MEDPAC

Advising the Congress on Medicare issues

Assessing payment adequacy and updating payments: Hospital inpatient and outpatient services; mandated report on rural emergency hospitals; and update on site-neutral payments

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December 4, 2025

Presentation roadmap

1. Overview of hospital use and spending under FFS Medicare
2. Assessment of payment adequacy
3. Chair's draft recommendation
4. Mandated report on rural emergency hospitals
5. Update on site-neutral payments
6. Discussion

Hospital use and spending under FFS Medicare, 2024

	IPPS	OPPS
Hospitals	3,095	3,060
Users	4.2 million	15.8 million
Services	6.5 million stays	64.7 million encounters
Payments for services	$104.6 billion	$52.4 billion
Other payments	$5.9 billion for uncompensated care	$22.0 billion for separately payable items

Note: FFS (fee-for-service), IPPS (inpatient prospective payment systems), OPPS (outpatient prospective payment system). "Hospitals" refers to Subsection (d) hospitals paid under the IPPS and/or OPPS.

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

Payment adequacy framework: Hospitals

Beneficiaries' access to care

- Hospital capacity and supply
- Volume of FFS Medicare inpatient and hospital outpatient services

Quality of care

- FFS Medicare risk-adjusted mortality rate and readmission rate
- Patient experience

Access to capital

- All-payer operating margin
- Investment income
- Borrowing costs

FFS Medicare payments and costs

- FFS Medicare margin
- Median FFS Medicare margin among relatively efficient hospitals
- Projected FFS Medicare margin

Update recommendation for hospital base payment rates

Note: FFS (fee-for-service).

Access: Hospitals continued to have available capacity in FY 2024

Inpatient beds stable

- 674,000 beds

Available inpatient capacity

- 71% occupancy rate
- Some exceeded capacity at times

Available ED capacity

- 150 minutes from ED arrival to departure

Employment increased

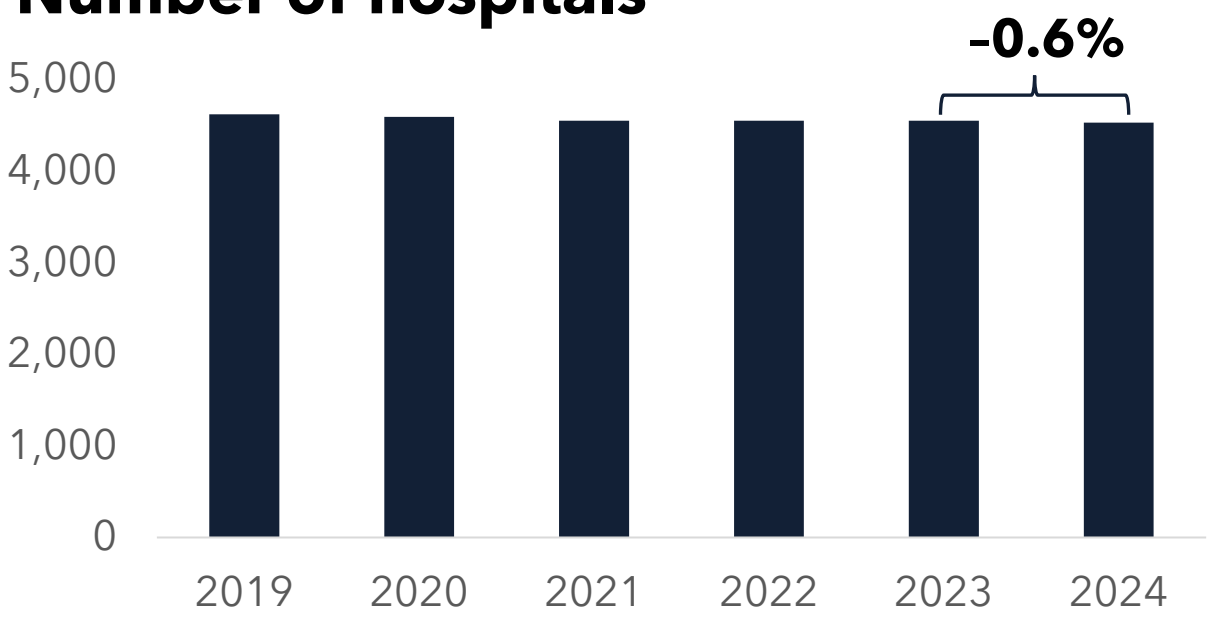
- 4.8 million employees (vs. 4.6 million in 2023)

Note: FY (fiscal year); ED (emergency department). "Hospitals" refers to Subsection (d) hospitals, as well as critical access hospitals and short-term acute care hospitals in territories.

