2021, we found that hospitals' Medicare margins increased in part because the federal relief funds and Medicare payment changes during the PHE exceeded hospitals' additional costs from the PHE. However, these additional payments may expire in 2023. (The last phase of Provider Relief Fund payments—a portion of which supports providers' care of FFS Medicare beneficiaries—began to be distributed in early fiscal year 2022. The 2 percent sequestration of Medicare payments was suspended from May 1, 2020, through March 31, 2022, and then phased in at a 1 percent reduction through June 30, 2022, when the full 2 percent sequestration resumed. The additional 20 percent payment for COVID-19 inpatient stays will be in effect through the end of the PHE, which is currently scheduled to extend through mid-May 2023.)
- Declines in Medicare's uncompensated care payments.** In 2021, 2022, and 2023, Medicare's uncompensated care pool declined from \$8.3 billion to \$7.2 billion to \$6.9 billion, respectively. These declines reflect CMS's projected drop in DSH payments and in the national uninsured rate. As Medicare payments for uncompensated care do not

have any corresponding Medicare costs, all declines in uncompensated care payments decrease hospitals' Medicare margins. (On the other hand, a decrease in the uninsured rate generally increases hospitals' all-payer margin.)

We anticipate that these factors which reduce net revenue growth will be partially offset by other factors that reduce cost growth, including reductions in hospitals' COVID-19-related costs as cases decline and hospitals become better at managing the disease, and the continued statutory 0.5 percent increase to inpatient operating payments to reverse prior temporary reductions in payments that recouped prior coding-induced overpayments.

The exact level of hospitals' Medicare margin in 2023 will depend in large part on the duration and severity of the coronavirus pandemic and associated PHE-related payment increases and whether the federal government enacts any additional coronavirus pandemic support. In addition, hospitals' 2023 Medicare margin may be affected by CMS's decisions on how to comply with the Supreme Court's recent ruling requiring the agency to reverse previous cuts to OPSS payments for drugs furnished by hospitals participating in the 340B drug program.³¹

How should Medicare payments change in 2024?

Our payment adequacy indicators suggest that Medicare payments to general ACHs were broadly adequate in 2021, and we project that they will decline in 2023 but remain broadly adequate.

Under current law, Medicare's base payment rates under the IPPS and OPSS increase annually based on the forecasted increase in the hospital market basket less a forecasted increase in productivity, as well as by any other statutory updates (see Table 3-6).

The final updates for 2024 will not be set until summer 2023, but CMS currently forecasts a 2.9 percent increase in the IPPS operating base payment rate and OPSS base payment rate and a 2.4 percent increase in the IPPS capital base payment rate. These forecasts, based on historical data through June 2022, anticipate a marked slowdown in input price inflation. The final

**TABLE
3-6**

IPPS and OPSS updates and forecast errors

	2019	2020	2021	2022	2023
Updates based on forecasts					
IPPS operating					
Market basket	2.9%	3.0%	2.4%	2.7%	4.1%
Productivity	-0.8	-0.4	0.0	-0.7	-0.3
Subtotal	2.1	2.6	2.4	2.0	3.8
Statutory updates	-0.3	0.5	0.5	0.5	0.5
Total	1.8	3.1	2.9	2.5	4.3
IPPS capital					
Total (market basket)	1.4	1.5	1.1	1.1	2.5
OPSS					
Total (same as IPPS operating subtotal)	2.1	2.6	2.4	2.0	3.8
Actual market basket					
IPPS operating					
Market basket	2.4	2.0	3.1	5.7*	4.3*
Forecast error	0.5	1.0	-0.7	-3.0*	-0.2
IPPS capital					
Market basket	1.4	1.2	1.0	1.9*	2.6*
Forecast error	0.0	0.3	0.1	-0.8*	-0.1*

Note: IPPS (inpatient prospective payment systems), OPSS (outpatient prospective payment system). Updates do not include budget neutrality adjustments to base rates. Not all IPPS and OPSS payments are increased by the updates to base rates, such as separately payable drugs. *Data include historical data through the second quarter of calendar year 2022 and forecasts for subsequent quarters.

Source: MedPAC analysis of IPPS and OPSS final rules and data provided by CMS Office of the Actuary.

2024 update will include newer forecasts of growth in input prices and productivity and thus could be lower or higher than the current projected update.

In considering how Medicare payments to general ACHs should change in 2024, the Commission contends that scarce Medicare resources should be used efficiently. To meet this goal, Medicare should aim to balance several objectives:

- maintain payments high enough to ensure beneficiaries' access to care;
- maintain payments close to hospitals' cost of providing high-quality care efficiently;
- maintain fiscal pressure on hospitals to constrain costs;
- minimize differences in payment rates for similar services across sites of care; and
- avoid implementing large, across-the-board payment rate increases to support a subset of hospitals with specific needs.

The Commission’s payment update recommendation for 2024 reflects the most recent inflation and other data from 2021, preliminary data from 2022, and projections for 2023. If current projections of input inflation and hospital costs turn out to be inaccurate, these discrepancies will be accounted for in our assessment of payment adequacy in our next recommendation cycle.

RECOMMENDATION 3-1

For fiscal year 2024, the Congress should update the 2023 Medicare base payment rates for general acute care hospitals by the amount specified in current law plus 1 percent.

RATIONALE 3-1

Hospitals’ payment adequacy indicators were generally positive in 2021. The number of hospital closures was the same as the number of openings, IPPS hospitals’ all-payer operating margin increased to a record high, and IPPS hospitals’ Medicare margin increased. In other words, federal relief funds and increased Medicare payments more than offset pandemic-induced costs.

However, indicators continued to vary substantially across hospitals, and some indicators remained below prepandemic levels. For example, some hospitals faced capacity and staffing constraints at times. In addition, FFS beneficiaries’ risk-adjusted hospital mortality rate remained higher than the rate in 2019, and patient experience measures declined.

For 2023, we project that IPPS hospitals’ Medicare margin will decrease to about -10 percent (similar to the level in 2017) and that relatively efficient hospitals’ median Medicare margin will decline to modestly below break-even, similar to prepandemic levels.

The Commission anticipates that a 2024 update to hospital payment rates of current law plus 1 percent would generally be adequate to maintain FFS Medicare beneficiaries’ access to hospital inpatient and outpatient care and keep IPPS and OPSS payment rates close to the cost of delivering high-quality care efficiently.

However, this update may not be sufficient for Medicare safety-net hospitals with a poor payer mix. A separate discussion of how to support Medicare safety-net hospitals follows.

Spending

- We expect the recommendation to increase spending relative to current law by over \$2 billion in 2024 and by over \$10 billion over five years.

Beneficiary and provider

- The increase in Medicare payment rates will help maintain hospitals’ willingness to treat Medicare beneficiaries and maintain beneficiaries’ access to care.

Supporting Medicare safety-net hospitals

The Medicare program strives to ensure access to care for all beneficiaries and to adequately pay providers for that access. Recommendation 3-1 above is designed to provide adequate payment to the average hospital. However, that level of payment may not be adequate to sustain access for Medicare beneficiaries at certain Medicare safety-net hospitals. Therefore, Medicare’s safety-net policies may need to be modified.

Medicare currently makes safety-net payments to hospitals in the form of disproportionate share hospital (DSH) payments and uncompensated care payments. But there are several problems with the formulas currently used to distribute safety-net payments. First, DSH payments are applied only to hospital inpatient rates, so hospitals get no boost to the payments they receive for providing outpatient care. Second, the DSH formula is primarily driven by Medicaid patient shares and does not factor in Medicare patient shares. Thus, Medicare subsidizes Medicaid through its DSH payments and hospitals that serve high shares of Medicare patients may be disadvantaged under the DSH formula. It is important for hospitals that treat large shares of Medicaid patients to be supported, but that cost should be Medicaid’s responsibility and not be absorbed by Medicare. Third, Medicare’s uncompensated care payments are biased toward providing greater uncompensated care payments to hospitals with few Medicare FFS inpatient stays and more Medicare Advantage (MA) inpatient stays. These issues are discussed in more detail in our June 2022 report to the Congress and the appendix to this chapter. A new Medicare safety-net policy should

improve how safety-net providers are identified by the Medicare program and the mechanisms for distributing Medicare safety-net payments.

Safety-net payments are warranted for providers serving low-income Medicare beneficiaries

We identify Medicare safety-net hospitals as those that disproportionately serve low-income Medicare patients, uninsured patients, or Medicare patients that are not materially profitable. For ACHs, Medicare patients—in particular, low-income Medicare patients—generate lower levels of profitability than hospitals’ commercial patients for two reasons:

Lower revenues per service—From 2011 to 2020, IPPS hospitals’ aggregate Medicare margin has been negative, ranging between –5 percent and –10 percent, suggesting Medicare is not a profitable payer in aggregate in the hospital sector (Medicare Payment Advisory Commission 2022d). In addition, hospitals serving a high share of low-income Medicare beneficiaries tend to receive less cost sharing because of beneficiaries’ lack of supplemental insurance or Medicaid not paying cost sharing for dual-eligible beneficiaries. Receiving less cost sharing results in higher levels of Medicare bad debt at Medicare safety-net hospitals.

Higher costs per service—Research has indicated that hospitals’ costs per discharge for low-income Medicare beneficiaries are slightly higher than costs for higher-income beneficiaries with similar diagnoses (Nguyen and Sheingold 2011).

The combination of lower revenue and higher costs can financially strain Medicare safety-net hospitals that have to compete for labor and technology with more profitable hospitals.