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

Access: Supply of hospitals relatively steady in FY 2024 and 2025

Number of hospitals



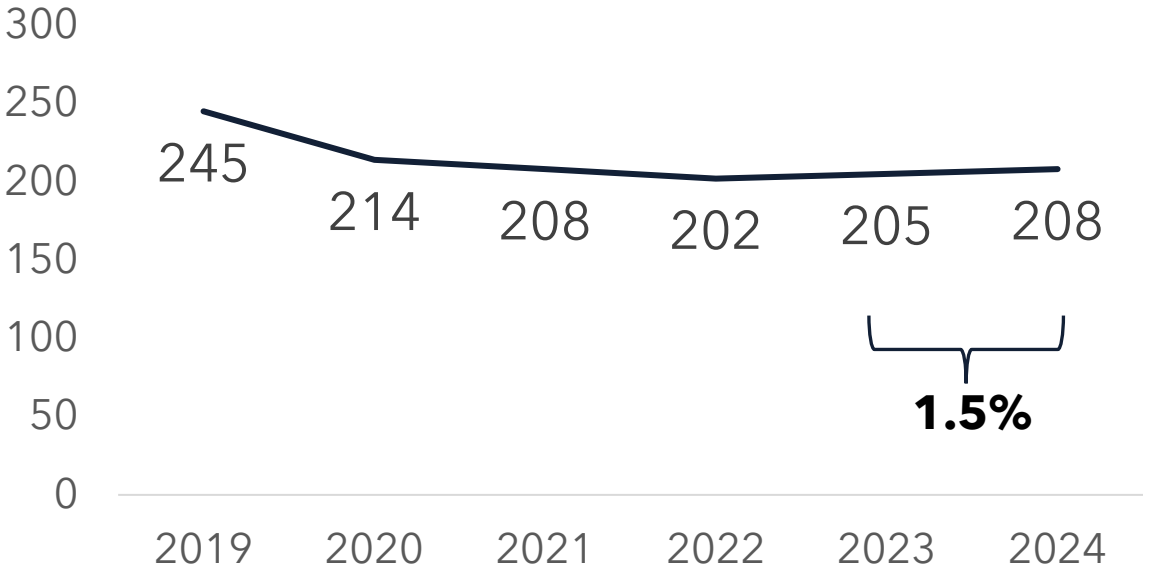
Note:. FY (fiscal year). "Number of hospitals" refers to the count of provider numbers for hospitals (Subsection(d) hospitals, critical access hospitals, rural emergency hospitals, and short-term acute care hospitals in territories) that provided both at least one inpatient service to a fee-for-service (FFS) Medicare beneficiary in that fiscal year (or was a rural emergency hospital) and at least one outpatient service to a FFS Medicare beneficiary in that calendar year.

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

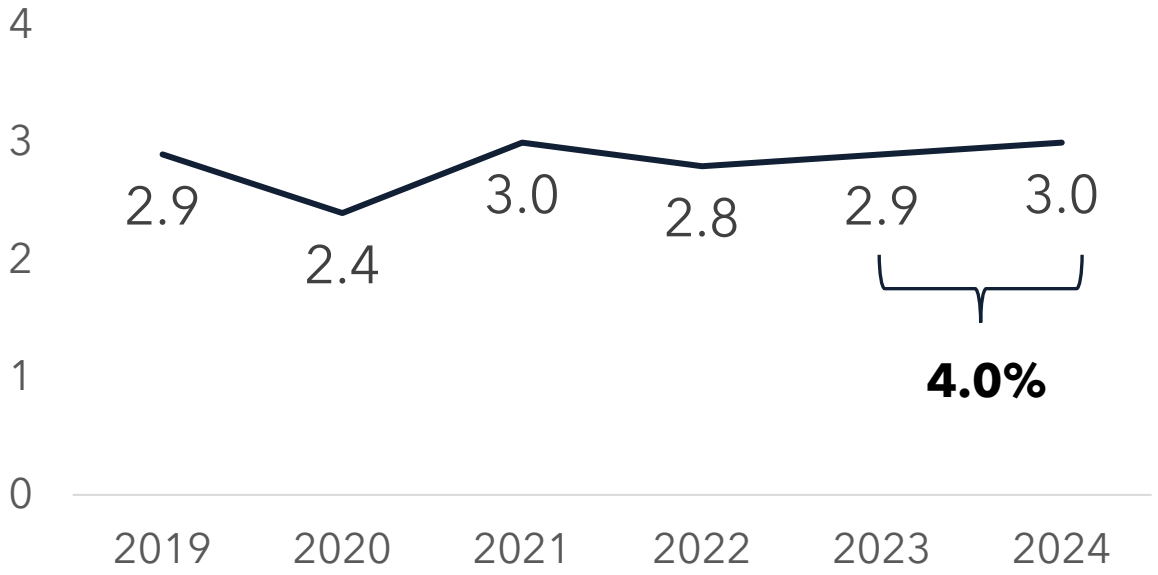
- In both FY 2024 and 2025:
  - 8 more hospitals closed than opened; low volume and high operating costs were most common reasons for closure
  - Several hospitals converted to rural emergency hospitals

Access: FFS Medicare inpatient stays and outpatient services per capita increased in 2024

Inpatient stays per 1,000 FFS Medicare beneficiaries



Hospital outpatient encounters per FFS Medicare beneficiary



Note: FFS (fee-for-service). "Hospital" refers to Subsection (d) hospitals, as well as critical access hospitals and short-term acute care hospitals in territories. FFS Medicare beneficiary enrollment limited to those residing in the U.S. who have Part A coverage for inpatient and Part B coverage for outpatient services. "Outpatient encounters" are unique combinations of claims, beneficiaries, and providers, where the claim included at least one outpatient-prospective-payment-system (OPPS)-equivalent service. Percentage changes were calculated on unrounded data. Years are fiscal for inpatient and calendar for outpatient; those are the years used by CMS in rate setting.

Source: MedPAC analysis of Medicare Provider Analysis and Review, hospital outpatient claims, and Common Medicare Environment files.

Quality: 2024 indicators mixed

FFS mortality rate improved

- 7.4% risk-adjusted mortality rate (−0.2 percentage points from 2023)
- Improvement from 2019 (−0.5 percentage points)

FFS readmission rate worsened

- 15.4% risk-adjusted readmission rate (+0.3 percentage points from 2023)
- Improvement from 2019 (−0.1 percentage points)

Patient experience stable

- Most measures were stable from 2023 to 2024
- Almost all are at least 1 percentage point worse than 2019

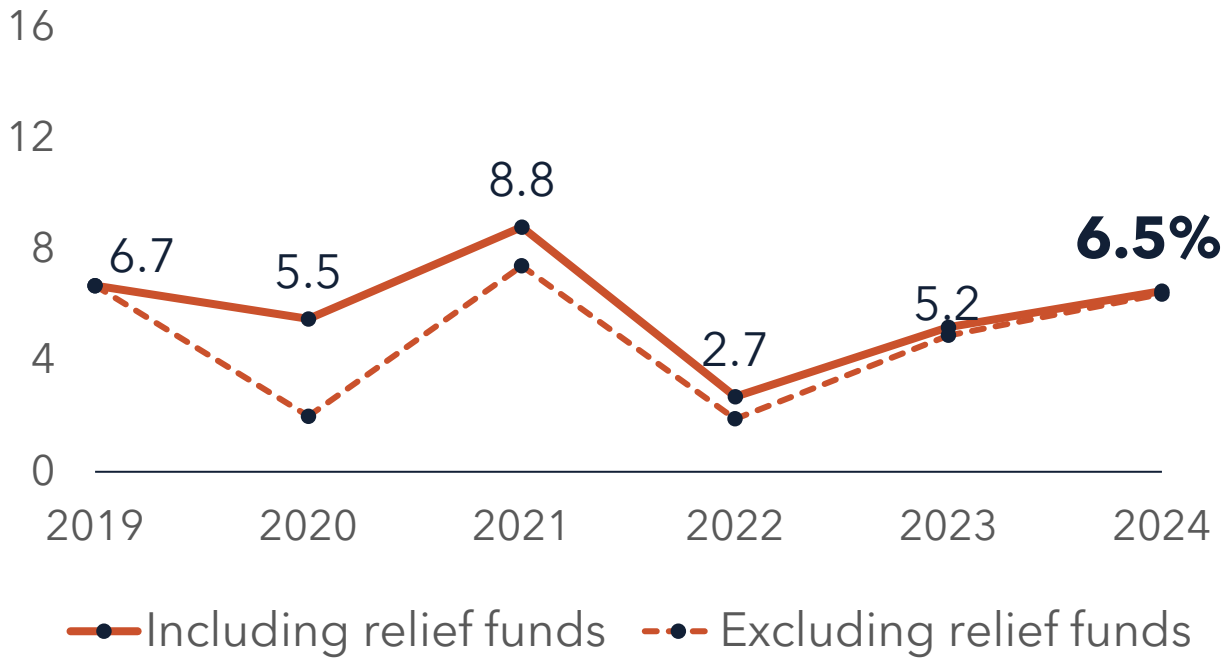
Note: FFS (fee-for-service). "Hospital" refers to hospitals paid under the inpatient prospective payment systems. "Mortality rate" refers to the share of inpatient stays that resulted in a death during or within 30 days after the stay. "Readmission rate" refers to the share of inpatient stays that resulted in a readmission during or within 30 days after the initial stay. Results differ from those published in prior years because of minor methodological updates.