In addition, hospitals that serve high shares of Medicare beneficiaries and in particular high shares of low-income beneficiaries may be less able to absorb unforeseen financial challenges. For example, as CMS forecasts input price inflation and then sets payment updates accordingly, it overestimates inflation in some years and underestimates inflation in other years. An unforeseen financial challenge such as an inflation forecast error is not an issue for a hospital with high profit margins and a large endowment. But for a hospital that just covers its expenses and has a large

number of Medicare patients and few commercial patients, an unforeseen deviation in the profitability of Medicare patients may be far more challenging to manage. Medicare may want to provide these safety-net hospitals with higher payments to give them a “cushion” to account for uncertainty regarding the future profitability of their Medicare patients.

Given Medicare safety-net hospitals’ greater unpaid coinsurance, higher costs of low-income Medicare beneficiaries, and lack of ability to absorb unforeseen variation in Medicare profits, we maintain that supplemental payments to hospitals disproportionately serving low-income Medicare beneficiaries are warranted. The theoretical frameworks for determining Medicare safety-net status and determining whether supplemental payments are necessary were discussed in detail in our June 2022 report to the Congress (Medicare Payment Advisory Commission 2022c). The Commission’s method of gauging hospitals’ safety-net status is Medicare-centric by design; safety-net definitions used by Medicaid and other payers likely will differ from our definition.

A new Medicare Safety-Net Index will direct safety-net payments to hospitals with high shares of low-income Medicare patients

To address the issues with the current DSH and uncompensated care payment metrics and better direct supplemental payments to hospitals that care for a high share of Medicare beneficiaries with low incomes, we developed a new measure called the Medicare Safety-Net Index (MSNI). Each hospital’s MSNI is computed using three components: (1) the share of its Medicare volume associated with low-income beneficiaries (identified as those who receive the Part D low-income subsidy (LIS)—see text box, p. 84, on identifying low-income Medicare beneficiaries and hospitals that serve them); (2) the share of revenue the hospital spends on uncompensated care (bad debts and charity care); and (3) the share of total volume associated with Medicare beneficiaries. Table 3A-1 (p. 97 in the appendix to this chapter) provides more detailed information about how each hospital’s MSNI is calculated; the rationale for the MSNI formula is discussed in our June 2022 report to the Congress (Medicare Payment Advisory Commission 2022c). Other payers may define safety-net status for their patients differently.

Identifying low-income Medicare beneficiaries and the hospitals that care for them

The Commission's definition of low-income Medicare beneficiaries includes all those who receive full or partial Medicaid benefits and those who do not qualify for Medicaid benefits in their states but who receive the Part D low-income subsidy (LIS) because they have limited assets and an income below 150 percent of the federal poverty level. Collectively, we refer to this population as "LIS beneficiaries" because Medicare beneficiaries who receive full or partial Medicaid benefits are automatically eligible to receive the LIS. To identify hospitals' low-income Medicare populations, we use LIS as the proxy for "low income" because it reduces the impact of variation across states in eligibility for Medicaid. However, the LIS definition is limited to beneficiaries who receive the LIS benefit and thus omits some non-dual-eligible beneficiaries who could qualify for the LIS but have not applied for the benefit. This limitation is a result of not having beneficiary income data. To the extent that future Medicare safety-net funding is attached to treating more LIS beneficiaries, that payment policy would encourage providers to make their patients aware of and help them enroll in Medicaid, the Medicare Savings Programs (i.e., programs in which Medicaid helps pay for Medicare premiums, cost sharing, or both), and the Part D LIS.³²

Compared with the full fee-for-service Medicare population, LIS beneficiaries are three times as likely to be disabled, nearly three times as likely to have end-stage renal disease, more likely to be female, slightly more likely to live in a rural area, and twice as likely to be Black or Hispanic. Given the demographic mix of the LIS population, directing Medicare safety-net funds to LIS patients' providers could promote greater equity in access to care and quality across demographic groups. More detail on LIS beneficiaries is provided in our June 2022 report to the Congress (Medicare Payment Advisory Commission 2022c).

Hospitals vary in the extent to which they care for low-income Medicare beneficiaries

In 2019, for the quarter of hospitals that treated the highest share of LIS beneficiaries, LIS beneficiaries made up 43 percent or more of the hospitals' Medicare inpatient and outpatient volume. In contrast, for the quarter of hospitals that treated the lowest share of LIS beneficiaries, LIS beneficiaries made up 23 percent or less of the hospitals' total Medicare volume. These data suggest that some hospitals take on a greater responsibility for treating low-income patients than do other hospitals, which could be financially disadvantageous. ■

The MSNI model and the current uncompensated care policy differ importantly in that the MSNI payments would be structured as add-on payments to Medicare payment rates (meaning a percentage increase to FFS rates for each claim). Providers with more financially challenging patient mixes would receive higher Medicare payment rates. In contrast, the current uncompensated care model is not directly tied to Medicare payment rates. Each hospital receives a fixed share of its uncompensated care costs from FFS Medicare. That in turn sets the add-on amount per FFS claim that is used by MA plans.³³ The net result is that,

under current policy, MA safety-net payments are not proportional to uncompensated care costs (see Table 3A-3, p. 99, in the appendix for details).

A second difference is that DSH payments currently increase as the share of patients insured primarily by Medicaid increases. Thus, Medicare subsidizes Medicaid through DSH payments. Under the MSNI model, Medicaid patients (other than dual-eligible beneficiaries) will not directly affect Medicare payments. While the MSNI does not directly support Medicaid, notably, hospitals with high shares of low-

income Medicare patients will benefit, and those hospitals typically also have high shares of Medicaid patients.

In our June 2022 report to the Congress, we used 2016 data to simulate how Medicare payments would have changed if the MSNI was used to distribute safety-net dollars. We used 2016 data because we wanted to examine hospitals that closed between 2016 and 2020 to determine the extent to which they would have been helped if safety-net payments had been distributed by the MSNI. We found that the MSNI would have directed more dollars toward hospitals with lower all-payer margins and to hospitals that closed from 2016 to 2020.

In this chapter, we update our analysis to simulate what would have happened in 2019 if the MSNI had been used to distribute safety-net payments rather than the DSH and uncompensated care policies that were in effect in 2019. Like the results using 2016 data, the simulation using 2019 data suggests that the MSNI would have helped redirect funds toward hospitals that tended to serve lower-income Medicare beneficiaries and had relatively low 2019 all-payer margins.

The MSNI is a better indicator of financial status of hospitals serving large shares of low-income Medicare beneficiaries than the DSH metric

To compare how well the DSH metric and the MSNI identify hospitals under financial strain, we examined characteristics of hospitals that were divided into quartiles based on the DSH and MSNI scores.³⁴ The DSH metric and the MSNI are moderately correlated (correlation = 0.56). They both have some ability to identify hospitals under financial strain. For example, hospitals in the highest quartile of both the DSH metric and the MSNI tend to have greater uncompensated care costs, larger amounts of unpaid Medicare cost sharing (Medicare bad debts), and lower all-payer total margins. However, the MSNI appears to do a better job differentiating hospitals according to their level of all-payer profitability and financial stress. For example, in 2019, the hospitals in the lowest DSH quartile had an aggregate all-payer total margin that was 5 percentage points higher than hospitals in the highest DSH quartile (10.1 percent vs. 5.1 percent). In contrast, hospitals in the lowest MSNI quartile had an aggregate all-payer total margin that was 6.9 percentage points higher than hospitals in the highest MSNI quartile (10.0 percent vs. 3.1 percent). As we discussed in our June 2022

report, the MSNI also has the benefit of not directly subsidizing Medicaid and not being inversely correlated with Medicare shares.

Redistributing DSH and uncompensated care funds using the MSNI would increase high-MSNI hospitals' Medicare revenue by about 3.9 percent in aggregate

We simulated how Medicare and all-payer payments would have changed for each IPPS hospital if we redistributed the \$11.7 billion of DSH and uncompensated care funds that hospitals received in 2019 using the MSNI. To allocate the MSNI dollars among hospitals, we used a linear model where the percentage add-on (to inpatient and most outpatient rates) increases as the MSNI increases. In this illustrative example, the MSNI add-on starts at zero for hospitals with an MSNI at the 10th percentile or below. These hospitals receive no Medicare safety-net payments.³⁵ For hospitals above this threshold, the percentage adjustment of the Medicare safety-net add-on continuously increases according to a linear model. It rises to 3 percent at the 25th percentile of the MSNI distribution, 8 percent at the 50th percentile, 14 percent at the 75th percentile, and 26 percent at the 95th percentile of the MSNI distribution. The maximum MSNI redistribution add-on was set at 26 percent (the 95th percentile) to avoid extreme add-ons for outlier hospitals.

As noted above, unlike the current DSH and uncompensated care payments, the MSNI payment add-ons would apply to both inpatient and most outpatient services. The one exception is separately payable Part B drugs. The acquisition costs of drugs are unlikely to be higher for Medicare safety-net hospitals, and they are lower than average if those hospitals qualify for 340B status. Therefore, we excluded separately payable Part B drug claims from eligibility for the MSNI add-on to prevent an unlevel playing field where certain safety-net providers could specialize in providing expensive Part B drugs. The exclusion of separately payable Part B drugs is a new refinement in our method that occurred after the June 2022 report to the Congress was published.