Source: MedPAC analysis of Medicare Provider Analysis and Review data and CMS summary of H-CAHPS public report of survey results tables.

Access to capital: Improved in FY 2024; preliminary data suggest continued improvement in FY 2025

- All-payer operating margin increased in FY 2024, driven by
  - 340B remedy payments
  - Slower growth in labor costs
- Financial statements from eight large hospital systems suggest increase in 2025
- Other measures improved in 2024 and 2025

All-payer operating margin (in percent)

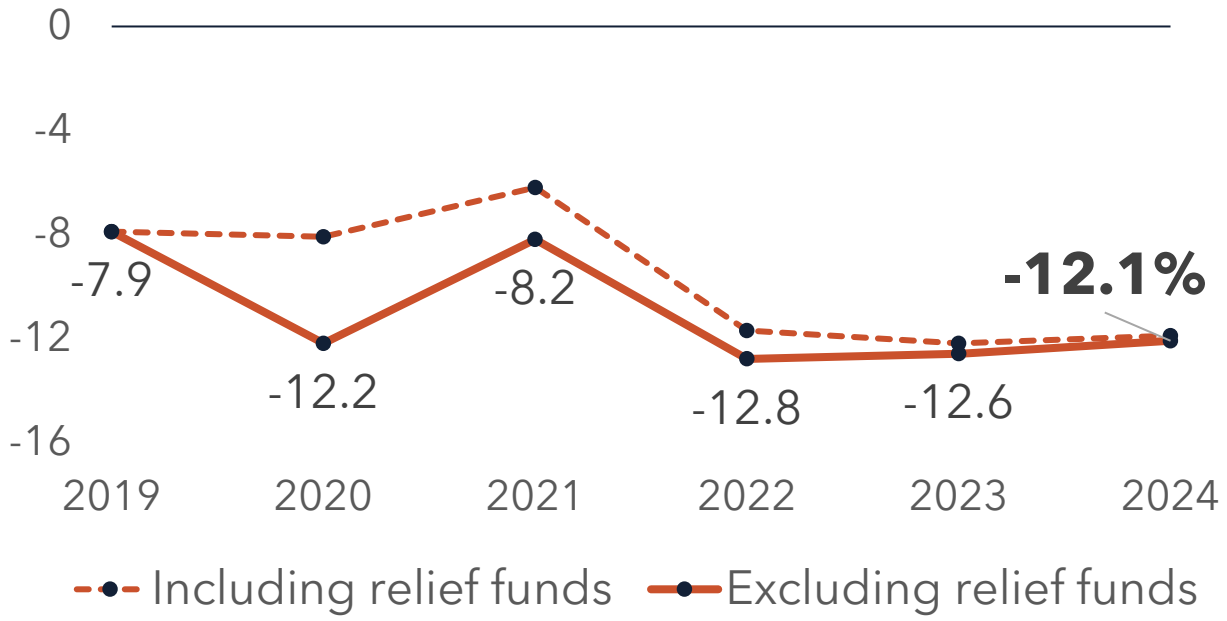


Note: FY (fiscal year). "All-payer operating margin" excludes reported investment and donation income. "Relief funds" refers to federal or other coronavirus relief funds. Results differ from those published last year in part because of newer data.