Our simulation allows almost all hospitals to receive MSNI payments. The simulation used a graduated linear increase in the MSNI percentage add-on for two reasons. First, as we explained in the June 2022

**TABLE
3-7**

Hospital financial characteristics under current DSH and uncompensated care policy and simulations of redistributing based on the MSNI, 2019

Characteristic	DSH quartiles				Medicare Safety-Net Index (MSNI) quartiles							
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Actual 2019 financial data given current DSH and uncompensated care policy												
DSH payments / FFS Medicare revenue	0.5%	1.3%	2.0%	3.4%	1.3%	1.7%	2.1%	3.3%	Current-law estimates are the same as in the center block of data			
Uncompensated care payments / FFS Medicare revenue	1.9	3.6	4.0	6.5	2.7	3.6	4.5	8.6				
Unpaid FFS Medicare bad debts / FFS Medicare revenue	0.5	0.6	0.7	0.8	0.3	0.5	0.7	1.0				
FFS Medicare margin	-11.0	-7.0	-8.9	-7.2	-12.4	-9.5	-5.5	-0.9				
All-payer total margin	10.1	8.1	8.8	5.1	10.0	8.3	6.0	3.1				
Illustrative simulations of distributing DSH and uncompensated care pools using MSNI payments												
	Redistribution of existing dollars								Adding \$1 billion to the FFS pool plus proportionate MA funding			
Mean FFS Medicare payment change (millions)	\$0.4	0.2	-0.1	-0.5	-\$2.8	-0.3	1.5	1.5	-\$2.7	0.1	2.0	2.1
Simulated MSNI payments / FFS Medicare revenue	3.1%	5.1	6.1	9.2	1.0%	5.0	8.9	15.9	1.1%	5.4	9.6	17.2
Percent change in FFS Medicare revenue	0.7	0.3	-0.1	-0.7	-3.0	-0.3	2.4	3.9	-2.9	0.1	3.1	5.3
Percent change in total revenue*	0.3	0.1	-0.1	-0.3	-0.9	-0.1	0.8	1.0	-0.9	0.0	1.0	1.4
Simulated FFS Medicare margin under MSNI	-10.1	-6.7	-9.0	-7.9	-15.8	-9.8	-3.1	3.0	-15.7	-9.4	-2.3	4.2
Simulated all-payer margin under MSNI*	10.4	8.2	8.8	4.8	9.2	8.2	6.7	4.0	9.2	8.3	6.9	4.4

Note: DSH (disproportionate share hospital), MSNI (Medicare Safety-Net Index), Q (quartile), FFS (fee-for-service), MA (Medicare Advantage). The DSH quartiles were based on the disproportionate share patient percentage. The unit of analysis is the quartile, with payments and costs of 651 hospitals in each quartile added to create aggregate payment changes and aggregate margins for the quartile. The aggregate margin is equivalent to a dollar-weighted margin for the hospitals. The full sample of 2,604 hospitals represents all hospitals paid through the acute inpatient prospective payment systems (excluding territories) with more than 200 Medicare discharges and complete data. The margins presented are the aggregate margins for each group. This analysis differs from the analysis in the June 2022 report in that it examines 2019 data (in which current-law payments were different) and does not allow any add-ons to Part B drug spending. In addition, we started payments at the 10th percentile of the MSNI distribution rather than the 5th percentile to increase targeting of the payments. We also did not allow any change in payments for hospitals currently choosing Medicare-dependent hospital status or sole community hospital status (and that thus receive payments partially based on historical costs). Despite these changes, the results are directionally consistent with the earlier analysis of how the MSNI would have affected payments in 2016.

*Estimates of change in aggregate all-payer margins assume that changes in Medicare Advantage (MA) payment rates equal changes in FFS Medicare rates (i.e., that MA plans pay FFS rates) and that the ratio of MA inpatient and outpatient volume to FFS volume can be approximated by the ratio of MA discharges to FFS discharges.

Source: MedPAC analysis of claims, cost report, and closure data.

report, we wanted to avoid a cliff where hospitals just below a threshold received no add-on and hospitals above that threshold received a dramatically higher

payment. Second, about 80 percent of IPPS hospitals now receive DSH and uncompensated care payments, and we wanted to limit the share of these hospitals that

would not receive any MSNI payments. In the current simulation, about 7 percent of hospitals would lose their DSH and uncompensated care payments and not receive any of the new MSNI payments. In 2019, these hospitals had an average all-payer total margin of 11.8 percent. At the same time, about 5 percent of hospitals currently do not receive any DSH or uncompensated care payments and would gain MSNI payments. In 2019, the hospitals that would gain Medicare safety-net funding had an average all-payer total margin of 4.5 percent.

We estimate that using the MSNI to redistribute existing DSH and uncompensated care funds would have increased Medicare payments to hospitals in the high-MSNI quartile by 3.9 percentage points, increasing the aggregate FFS Medicare margin from -0.9 percent to 3.0 percent (Table 3-7).

In turn, the higher Medicare margin for high-MSNI hospitals would result in a smaller difference in the all-payer total margin between hospitals in the highest and lowest MSNI quartiles. The difference would fall from 6.9 percentage points (10.0 percent to 3.1 percent) under current law to 5.2 percentage points (9.2 percent to 4.0 percent) under the MSNI redistribution.

To provide an illustrative example of how changing the pool of dollars would change the add-on payment, we estimated the effect on hospitals if the size of the FFS DSH and uncompensated care pool of dollars were increased from the approximately \$11.7 billion that was disbursed in 2019 to an illustrative \$12.7 billion.³⁶ For every billion dollars added to the MSNI pool, overall Medicare FFS hospital spending would increase by about a half percent. The net effect is that the add-on would grow from zero at the 10th percentile of the distribution to about 29 percent at the 95th percentile and above in the distribution. In 2019, MSNI hospitals in the top quartile (which would receive a disproportionate share of any additions to the MSNI pool) would have seen their FFS Medicare margin increase by about 5.1 percentage points (from -0.9 percent to 4.2 percent). Our simulation assumed that CMS would provide hospitals serving MA patients with a commensurate adjustment; those additional MA payments would have totaled about \$0.5 billion in 2019. The combination of additional FFS and MA payments would cause high-MSNI hospitals' all-payer total margins to increase by about 1.3 percentage points

(from 3.1 percent to 4.4 percent) (Table 3-7). In 2019, the total cost of increasing FFS MSNI payments by \$1 billion and a commensurate add-on for hospitals treating MA patients would have been about \$1.5 billion. We expect that an equivalent percentage add-on to FFS and MA payments in 2024 would cost close to \$2 billion due to updates in Medicare payment rates and increases in total Medicare enrollment (primarily in MA) from 2019 to 2024.

The MSNI tends to benefit hospitals with high Medicare shares and reduce payments to hospitals with low Medicare shares and high uncompensated care costs

Shifting safety-net payments from the current DSH and uncompensated care payments to new MSNI-based payments would change the distribution of payments in three important ways. First, because hospitals' dependence on Medicare patients is a factor in computing the MSNI, hospitals with higher shares of Medicare patients would tend to receive higher add-on payments per case. These hospitals also would receive the MSNI add-on payment for a greater share of the services they furnish because Medicare is a large share of their patient mix. Second, because Medicare would no longer directly subsidize Medicaid patients, hospitals with few Medicare patients and large Medicaid patient loads would see a reduction in payments. Third, because Medicare would provide only modest indirect support for uncompensated care, hospitals with low Medicare volume but high levels of uncompensated care would tend to receive less funding. Under the scenario in which current DSH and uncompensated care dollars would be redistributed and \$1 billion would be added to the FFS pool of safety-net funds, hospitals would still experience a decline in revenue if their current uncompensated care payments from Medicare were larger than the value of the proposed MSNI add-on payments (up to 29 percent). Overall, payments would shift toward hospitals serving high volumes of Medicare patients and, in particular, low-income Medicare patients.

To provide a greater understanding of which types of IPPS hospitals would gain and lose under a shift from the current DSH and uncompensated care payments to payments based on the MSNI, we provide some descriptive statistics on payment changes for 10 categories of hospitals under our MSNI

**TABLE
3-8**

Simulated effect of redistributing current DSH and UC payments under the MSNI and adding \$1 billion to the FFS MSNI pool by type of hospital, 2019

Hospital characteristic	Mean MSNI percentage add-on to FFS Medicare payments*	Aggregate percentage change in:		Percentile effect on all-payer total margins in percentage points**			
		FFS Medicare revenue	All-payer total revenue	5th	25th	75th	95th
All IPPS hospitals	10.4%	0.5%	0.1%	-1.7%	-0.4%	1.7%	4.6%
Government (n = 349)	14.0	-1.5	-0.6	-2.6	-0.5	1.6	4.6
For profit (n = 592)	11.6	2.3	0.8	-1.7	0.0	2.4	5.7
Nonprofit (n = 1,663)	9.2	0.5	0.2	-1.6	-0.4	1.4	4.2
Rural (n = 611)	13.7	3.3	1.1	-0.4	0.0	2.6	5.7
Urban (n = 1,990)	9.3	0.2	0.1	-2.0	-0.6	1.4	4.2
Teaching (n = 1,568)	10.1	0.1	0.0	-2.3	-0.6	1.4	4.0
Nonteaching (n = 1,033)	10.5	1.3	0.4	-1.4	0.0	1.8	5.1
MA share of stays							
< 25% (n = 1,308)	9.7	0.7	0.2	-1.2	0.0	1.4	5.0
25% to 50% (n = 949)	10.2	0.5	0.2	-1.7	-0.4	1.9	4.3
> 50% (n = 347)	12.5	-0.3	-0.1	-3.1	-1.0	1.6	4.4

Note: DSH (disproportionate share hospital), UC (uncompensated care), MSNI (Medicare Safety-Net Index), FFS (fee-for-service), IPPS (inpatient prospective payment systems), MA (Medicare Advantage). The table presents unweighted mean values comparing payments that occurred in 2019 with what payments would have been under an MSNI distribution of safety-net dollars. Data include all IPPS hospitals in the United States (excluding territories) with more than 200 discharges and complete cost report data in 2019. The 5th and 95th percentiles on the right-hand side of the table illustrate that 5 percent had a reduction equal to or larger than the 5th percentile and 5 percent had an increase equal to or larger than the 95th percentile in our 2019 simulation.

*Add-on adjustments are applied to inpatient and outpatient payments excluding Part B drugs.

**Estimates of change in total margins assume that MA plans shift payment rates to equal the shift in FFS payment rates and that the ratio of MA to FFS volume can be estimated using the ratio of MA discharges to FFS discharges.

Source: MedPAC analysis of cost report and claims data.

model and the addition of \$1 billion to the FFS MSNI pool (Table 3-8).³⁷ Most of the hospitals that would gain under the redistribution are smaller hospitals with higher Medicare shares. Most hospitals that would experience a reduction in payments are larger hospitals that currently receive high uncompensated care payments.

On average, government-owned hospitals and rural hospitals would receive the highest MSNI add-on percentages (14.0 percent and 13.7 percent,

respectively) (Table 3-8). Nevertheless, because some government hospitals currently receive high levels of DSH and uncompensated care payments relative to their Medicare volume, under the MSNI, government hospitals in aggregate would see a decline in FFS Medicare payments of 1.5 percent (Table 3-8).³⁸ Rural hospitals in aggregate would see an increase in FFS Medicare payments of 3.3 percent. Such hospitals would benefit because they tend to have high Medicare shares that are not factored into

current DSH percentages or uncompensated care payments. Rural hospitals would also tend to benefit from removing the distortion in uncompensated care payments that direct payments to hospitals with high MA shares (see Table 3A-3, p. 99, in the appendix to this chapter). In addition, for-profit hospitals would be slightly more likely to benefit from the policy than nonprofit hospitals because the Medicare patients served by for-profit hospitals are more likely to receive the LIS. In 2019, for-profit hospitals had an LIS share of 36 percent compared with nonprofits' 32 percent share (data not shown). (Government hospitals had an LIS share of 42 percent.)

Shifting to MSNI-based payments would also tend to increase add-on payments for hospitals with low MA shares of Medicare admissions and decrease payments for hospitals with higher shares of MA admissions (Table 3-8). This result could be due to several factors. One factor is that the current method of distributing uncompensated care funds favors hospitals with few FFS Medicare stays and higher numbers of MA stays (see Table 3A-3, p. 99, in the appendix to this chapter). The new MSNI method would address this issue.³⁹

In Table 3-8, we present the 5th percentile of hospitals, which would see the largest declines in total margins, and the 95th percentile of hospitals, which would see the largest increases in total margins. The similarity across hospital types in total margin changes at the 5th and 95th percentiles indicates that the distribution of changes in Medicare revenue would be similar across the different types of hospitals. Under the MSNI policy, we expect that about 5 percent of providers in all categories would experience declines of at least 1 percent to 2 percent of all-payer total revenue, while about 5 percent of providers in all categories would experience at least a 4 percent to 5 percent increase in revenue. The percentage increases at the top end of the tail are larger than the decreases at the bottom end of the tail because smaller hospitals tend to gain more with the MSNI. In other words, a 1 percent to 2 percent decline in payments to a larger hospital can fund a 3 percent to 4 percent increase in payments to smaller hospitals.

Most hospitals in our simulation saw increases in Medicare payment rates under the MSNI policy because of the additional \$1 billion in FFS uncompensated care payments added to the

MSNI pool of funds. About 20 percent of hospitals would increase their total revenue by more than 2 percent, with the largest gains often going to hospitals with high FFS Medicare shares and few MA patients. In contrast, about 4 percent of hospitals would have their total revenue reduced by at least 2 percent. These hospitals tend to have relatively high uncompensated care payments and relatively small shares of FFS Medicare patients. Their revenue would see a decrease as Medicare safety-net payments transitioned away from directly funding uncompensated care to focus on assisting hospitals with high Medicare shares and, in particular, high shares of low-income Medicare patients.

Because there are some hospitals that would face material reductions in revenue under the MSNI policy, the Congress could phase in the policy for all hospitals over a set period of time (e.g., transition to the MSNI policy over three to five years). Alternatively, a transition could be managed through a stop-loss policy so that no hospital would experience changes (positive or negative) in Medicare payments of more than 5 percent in any one year because of the transition. This change would produce a variable transition, with some hospitals fully transitioned to the MSNI payments sooner than others. Both approaches would allow time for the hospitals facing the most substantial revenue reductions to try to augment revenues from existing sources and request additional financial support from state and local governments, as warranted. The portion of these hospitals with high cost structures may also be able to improve efficiencies.

Incorporating the MSNI across FFS and MA

Nearly half of Medicare beneficiaries are enrolled in MA.⁴⁰ Therefore, the MSNI was calibrated using FFS and MA data (when possible) and should be applied to hospital care provided to both MA and FFS beneficiaries. MA beneficiaries should be included when computing the MSNI because MA plans largely pay hospitals rates similar to FFS Medicare and hospitals likely incur similar costs for treating MA and FFS beneficiaries.⁴¹

Policymakers may choose different ways to incorporate the FFS MSNI payments (which are structured as claims-based add-ons) into MA per capita payments. Under a preferred pathway, CMS would calculate an

MSNI add-on percentage for each hospital, calculate MSNI add-on payments by applying the add-on percentage to each hospital's encounter claims for MA beneficiaries, and directly provide the add-on payment to hospitals, bypassing the MA plan itself in the transaction.⁴² Because the MSNI funds would be paid directly to hospitals, MSNI payments for FFS beneficiaries would be excluded from MA benchmarks, comparable with the way indirect medical education payments are currently made to hospitals for their FFS and MA patients. We believe there are several benefits to this approach:

- Safety-net payments would flow directly to Medicare safety-net providers and would not simply represent additional funds for MA plans to use at their discretion (which might be the case if MSNI payments were included in benchmarks).
- MA plans would not have an incentive to exclude safety-net providers with high MSNI add-on payments from their networks. Under current regulations, MA plans have an incentive to exclude hospitals with high DSH and uncompensated care add-ons from their networks because MA plans often pay FFS rates.
- Linking funds to encounter data could incentivize providers to encourage MA plans to improve their submission of encounter data.
- A key distortion in the way uncompensated care payments affect MA benchmarks would be removed. Currently, Medicare's uncompensated care add-on payment per FFS discharge varies such that the aggregate additional FFS add-on payments to each hospital equals a common expected percentage (e.g., 20 percent) of all hospitals' historical uncompensated care costs. This add-on can increase FFS payment rates by 30 percent or more (even 100 percent at hospitals with few FFS discharges). These higher FFS payments are incorporated into MA benchmarks. Because the uncompensated care payments are spread only across FFS discharges, the current policy favors hospitals with higher MA penetration (that is, with fewer FFS discharges over which to spread the additional payments). Fewer FFS discharges results in a higher adjustment per FFS discharge and a larger increase in MA benchmarks

(see Table 3A-3, p. 99, in the appendix to this chapter for an example).

Interactions between the MSNI and other Medicare special payments

The MSNI is intended to compensate hospitals for the higher costs and lower revenues associated with treating a high share of Medicare beneficiaries, particularly low-income Medicare beneficiaries, and patients without insurance. However, many hospitals already receive special payment rates from Medicare that help compensate for these costs (to the extent that hospitals incur them) and help maintain access in certain areas or for specific populations. Such hospitals include sole community hospitals, Medicare-dependent hospitals, critical access hospitals, and rural community hospital demonstration hospitals. Policymakers should consider requiring hospitals to choose between retaining their current special payment designations or receiving the IPPS rates with an MSNI supplement. Giving hospitals the option to choose their preferred payment mechanism maximizes flexibility for hospitals while making sure Medicare payments are not excessive (e.g., providing a 20 percent MSNI add-on to a hospital that Medicare already pays on a cost basis). In addition, policymakers may want to cap interactions with other existing IPPS payment adjustments, such as the low-volume hospital adjustment (which increases IPPS payments by up to 25 percent), such that the maximum cumulative add-on to IPPS payments from all special designations could not exceed a specified threshold (e.g., 30 percent).

Recommendation

To better target hospitals serving low-income Medicare beneficiaries and fix adverse incentives with the current DSH and uncompensated care payments, current safety-net payments should be redirected to hospitals that have high MSNIs. These MSNI-based payments would adjust for the lower cost sharing received by high MSNI hospitals, the higher costs of low-income Medicare patients, and the need for an additional support to absorb any unforeseen costs of serving Medicare beneficiaries. Without additional safety-net funding, unforeseen reductions in the profitability of serving Medicare beneficiaries could be difficult to absorb for hospitals with high Medicare shares and few commercial patients.

RECOMMENDATION 3-2

In fiscal year 2024, the Congress should:

- **begin a transition to redistribute disproportionate share hospital and uncompensated care payments through the Medicare Safety-Net Index (MSNI);**
- **add \$2 billion to the MSNI pool;**
- **scale fee-for-service MSNI payments in proportion to each hospital's MSNI and distribute the funds through a percentage add-on to payments under the inpatient and outpatient prospective payment systems; and**
- **pay commensurate MSNI amounts for services furnished to Medicare Advantage (MA) enrollees directly to hospitals and exclude them from MA benchmarks.**

Each hospital's MSNI should be computed using three components: (1) the share of its Medicare volume associated with low-income beneficiaries, (2) the share of its revenue the hospital spends on uncompensated care (bad debts and charity care), and (3) the share of total volume associated with Medicare beneficiaries. Under this computation, Medicare would no longer subsidize Medicaid, as it does through its DSH payments. While the Commission emphasizes that scarce Medicare funds should be used to support care provided to Medicare beneficiaries and not cross-subsidize the care of other patient populations, we also acknowledge that replacing the current DSH and uncompensated care payments with new MSNI-based payments would lead to material changes for certain hospitals. A multiyear transition would provide time for hospitals and other payers to adjust to this new Medicare payment approach. (See text box, pp. 92–93, on the future roles of Medicare and Medicaid payments in supporting Medicare and Medicaid safety-net hospitals.)