Source: MedPAC analysis of hospital cost report data.

Payments and costs: Hospitals' FFS Medicare margin increased but remained low in FY 2024

FFS Medicare margin (in percent)



Note: FY (fiscal year), FFS (fee-for-service). "FFS Medicare margin" is limited to revenue and costs for services included under the inpatient or outpatient prospective payment systems, and excludes 340B remedy payments hospitals received in FY 2024. "Relief funds" refers to federal or other coronavirus relief funds. Results differ from those published last year in part because of newer data.

Source: MedPAC analysis of hospital cost report data.

- FY 2024 change in FFS Medicare margin driven by:
  - (+) Growth in profitable outpatient drugs
  - (+) Slowed growth in labor costs
  - (–) Decline in uncompensated care payments
- Substantial variation across hospitals persisted

Payments and costs: Relatively efficient hospitals' median FFS margin increased to −1% in FY 2024

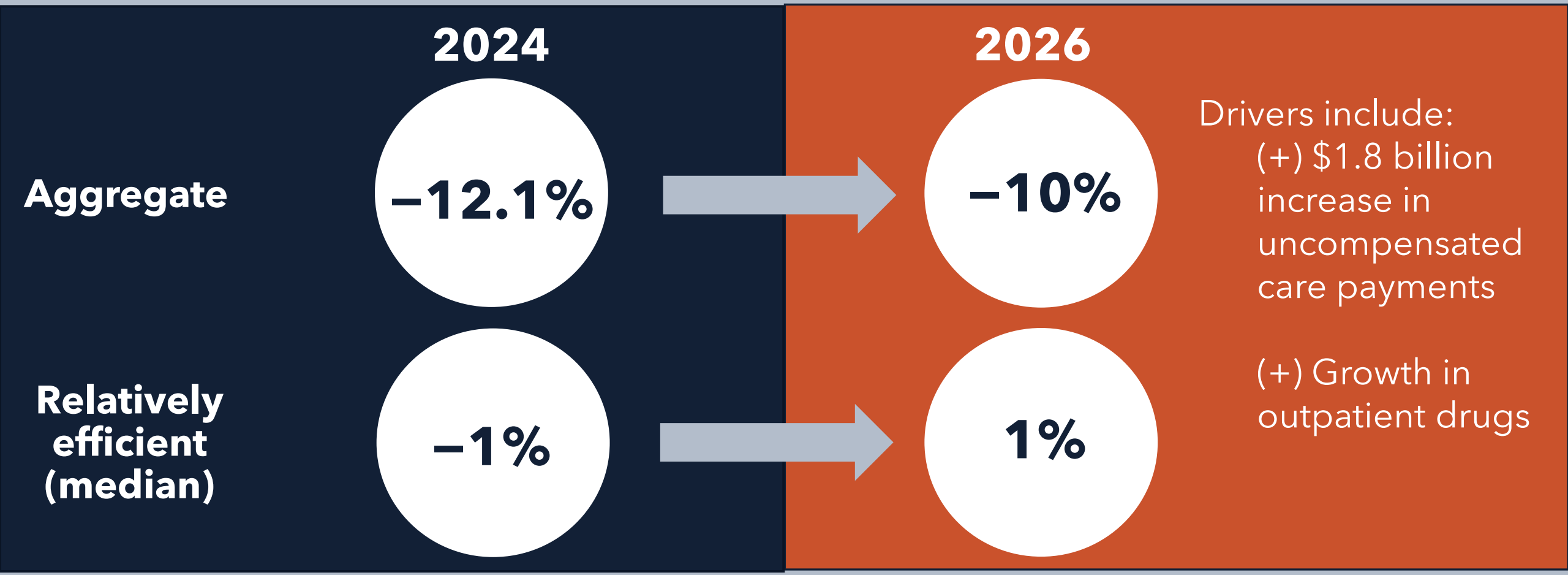
- "Relatively efficient" hospitals are those that historically performed relatively well on both quality and cost metrics
- This year made refinements, including relaxing consistency criteria to 3 out of prior 4 years
  - 13% of hospitals met our criteria

Relatively efficient hospitals

	Share of hospitals	FFS Medicare margin
2023	6%	−2%
2024	**13%**	**−1%**

Note: FFS (fee-for-service), FY (fiscal year). "FFS Medicare margin" is limited to revenue and costs for services included under the inpatient or outpatient prospective payment systems, and excludes 340B remedy payments hospitals received in FY 2024 and federal or other coronavirus relief funds.
Source: MedPAC analysis of hospital cost report and claims data.

Payments and costs: Hospitals' FFS Medicare margin projected to increase in FY 2026



Note: FFS (fee-for-service), FY (fiscal year). "FFS Medicare margin" is limited to revenue and costs for services included under the inpatient or outpatient prospective payment systems, and excludes 340B remedy payments hospitals received in FY 2024 and federal or other coronavirus relief funds.
Source: MedPAC analysis of hospital cost report, claims, market basket, and final rule data.

Since 2023, MedPAC has recommended redistributing DSH and UC payments via the MSNI

- The MSNI identifies safety-net hospitals that serve large shares of low-income Medicare patients
- A hospital's MSNI is the sum of:
  - Low-income share of Medicare volume
  - Uncompensated-care costs as share of all-payer revenue
  - Medicare share of volume (divided by 2)

- MSNI continues to be a better predictor of hospitals' all-payer operating margin than the current DSH metric
- MSNI mechanism has other advantages, including direct payments to hospitals for both their FFS and MA patients

Note: MSNI (Medicare safety-net index), DSH (disproportionate-share-hospital), UC (uncompensated care), FFS (fee-for-service), MA (Medicare Advantage). "Low-income" refers to eligible for the low-income subsidy or dually-eligible for Medicare and Medicaid. "Volume" refers to inpatient stays and hospital outpatient share of charges. "Medicare" refers to FFS and MA.

Source: Medicare Payment Advisory Commission. 2023. Report to the Congress: Medicare and the health care delivery system. Washington, DC: MedPAC

Summary: Hospital payment adequacy indicators

Beneficiaries' access to care

- Hospitals maintained available capacity in FY 2024
- Supply relatively stable in both FY 2024 and FY 2025
- FFS Medicare inpatient and outpatient volume per capita increased

Positive

Quality of care

- Mortality rate improved in FY 2024
- Readmission rate worsened but still improved from 2019
- Most patient experience measures stayed the same but still below 2019 levels

Mixed

Access to capital

- All-payer operating margin increased to 6.5% in FY 2024 and data suggest increase in FY 2025
- Investment income increased
- Risk premium on hospital bonds decreased

Positive

FFS Medicare payments and costs

- FFS Medicare margin exclusive of relief funds:
  - −12.1% in aggregate
  - −1% median among relatively efficient hospitals
- Project 2026 margins to increase

Negative

Chair's draft recommendation involves balancing objectives

- Maintain payments high enough to ensure beneficiaries' access to care
- Maintain payments close to hospitals' cost of providing high-quality care efficiently to ensure value for taxpayers
- Maintain fiscal pressure on hospitals to constrain costs
- Limit the need for large, across-the-board payment rate increases by better targeting Medicare payments to Medicare safety-net hospitals serving large shares of vulnerable Medicare patients

Chair's draft recommendation

Chair's draft recommendation

The Congress should:

- for 2027, update the 2026 Medicare base payment rates for general acute care hospitals by the amount specified in current law, and
- implement the Medicare Safety-Net Index (MSNI) described in our March 2023 report, with $1 billion added to the MSNI pool.

Implications

Spending:

- Increase relative to current law

Beneficiary and provider:

- Will help maintain hospitals' willingness to treat fee-for-service Medicare beneficiaries and maintain beneficiaries' access to care by improving the financial stability of hospitals serving large shares of low-income Medicare beneficiaries

Mandated report: Rural emergency hospitals

In 2018, MedPAC recommended the creation of a new category of hospital: rural, outpatient-only

- Historically, rural hospitals and rural Medicare payment policies were inpatient-centric
- But inpatient volume at some rural hospitals had declined substantially, while the need for emergency care remained
- MedPAC recommended the creation of a new category of hospital: a rural, outpatient-only hospital that would receive fixed payments to support stand-by costs of maintaining an emergency department