CMS should define low-income Medicare beneficiaries as those who receive full or partial Medicaid benefits and those who do not qualify for Medicaid benefits in their states but who receive the Part D LIS because they have limited assets and an income below 150 percent of the federal poverty level. Using this definition would reduce the impact of variation in state Medicaid policies on Medicare payment and could encourage providers to make their patients aware of and help them enroll in Medicaid, the Medicare Savings

Programs (i.e., programs in which Medicaid helps pay for Medicare premiums and cost sharing), and the Part D LIS.

CMS should use a graduated linear increase in the MSNI percentage add-on amount. Using a continuous scale will minimize payment “cliffs” and ensure that most hospitals continue to receive some level of Medicare safety-net funding.

MSNI payments should be structured as add-on payments to Medicare payment rates and should apply to services provided under both the IPPS and the OPSS. However, coinsurance would continue to be based on the pre-MSNI payment amount to ensure that beneficiaries using Medicare safety-net hospitals would not pay more than patients at hospitals with fewer low-income patients. However, separately payable Part B drugs should not be eligible for MSNI add-on payments because the acquisition costs of these drugs are unlikely to be higher for Medicare safety-net hospitals (and may even be lower for hospitals that qualify for 340B status). Further, including separately payable Part B drugs in this policy would create incentives for certain safety-net providers to specialize in providing expensive Part B drugs.

Policymakers should consider calculating MSNI add-on payments for services provided to MA enrollees by applying the add-on percentage to each hospital's encounter claims for MA beneficiaries and paying the resulting amount directly to hospitals. In doing so, MSNI payments for FFS beneficiaries would be excluded from MA benchmarks. This method would be similar to the way indirect medical education payments are currently made to hospitals for their FFS and MA patients. Making MSNI payments for MA enrollees directly to hospitals would reduce current incentives for MA plans to steer patients away from Medicare safety-net hospitals with high MSNI add-on payments. At the same time, linking funds to encounter data could incentivize hospitals to encourage MA plans to improve their submission of encounter data.

Many hospitals already receive special payment rates from Medicare to help ensure access to care for Medicare beneficiaries, including sole community hospitals, Medicare-dependent hospitals, critical access hospitals, and rural community hospital demonstration hospitals. Policymakers should

The future roles of Medicare payments and Medicaid payments in supporting Medicare safety-net hospitals and Medicaid safety-net hospitals

To ensure access to care for patients with low incomes, it is important to understand the roles of Medicaid and Medicare in supporting Medicaid patients, Medicare dual-eligible patients, and uninsured patients. In 2019, the Medicaid program made about \$13 billion of Medicaid disproportionate share hospital (DSH) payments (which differ from Medicare DSH payments) to acute care hospitals (Medicaid and CHIP Payment and Access Commission 2022a). States have broad discretion in how their Medicaid DSH and other safety-net funds are allocated among hospitals. In some states, Medicaid DSH payments are highly concentrated at a few safety-net hospitals, while in other states they are more widely distributed across almost all hospitals. States can choose whether to allocate these funds based on hospitals' uncompensated care burdens. However, states must limit each individual hospital's Medicaid DSH payments to the sum of that hospital's Medicaid shortfall (the difference between the hospital's Medicaid costs and Medicaid revenues) and the uncompensated care costs associated with uninsured patients.⁴³

There are three situations under which Medicare and Medicaid can make DSH or uncompensated care payments to help cover the costs of the same uninsured patients. First, uncompensated care costs for the uninsured can both be partially covered by the Medicare uncompensated care pool and be a qualified expense for Medicaid DSH payments. When Medicaid computes uncompensated care costs, the program measures the amount of uncompensated care provided to uninsured patients. These costs are computed prior to any payments by Medicare from its uncompensated care pool and are therefore measured as gross uncompensated care costs and not costs net of Medicare support. Second, some states have also received Section 1115 demonstration authority to make Medicaid uncompensated care pool payments that are similar to DSH payments and may similarly pay for uncompensated care. Third, states can require Medicaid managed care plans to provide "directed payments" to specific hospitals. For example, the state can mandate higher Medicaid rates to safety-net hospitals (Medicaid and CHIP Payment and Access Commission 2022b).

(continued next page)

consider requiring such hospitals to choose between retaining their current special payment designations or receiving IPPS rates with an MSNI supplement. Giving hospitals the option to choose their preferred payment mechanism maximizes flexibility for hospitals while ensuring that Medicare payments are not excessive. In addition, policymakers may want to cap interactions with other existing IPPS payment adjustments (e.g., the low-volume hospital adjustment) such that the maximum cumulative add-on to IPPS payments from all special designations could not exceed a specified threshold (e.g., 30 percent).

RATIONALE 3-2

The Commission's analyses have shown, on average, that Medicare beneficiaries have good access to hospital care, and hospitals' total (all-payer) margins are near record highs as a result of rapidly increasing rates paid by commercial insurers. However, hospitals' aggregate Medicare margin is negative and near zero even for relatively efficient hospitals. For ACHs, Medicare patients—in particular low-income Medicare patients—generate lower revenues per service and may be associated with higher costs. This lower level of profitability may render Medicare safety-net hospitals

The future roles of Medicare payments and Medicaid payments in supporting Medicare safety-net hospitals and Medicaid safety-net hospitals (cont.)

In recent years, Medicaid has shifted away from supporting Medicare dual-eligible patients. Under the Consolidated Appropriations Act, 2021 (P.L. 116-260), beginning in October 2021, losses on Medicare dual-eligible beneficiaries can no longer be used to justify Medicaid DSH payments.⁴⁴ Medicaid DSH payments now focus almost exclusively on the costs of Medicaid patients and the uninsured. Consistent with this approach, the Commission's recommendation that Medicare begin to redistribute DSH and uncompensated care payments through the Medicare Safety-Net Index (MSNI) would distinguish Medicare's responsibilities from those of Medicaid. Under the MSNI proposal, the Medicare program would have full responsibility for Medicare patients (including dual-eligible patients) but would no longer provide higher Medicare payments for hospitals with greater Medicaid patient shares. The recommendation would also limit Medicare's support of uncompensated care and tie that support to a hospital's Medicare volume. By contrast, the Medicaid program would have full responsibility for Medicaid patients (excluding dual-eligible

patients) and would continue to directly support the uninsured through Medicaid DSH payments.

If Medicare shifted to providing safety-net support based on the MSNI, direct support for uncompensated care would come only from Medicaid, and Medicaid's uncompensated care support would be limited to covering the costs of the uninsured. The Medicare program would indirectly support uncompensated care, but most Medicare safety-net funding would be focused on supporting the costs of low-income Medicare patients. The Commission takes no position on whether hospitals with high Medicaid patient shares and uncompensated care burdens should receive more or less funding from Medicaid and local governments. However, the Commission asserts that, just as Medicaid DSH payments are focused on hospitals with high uninsured and Medicaid shares, Medicare safety-net payments should be used primarily to support hospitals that provide care to larger shares of low-income Medicare patients rather than the uninsured or Medicaid patients. ■

less able to absorb unforeseen financial challenges and can undermine their ability to compete with wealthier hospitals for labor and technology.

Medicare already provides substantial safety-net funding to hospitals, but there are several problems with the way Medicare distributes these funds, including omitting a hospital's Medicare share from its funding formulas in favor of subsidizing Medicaid payments and making supplemental payments only for inpatient services. The Commission-developed MSNI better identifies hospitals at financial risk and would better focus scarce Medicare resources to support hospitals that are key sources of care for low-income Medicare beneficiaries.

The MSNI would not only create greater financial stability for hospitals serving high shares of low-income Medicare patients, it would also increase all hospitals' incentives to serve Medicare patients. The Commission estimates that the marginal profit on Medicare patients was about 8 percent in 2021. This marginal profit is computed by examining marginal revenue from serving Medicare patients compared with marginal costs. Because FFS uncompensated care (UC) payments are not tied to Medicare volume, they do not increase as the hospital serves more Medicare patients. Thus, UC payments are not part of marginal revenue per unit of service. In contrast, if Medicare's UC payments were distributed via the MSNI, they would become add-on payments and increase the marginal revenue of serving Medicare patients. In aggregate,

hospitals' marginal profit on providing inpatient and outpatient services to FFS Medicare beneficiaries would increase from about 8 percent to about 12 percent.⁴⁵

The Commission anticipates that adding a combined \$2 billion in additional Medicare payments for FFS and MA payments would be enough to help maintain the financial viability of Medicare safety-net hospitals. (The magnitude of the \$2 billion add-on could grow annually by the hospital market basket.)

We expect the additional funds to immediately be distributed through the MSNI in 2024 and future years, thus increasing MSNI hospitals' FFS and MA payments by about \$2 billion in each year. In addition, over a period of years, the current FFS DSH funds, FFS UC funds, and the share of MA benchmarks derived from those funds would be transferred to the MSNI pool. Eventually the MSNI would replace all DSH funds, UC

funds, and the share of MA benchmarks derived from that spending. With this transition, the MSNI would remove the adverse incentives and inaccurate targeting of Medicare's current safety-net payments. However, DSH computations could still be made to determine eligibility for certain programs, such as the 340B program.

IMPLICATIONS 3-2

Spending

- We expect the recommendation to increase spending relative to current law by between \$750 million and \$2 billion in 2024 and by over \$10 billion over five years.

Beneficiary and provider

- We expect the recommendation to increase hospitals' willingness and ability to treat low-income Medicare beneficiaries. ■

3 — A

APPENDIX

**Supplemental
information on the
Medicare Safety-Net Index**

Developing the Medicare Safety-Net Index

Table 3A-1 explains in detail how the MSNI was created. It is designed to target financially vulnerable hospitals and in particular hospitals that serve large shares of low-income Medicare beneficiaries. These hospitals are vulnerable to unforeseen circumstances (such as the underestimate of input price inflation) that cause Medicare program payments to be lower than optimal in some years and too high in other years.

The new Medicare safety-net payment would continue the evolution of Medicare's hospital safety-net payments away from traditional DSH payments

To put the proposed MSNI change to safety-net payments in context, Table 3A-2 (p. 98) provides a summary of how Medicare safety-net payments have evolved over time. The table explains how the original DSH payments supported hospitals with higher Medicaid shares and higher Medicare inpatient volume, how the program shifted in 2018 away from supporting higher Medicaid and Medicare volumes to more directly supporting uncompensated care, and how the MSNI would shift support to hospitals with higher shares of low-income Medicare patients. Should the MSNI approach be adopted, the program will have evolved from directing higher payments to providers with high Medicaid shares, then to hospitals with high uncompensated care costs, and finally, under the MSNI, to supporting hospitals that serve a disproportionate share of low-income Medicare beneficiaries.

Medicare's current method of distributing UC payments is biased against hospitals with high FFS volume and low MA volume

The Affordable Care Act of 2010 (ACA) requires CMS to redistribute a portion of DSH payments to fund hospitals' uncompensated care costs. Starting in 2014, the ACA required CMS to reduce operating DSH payments to an amount equal to 25 percent of prior-law operating DSH payments. The remaining 75 percent is then primarily used to fund a UC pool. (For more information on Medicare's DSH and UC costs, see our June 2022 report to the Congress.) Each DSH hospital receives a share of the FFS UC pool equal to its share of aggregate UC costs at all DSH hospitals. The ACA did not specify the mechanism CMS should use to distribute these UC funds.

In IPPS rulemaking for fiscal year 2014, CMS originally proposed to make interim UC payments on a periodic basis (not associated with any claims). However, in the final rule, CMS implemented a policy that makes interim UC payments as add-on payments to each FFS IPPS discharge.⁴⁶ CMS made this change after hospitals raised concerns that almost all hospitals had contracted with MA organizations to use the Medicare IPPS Pricer software in setting their payment rates, resulting in MA plans generally paying FFS rates (Berenson et al. 2015, Centers for Medicare & Medicaid Services 2013, Maeda and Nelson 2017). Therefore, if CMS had excluded UC payments from the IPPS payment rate, MA plans would have reduced payments to DSH hospitals (Centers for Medicare & Medicaid Services 2013). Because CMS decided to include the UC payments in the IPPS Pricer, MA plans make UC payments to hospitals on a per discharge basis similar to FFS UC payments per discharge.

For 2023, CMS established the FFS UC pool at \$6.9 billion dollars. Since DSH hospitals' historical UC costs were about \$34 billion, each DSH hospital therefore will receive approximately 20 percent of its historical UC costs as FFS add-on payments. These add-on payments are distributed as an interim payment per FFS discharge based on the hospital's historical FFS stays.⁴⁷ In addition, because MA plans generally pay the same rates as those under FFS, hospitals effectively receive UC payments from MA plans for their enrollees on a per discharge basis, similar to FFS UC payments per discharge.

However, as illustrated in Table 3A-3 (p. 99), the current system is inequitable. Because the FFS interim per discharge UC payments are included in the IPPS Pricer used by MA plans, the net UC payments that hospitals will receive from FFS and from MA plans in 2023 are approximately the sum of:

- add-on payments to FFS rates = historical UC costs × 0.20
- add-on payments to MA rates = MA discharges × (historical UC costs × 0.20 / historical FFS discharges)

Notably, the MA add-on payment formula can be rewritten as (MA discharge / FFS discharges) × (historical UC costs × 0.20). The formulas above illustrate how hospitals with larger MA shares (i.e., a

**TABLE
3A-1**

The MSNI supports hospitals that treat a high share of low-income Medicare beneficiaries, have high uncompensated care burdens, or serve a high share of Medicare beneficiaries

MSNI components	Weight	Data	Principle	Considerations
LIS share of FFS Medicare claims (inpatient and outpatient)	1	<p>Average of inpatient and outpatient percentages:</p> <p><i>Inpatient</i></p> <ul style="list-style-type: none"> • FFS inpatient claims for LIS beneficiaries (numerator) • FFS inpatient claims for all beneficiaries (denominator) <p><i>Outpatient</i></p> <ul style="list-style-type: none"> • FFS outpatient claims for LIS beneficiaries (numerator) • FFS outpatient claims for all beneficiaries (denominator) 	<ul style="list-style-type: none"> • Treating LIS beneficiaries could entail costs not captured by the MS-DRG or APC systems. • Hospitals that treat a large share of LIS beneficiaries tend to have more Medicare bad debts (i.e., receive a smaller share of allowed cost sharing). Medicare currently pays for 65 percent of these bad debts for FFS Medicare beneficiaries. • Measure is similar to the current DPP measure but includes a broader measure of low-income Medicare beneficiaries and does not explicitly include a measure of Medicaid dependence. While Medicaid is not explicitly in the formula, hospitals with high shares of LIS beneficiaries also tend to have higher Medicaid shares. 	<ul style="list-style-type: none"> • This component could be expanded to include LIS share of MA claims if/when the encounter data are sufficiently complete.
Uncompensated care costs as a share of a hospital's total revenue	1	<ul style="list-style-type: none"> • Uncompensated care costs (non-Medicare bad debt and charity care) (numerator) • Total, all-patient revenue (denominator) • Data pulled from cost reports 	<ul style="list-style-type: none"> • Hospitals that have a high share of uncompensated costs could face more financial pressure than the average hospital. • Uncompensated care costs could stem from treating patients without insurance or patients with insurance who cannot afford to pay their deductibles or cost sharing. 	<ul style="list-style-type: none"> • This component implies that Medicare would indirectly subsidize non-Medicare patients, but the effect would be much less direct than the current system and would be tied to Medicare volume.
Medicare share of all hospital inpatient days	0.5	<ul style="list-style-type: none"> • MA + FFS hospital acute inpatient days (numerator) • Total, all-payer hospital inpatient days (denominator) • Data pulled from cost reports 	<ul style="list-style-type: none"> • Over the last 25 years, hospitals' Medicare margins have shifted from being substantially positive to substantially negative. • Therefore, hospitals that disproportionately treat Medicare beneficiaries face increased risk of financial pressure or closure. • Weight of 0.5 is based on regression analyses that show the effect of Medicare shares on margins is about half that of the LIS share and uncompensated care cost measures. 	<ul style="list-style-type: none"> • Outpatient volume could be included if/when MA encounter data are more complete. • MA days should be included in determining safety-net status because those hospital patients have similar costs and revenue as FFS patients.

Note: MSNI (Medicare Safety-Net Index), LIS (low-income subsidy), FFS (fee-for-service), MS-DRG (Medicare severity–diagnosis related group), APC (ambulatory payment classification), MA (Medicare Advantage), DPP (disproportionate patient percentage). The MSNI identifies low-income beneficiaries as those receiving Part D's LIS, which includes all beneficiaries who receive full or partial Medicaid benefits, as well as those who do not qualify for Medicaid benefits in their state but who receive the Part D LIS because they have limited assets and an income below 150 percent of the federal poverty level. The measure of low-income beneficiaries incorporated in the DPP is limited to inpatient days for Medicare beneficiaries eligible for Supplemental Security Income; in 2021, these beneficiaries had incomes below 74 percent of the federal poverty level.

Source: MedPAC.

**TABLE
3A-2**

Characteristics of hospitals that benefit from four different safety-net payment mechanisms

Safety-net payment policy	Characteristics of hospitals that benefit more	Characteristics of hospitals that benefit less
<p>Traditional DSH From 1986 to 2013, there was a percentage add-on to IPPS payments based on each hospital's (1) Medicaid share of total inpatient days and (2) SSI beneficiaries' share of Medicare inpatient days.</p>	<ul style="list-style-type: none"> • High Medicare inpatient volume (the add-on is a Medicare inpatient add-on) • High share of Medicaid days • High share of Medicare patients on SSI 	<ul style="list-style-type: none"> • High level of uncompensated care relative to Medicare revenue • Outpatient-focused hospitals
<p>DSH and temporary UC From 2014 to 2017,* CMS paid hospitals add-ons to IPPS payments equal to:</p> <ul style="list-style-type: none"> • 25% of the traditional DSH payment • plus a fixed payment per Medicaid or Medicare SSI day (e.g., \$174/day in 2016). Both are add-ons to FFS IPPS payments. 	<ul style="list-style-type: none"> • High number of Medicaid days • High number of Medicare SSI days 	<ul style="list-style-type: none"> • Few Medicaid inpatient days relative to overall Medicare revenue • Outpatient-focused hospitals
<p>Current DSH and UC</p> <ul style="list-style-type: none"> • From 2018 to 2020,* CMS transitioned from the temporary model to the current DSH/UC model. Hospitals currently receive 25% of traditional DSH. • Hospitals also currently receive approximately 20% of uncompensated costs as an add-on to FFS inpatient payments. 	<ul style="list-style-type: none"> • High level of UC relative to total revenue • High levels of MA patients relative to FFS patients 	<ul style="list-style-type: none"> • High number of FFS Medicare patients but relatively little UC
<p>Illustrative MSNI CMS would pay hospitals add-ons to Medicare IPPS and OPPS payments based on each hospital's (1) Medicare shares, (2) share of their Medicare patients receiving LIS benefits, and (3) UC costs relative to total revenue.</p>	<ul style="list-style-type: none"> • High Medicare share of days relative to all inpatient days • High share of LIS Medicare claims relative to all Medicare claims • Outpatient-focused hospitals benefit more than in the other models 	<ul style="list-style-type: none"> • High UC burden but few Medicare patients

Note: DSH (disproportionate share hospital), IPPS (inpatient prospective payment systems), SSI (Supplemental Security Income), UC (uncompensated care), FFS (fee-for-service), MA (Medicare Advantage), MSNI (Medicare Safety-Net Index), OPPS (outpatient prospective payment system), LIS (low-income subsidy). LIS beneficiaries include all beneficiaries who receive full or partial Medicaid benefits, as well as those who do not qualify for Medicaid benefits in their state but who receive the Part D LIS because they have limited assets and an income below 150 percent of the federal poverty level.