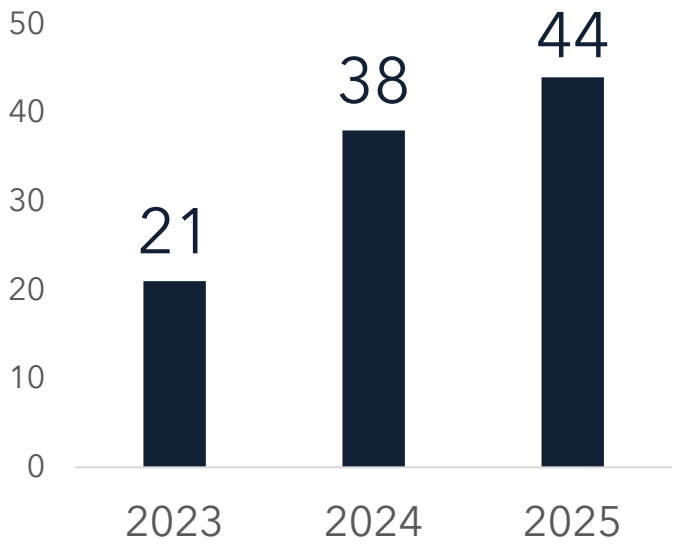
CAA, 2021, created new Rural Emergency Hospital (REH) designation starting in 2023

- Critical access or rural hospitals with 50 or fewer beds as of December 27, 2020, can choose to transition to an REH
- REHs:
  - Do not furnish inpatient care
  - Staff an emergency department 24/7
  - Receive fixed payments from Medicare
  - Are paid 105% of standard OPPS rates for emergency and outpatient FFS services

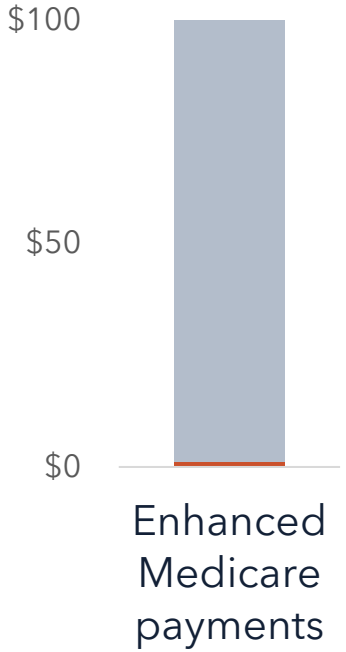
Note: CAA (Consolidated Appropriations Act); FFS (fee-for-service), OPPS (outpatient prospective payment system).

Mandated report: Rural emergency hospitals (REHs)

Number of REHs increased



Over $100 million in enhanced payments to REHs in 2024



$100 million from fixed payments (~$276,000 per REH per month)

$1.2 million for FFS outpatient services

MedPAC continues to monitor REH designation

- Conducted site visits and interviews
- Hospitals reported that MA plans tend to match FFS's enhanced claims-based payments but do not pay REHs' fixed payments

Notes: REHs (rural emergency hospitals), FFS (fee-for-service), MA (Medicare Advantage).
Source: MedPAC analysis of hospital outpatient claims data and outpatient prospective payment system final rule.

Update: site-neutral payments

MedPAC has supported moving to site-neutral payments where appropriate

- MedPAC recommendation (2023): Align payment rates for select services across ambulatory settings where safe and appropriate
- Potential impacts of aligning payment rates are substantial:
  - Improves incentives by setting payments based on efficient delivery of care and not on setting
  - Reduces incentives for providers to consolidate

Note: HOPD (hospital outpatient department).
Source: MedPAC 2014, 2023.

Medicare's site-neutral payment policies and future opportunities

- Current site-neutral policies:
  - Beginning in 2017, most services in non-excepted off-campus PBDs are subject to site-neutral payment policy
  - In 2019, policy was expanded to clinic services in excepted off-campus PBDs
  - Starting in 2026, drug administration services in excepted off-campus PBDs
- Additional opportunities to expand site-neutral policies:
  - Clinic visits in on-campus HOPDs
  - Services in excepted off-campus PBDs

Note: PBD (provider-based department), BBA (Balanced Budget Act), HOPD (hospital outpatient departments). "Off-campus" refers to PBDs more than 250 yards from a hospital campus. "Excepted" PBDs were those established before November 2, 2015, and therefore excepted from the BBA of 2015 policies.
Source: MedPAC analysis of hospital outpatient claims data and OPPS final rules.

Discussion

- Questions?
- Feedback?

Chair's draft recommendation

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