*The uncompensated care payments in 2019 were still a blend of one-third payment based on Medicaid and SSI days and two-thirds based on reported uncompensated care costs. Uncompensated care payments were fully based on uncompensated care costs in 2020.

Source: MedPAC.

large MA discharges to FFS discharges ratio) will receive a higher share of their UC costs paid by Medicare and hospitals with low MA shares will receive a lower share of their UC costs paid by Medicare. (For an example, see Table 3A-3.)

As shown in Table 3A-3, Hospitals A and B both have historical UC costs of \$2 million and will admit 1,000 Medicare beneficiaries in 2023. However, Hospital A will admit 250 FFS beneficiaries and 750 MA enrollees, while Hospital B will admit 750 FFS beneficiaries and

**TABLE
3A-3**

Example of how uncompensated care payments are biased against hospitals in markets with primarily Medicare fee-for-service patients

	Illustrative Hospital A (higher MA share)	Illustrative Hospital B (lower MA share)
Historical uncompensated care costs	\$2 million	\$2 million
Medicare discharges in 2023		
FFS (historical and 2023)	250	750
MA	750	250
Total	1,000	1,000
Uncompensated care payments in 2023		
FFS	\$0.4 million (\$2 million × 20%)	\$0.4 million (\$2 million × 20%)
MA (pays FFS prices)	\$1.2 million (\$0.4 million / 250 × 750)	\$0.13 million (\$0.4 million / 750 × 250)
Total FFS + MA	\$1.6 million	\$0.53 million
Share of uncompensated care costs paid by Medicare	80%	27%

Note: MA (Medicare Advantage), FFS (fee-for-service). In 2023, disproportionate share hospitals will receive FFS uncompensated care payments equal to approximately 20 percent of their historic uncompensated care costs. Based on the literature and staff discussions with insurers and hospital systems, we assume that MA plans pay hospitals rates approximately equal to FFS rates.

Source: MedPAC.

250 MA enrollees. However—despite having equal UC costs—the second hospital receives about one-third the UC payments received by the first hospital because the second hospital’s FFS share of discharges is one-third the first hospital’s FFS share. The system is set up to make sure that FFS Medicare pays each DSH hospital an equal share of its UC costs, but current policy’s unintended consequence is that MA plans can pay each hospital vastly different shares of their UC costs. Larger ratios of MA discharges to FFS discharges result in higher total UC payments.

To avoid the payment rate distortions and MA benchmark distortions caused by the current system for distributing UC payments, the Commission has repeatedly suggested that CMS pay hospitals directly for a portion of their UC costs and that the MA plans’ portion also be paid directly by the Medicare program (Medicare Payment Advisory Commission 2022b, Medicare Payment Advisory Commission 2013). ■

Endnotes

- 1 Throughout this chapter, we use the term “FFS Medicare” as equivalent to the CMS term “Original Medicare.”
- 2 For example, Medicare pays separately for general acute care hospitals’ facility costs for services provided in hospital-based psychiatric units, post-acute care units, and clinics. Medicare also pays separately (outside of the IPPS and OPPS) for hospitals’ direct costs of graduate medical education, as well as organ acquisition. These other Medicare payment methodologies are beyond the scope of this chapter.
- 3 Unless otherwise noted, all years referring to inpatient services refer to fiscal year while those referring to outpatient services refer to calendar year, consistent with when CMS updates these payment systems. For more details on the IPPS and OPPS, see Hospital Acute Inpatient Services Payment System at https://www.medpac.gov/wp-content/uploads/2021/11/MedPAC_Payment_Basics_22_hospital_FINAL_SEC.pdf and Outpatient Hospital Services Payment System in our Payment Basics series at https://www.medpac.gov/wp-content/uploads/2021/11/MedPAC_Payment_Basics_22_OPD_FINAL_SEC.pdf.
- 4 Under the IPPS and OPPS, FFS Medicare pays the prospective rate minus any beneficiary cost-sharing responsibilities (which the provider collects from the beneficiary or a supplemental insurer). Medicare reimburses hospitals for 65 percent of bad debts resulting from beneficiaries’ nonpayment of cost sharing after hospitals have made reasonable efforts to collect the unpaid amounts.
- 5 For more details on the CAH payment system, see Critical Access Hospitals Payment System in our Payment Basics series at https://www.medpac.gov/wp-content/uploads/2021/11/MedPAC_Payment_Basics_22_CAH_FINAL_SEC.pdf.
- 6 Medicare uses the OPPS to pay for the facility costs of outpatient services at post-acute care hospitals (i.e., long-term care and rehabilitation hospitals), at certain specialized short-term acute care hospitals (i.e., psychiatric, cancer, and children’s hospitals), and at community mental health centers.
- 7 While the focus of this chapter is on assessing the adequacy of IPPS and OPPS payments, we include all general ACHs (defined as those paid under the IPPS as well as CAHs and ACHs in Maryland and in U.S. territories) in our indicators of beneficiaries’ access to care because all general ACHs provide a range of acute hospital inpatient and outpatient services to FFS Medicare beneficiaries and therefore can serve as substitutes for care at general ACHs paid under the IPPS and OPPS.
- 8 Hospital closures are defined as cessation of Medicare beneficiaries’ access to inpatient services at a general short-term ACH or CAH in the United States (exclusive of territories). Closures do not include the relocation of inpatient services from one hospital to another under common ownership within 10 miles, nor do closures include hospitals that both opened and closed within a 5-year time period. The number of hospital closures and openings in a given year can change over time as hospitals reopen or dates of closure are updated.
- 9 We measure closures during each fiscal year (to match the timeframe of Medicare inpatient payment rate changes). Other sources such as the University of North Carolina measure closures during each calendar year.
- 10 Small rural hospitals are eligible to convert to REHs, which provide 24/7 emergency services and other outpatient services. REHs receive a monthly fixed rate for their standby costs, enhanced outpatient rates, and standard rates for other services.
- 11 Since mid-2020, hospitals have had to report weekly occupancy data to the Department of Health and Human Services. According to these data, general ACHs’ occupancy rates in fiscal years 2021 and 2022 were about 74 percent and 77 percent, respectively, with some hospitals exceeding 90 percent in certain months. These higher occupancy rates may more accurately reflect decreases in staffed beds during part of the year, but they may also reflect inaccurate data from some hospitals.
- 12 The decline in the number of inpatient stays (–6.1 percent) was larger than the decline in stays per beneficiary (–1.8 percent) because there was a 4.3 percent decline in FFS beneficiaries (as a greater share of Medicare beneficiaries enrolled in MA).
- 13 CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.
- 14 The all-payer operating margin at CAHs was also a record high of 10.8 percent (6.0 percent exclusive of federal relief funds).
- 15 The federal relief funds are primarily from the Provider Relief Fund but in 2020 also included forgiven loans from the Paycheck Protection Program.
- 16 The increase in IPPS hospitals’ operating margin in 2021 was even larger prior to the inclusion of relief funds (over 5 percentage points), as hospitals’ revenue prior to relief

- funds increased faster (over 13 percent). The rapid revenue growth from 2020 reflects the low 2020 level of operating revenue (excluding relief funds). IPPS hospitals' all-payer total margin had an even larger increase in 2021, growing over 4 percentage points (near 6 percentage points excluding relief funds), reflecting strong investment returns.
- 17 We calculated aggregate operating margins net of interest expense, before taxes and extinguishment of debt, based on hospital systems' financial reports.
 - 18 "Same-hospital net patient service revenue per adjusted admission decreased 4.2 percent year-over-year for third quarter 2022, primarily due to lower COVID-19-related acuity and lower COVID-19 volumes, partially offset by improved pricing yield. COVID-19 admissions were 6 percent of total admissions in the third quarter of 2022 versus 10 percent in the third quarter of 2021" (Tenet Health 2022).
 - 19 Given that hospitals with distinct units can affect the margin of inpatient and outpatient service lines based on where they treat patients (e.g., having a SNF in the hospital may allow earlier discharges from the inpatient unit), we focus our Medicare margin discussion on hospitals' aggregate Medicare margin across multiple hospital service lines (including inpatient, outpatient, swing bed, skilled nursing, rehabilitation, psychiatric, and home health services) as well as direct graduate medical education and uncompensated care payments.
 - 20 Because federal relief funds were intended to help cover lost revenue and payroll costs—including lost revenue from Medicare patients and the cost of staff who help treat these patients—we include a portion of these relief funds (based on FFS Medicare's share of 2019 all-payer operating revenue) in our Medicare margins. Using this method, we allocated \$3.5 billion of the \$18 billion in federal funds that hospitals reported on their cost reports with midpoints in fiscal year 2021 toward hospitals' care of FFS Medicare beneficiaries.
 - 21 We estimated that the effect of the suspension of the 2 percent sequestration on IPPS payments per stay in fiscal year 2021 was a 1.1 percent increase relative to 2020 for two reasons. First, the suspension was in effect for all of fiscal year 2021, compared with five months of fiscal year 2020. Second, the 2 percent sequestration does not apply to FFS Medicare beneficiary cost sharing, which is about 20 percent of all IPPS payments.
 - 22 Under current law, aggregate uncompensated care payments are set prospectively by CMS as the product of two estimates for the upcoming payment year: 75 percent of DSH payments under prior law and the uninsured rate as a percentage of the rate in 2013. Like other Medicare payments, uncompensated care payments are subject to sequestration (when it is in effect). In 2021, estimated DSH payments decreased about 9 percent while uninsured rates increased by slightly less. However, as sequestration was suspended for all of 2021 but only part of 2020, the net effect was a minimal change in Medicare's uncompensated care payments to IPPS hospitals.
 - 23 The OPSS also applies budget-neutrality factors to the base rate; however, these offset the estimated effects of other policy changes (such as updated geographic adjustments and pass-through payments) and therefore should not affect total payments.
 - 24 We estimated that the effect of the suspension of the 2 percent sequestration on Medicare program OPSS payments per beneficiary in calendar year 2021 was a 0.6 percent increase relative to 2020 for two reasons. First, the suspension was in effect for all of calendar year 2021, compared with eight months of calendar year 2020. Second, the 2 percent sequestration does not apply to FFS Medicare beneficiary cost sharing, which is about 20 percent of all OPSS payments.
 - 25 If costs would have been reduced more in the absence of relief funds, the margin decline would have been smaller.
 - 26 We have also found that hospitals under financial pressure (those that do not have material profits on non-Medicare patients) have a stronger incentive to control costs and roughly broke even in Medicare in recent years. For-profit hospitals, which have an incentive to maximize shareholder returns, have also roughly broken even in Medicare in recent years (Medicare Payment Advisory Commission 2021).
 - 27 The objective of this analysis is to find a subset of the relatively efficient hospitals rather than to identify all efficient hospitals. For example, we exclude from our analysis small hospitals with less than 500 inpatient stays, not because we know they are inefficient but because we have an insufficient volume of claims to know whether they performed at a relatively efficient level.
 - 28 We use medians rather than means to limit the influence of outliers on our set of efficient providers.
 - 29 We do not adjust our costs per inpatient stay for economies of scale. However, we excluded all hospitals with fewer than 500 Medicare inpatient stays from our analysis. For the remaining hospitals, economies of scale are not a material factor when evaluating costs per discharge because costs are roughly proportionate to the volume of stays for hospitals with over 500 Medicare stays per year (generally over 1,000 all-payer stays). Teaching hospitals tend to have higher costs per stay, but we standardize costs per stay by adjusting for the effect of case mix, outlier cases, and the cost of training residents. After these adjustments, teaching hospital costs,

on average, are similar to nonteaching hospital costs. For a more complete description of the methodology, see online Appendix 3-B from our 2016 report to the Congress, available at <http://www.medpac.gov>.

- 30 We adjust costs per stay for the share of Medicare patients that are on Supplemental Security Income (SSI). However, we do not adjust readmission or mortality metrics for patient income, in keeping with our policy of not adjusting quality metrics for income. The efficient group of hospitals tends to have a smaller share of low-income Medicare beneficiaries. The median share of Medicare patients on SSI for efficient hospitals is 6.3 percent and the median share for other hospitals is 7.8 percent. In 2022, we also developed a measure of Medicare safety-net status called the Medicare Safety-Net Index (MSNI) (see the appendix to this chapter). Hospitals in the highest quartile of the MSNI metric (the sum of the share of Medicare beneficiaries receiving Part D's low-income subsidy (LIS) benefit, one-half the Medicare patient share, plus uncompensated care costs divided by total revenues) are half as likely to be in our efficient-provider group. These hospitals tend to have low costs, but they perform worse on mortality and readmission metrics, possibly due to their small size and the fact that high-MSNI hospitals have higher shares of low-income Medicare beneficiaries.
- 31 CMS is still evaluating how to apply the Supreme Court's decision in *American Hospital Association v. Becerra*, 142 S. Ct. 1896 (2022) to 2018–2012. In the 2023 OPPI final rule, CMS addressed the court ruling only for 2023 by reverting the payments for 340B drugs back to average sales price plus 6 percent (the rate prior to 2018, when CMS lowered the rate to average sales price minus 22.5 percent).
- 32 Our low-income definition (those receiving the LIS in Part D) is much more inclusive than the current definition of low-income patients used in the current disproportionate share formula (those receiving Supplemental Security Income (SSI)). Our prior work indicated that the LIS variable was a better predictor of closure and margins than the SSI variable, but they are positively correlated (correlation coefficient of 0.81).
- 33 The add-on amount determines the amount in the FFS Pricer and thus most MA payment amounts. The add-on is seen as an interim payment amount. At the end of the year, CMS makes additional adjustments to uncompensated care payments so that each hospital receives a share of uncompensated care payments equal to that hospital's share of all DSH hospitals' uncompensated care costs. Thus, the FFS Pricer amount (the Pricer is software CMS uses to set interim FFS Medicare prices and that MA plans in turn base their prices on) does not determine the final amount of uncompensated care payments received by DSH hospitals. In contrast, MA payments are determined by the FFS Pricer and are not reconciled at the end of the year.
- 34 The DSH metric we use is called the DSH patient percentage, which is the sum of two ratios: Medicare Supplemental Security Income (SSI) days (for MA and FFS patients) as a share of all Medicare days, and days in which Medicaid is a primary payer as a share of all inpatient days.
- 35 Starting at the 10th percentile would result in about 170 hospitals that currently receive DSH and uncompensated care payments not receiving any Medicare safety-net payments. Alternatively, the policy could start at the 5th percentile to reduce the number of hospitals that currently receive DSH payments but would then receive no MSNI payments.
- 36 While the total amount of DSH and uncompensated care payments distributed to hospitals in 2019 (after accounting for sequestration) was about \$11.7 billion, the amount distributed to the hospitals in our simulation was \$11.2 billion. Not all hospitals were included in our simulation because some hospitals had incomplete data to create the MSNI or did not meet our simulation requirement of having a minimum of 500 FFS discharges.
- 37 Under this model of the MSNI, certain hospitals that currently are paid based on historical costs as a sole community hospital (SCH) or partially based on historical costs as a Medicare-dependent hospital (MDH) would not see an FFS shift in revenue. Under an MSNI policy, these hospitals would receive the higher of the current MDH or SCH payments based on historical costs or the benefit of the MSNI adjustment. Therefore, the benefits to rural hospitals are conservatively stated in this chapter.
- 38 Currently, government-owned hospitals' DSH and uncompensated care payments in some cases can result in an 80 percent or larger increase in their Medicare payments relative to standard Medicare rates.
- 39 We tested to see if the difference was due to rural areas, but even limiting the analysis to urban hospitals, hospitals in markets with lower MA penetration tended to benefit more from the transition to the MSNI.
- 40 In 2021, about 46 percent of beneficiaries with Part A and Part B were enrolled in MA plans, up from 26 percent in 2010 (Medicare Payment Advisory Commission 2021).
- 41 Hospital representatives have said that MA plans typically pay FFS rates for hospital care but that hospitals (1) receive lower total payments from MA plans because of increased rates of medical necessity denials by MA plans and (2) incur higher administrative costs for MA beneficiaries relative to FFS beneficiaries because of prior authorization processes put in place by MA plans. We cannot quantify these effects.

- 42 The claims could be priced using FFS prices.
- 43 The Medicaid program does not have a definition of “safety-net” hospital. However, hospitals with a Medicaid inpatient utilization rate at least one standard deviation above the mean for the state are “deemed DSH hospitals” and states are required to provide some Medicaid DSH payments to those hospitals (Medicaid and CHIP Payment and Access Commission 2022a).
- 44 The law exempts the 3 percent of hospitals with the highest number and share of patients who are eligible for Medicare and receive Supplemental Security Income (SSI) from this change (Medicaid and CHIP Payment and Access Commission 2022a).
- 45 There is also a secondary effect. As FFS inpatient stays increase, UC payments per stay decrease, which creates a decrease in MA prices paid per unit of service. Shifting to the MSNI would remove this distortion.
- 46 In each year’s IPPS final rule, CMS first computes the FFS UC pool as an amount equal to 75 percent of what DSH payments would have been under prior law (reduced by an

amount to reflect declines in the share of the population that is uninsured). This computation yields a fixed pool of FFS UC dollars to be distributed among DSH hospitals. Each DSH hospital’s share of that pool of dollars is equal to that hospital’s historical UC costs divided by the aggregate of all DSH hospitals’ historical UC costs.

The uncompensated care payments due to each hospital are then divided by that hospital’s historical number of FFS discharges to arrive at a per discharge add-on amount. That hospital-specific add-on amount is added to each hospital’s inpatient payment rate. To the extent that actual FFS discharges differ from this historical number, the difference is reconciled in the final cost report settlement each year, to ensure that each hospital receives exactly the amount it is due as published in that year’s final IPPS rule.

- 47 For 2023, the historical UC costs are based on the average of 2018 and 2019 cost reports, and historical FFS discharges are the average of 2018, 2019, and 2021 FFS discharges. In addition, starting in 2023, DSH hospitals in Puerto Rico and hospitals administered by the Indian Health Service will receive supplemental UC payments.

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