CHAPTER 3

Hospital inpatient and outpatient services

RECOMMENDATION

3 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.

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

CHAPTER 3

Hospital inpatient and outpatient services

Chapter summary

General acute care hospitals primarily provide inpatient medical and surgical care to patients needing an overnight stay and provide outpatient services, including procedures, tests, evaluation and management services, and emergency care. To pay hospitals for the facility share of providing these services, fee-for-service (FFS) Medicare generally sets prospective payment rates under the inpatient prospective payment systems (IPPS) and the outpatient prospective payment system (OPPS). In 2024, the FFS Medicare program and its beneficiaries spent $185 billion on services paid under the IPPS and OPPS, including nearly $6 billion in uncompensated-care payments made under the IPPS and $22 billion on separately payable drugs and other inputs under the OPPS.

Assessment of payment adequacy

In fiscal year (FY) 2024, FFS Medicare payment-adequacy indicators for general acute care hospitals were mixed. Beneficiary access to care remained good overall, and hospitals' all-payer margin increased to 6.5 percent. However, quality indicators were mixed. Hospitals' FFS Medicare margin improved slightly to –12.1 percent and to –1 percent for the median relatively efficient hospital.

In this chapter

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

- ***Capacity and supply of providers—***Hospitals continued to have available capacity in FY 2024: The number of inpatient beds remained relatively stable at about 674,000, hospitals' occupancy rate remained below capacity (71 percent), the median time from patients' emergency-department arrival to departure remained relatively stable at about 150 minutes, and hospital employment increased. The supply of hospitals was relatively steady, though eight more hospitals closed than opened in each of 2024 and 2025.
- ***Volume of services—***FFS Medicare beneficiaries' use of inpatient and hospital outpatient services increased in 2024. In FY 2024, FFS Medicare beneficiaries had 208.3 inpatient stays per 1,000 beneficiaries, a 1.5 percent increase from 2023 but still nearly 15 percent below the level in 2019. In calendar year (CY) 2024, FFS Medicare beneficiaries had 3.0 hospital outpatient encounters per beneficiary, a 4.0 percent increase from 2023 but still in line with the 2019 level (within 0.1 encounters per beneficiary).

Quality of care—Quality of hospital care in FY 2024 was mixed. FFS Medicare beneficiaries' risk-adjusted hospital mortality rate improved to 7.4 percent, a 0.2 percentage point improvement from 2023. FFS Medicare beneficiaries' risk-adjusted readmission rate was 15.4 percent in 2024, 0.3 percentage points worse than in 2023. Most patient-experience scores remained the same in 2024.

Providers' access to capital—Hospitals' access to capital improved in FY 2024, and preliminary data suggest continued improvement in 2025. Hospitals' all-payer operating margin increased to 6.5 percent, a 1.3 percentage point increase from 2023, and preliminary data from eight large hospital systems suggest an increase in 2025. Other measures of hospitals' access to capital also improved or remained positive in both 2024 and 2025: Hospitals' investment income increased, and investors' risk premium on hospital bonds decreased slightly.

FFS Medicare payments and providers' costs—In FY 2024, FFS Medicare payments for inpatient and outpatient services continued to be well below hospitals' costs in aggregate but near hospitals' costs for the median relatively efficient hospital, and we project hospitals' FFS Medicare margin to increase slightly in 2026. In FY 2024, hospitals' FFS Medicare margin was –12.1 percent,

a 0.5 percentage point increase from 2023. However, among hospitals we identified as "relatively efficient"—those that achieved relatively low costs while maintaining relatively high quality during a baseline period—the median FFS Medicare margin was –1 percent, an increase from last year (–2 percent). For 2026, we project that hospitals' FFS Medicare margin will increase to about –10 percent and to 1 percent for the median relatively efficient hospital.

Medicare Safety-Net Index—The Commission-developed Medicare Safety-Net Index (MSNI) continued to be a better predictor of hospitals' all-payer operating margin than the current disproportionate-share (DSH) metric. While hospitals with higher values on the MSNI generally already have higher FFS Medicare margins (since most receive some additional FFS Medicare DSH and uncompensated-care payments), the MSNI would better target limited Medicare resources toward those hospitals that are key sources of care for low-income Medicare beneficiaries and are facing financial challenges. Our recommended MSNI implementation would include direct payments to hospitals for both their FFS and Medicare Advantage patients. (Our definition of "Medicare safety-net hospital" used for the purpose of supporting hospitals that are key sources of care for low-income Medicare beneficiaries is Medicare-centric by design; safety-net definitions used for other purposes by Medicaid and other payers would likely differ. For example, DSH computations could still be made to determine eligibility for certain programs, such as the 340B program.)

How should FFS Medicare payments change in 2027?

Because some of our payment indicators are intertwined between the IPPS and OPPS and there are analytic challenges to calculating FFS Medicare margins separately for services paid under the IPPS and OPPS, we make a single update recommendation. The current-law updates to payment rates for 2027 will not be finalized until summer 2026, but CMS's current forecasts and other required updates are currently projected to increase the IPPS and OPPS base rates by over 2 percent.

Based on our assessment of the payment-adequacy indicators listed above, the Commission recommends that the Congress (1) for 2027, update the 2026 Medicare base payment rates for general acute care hospitals by the amount reflected in current law and (2) implement the MSNI described in our March 2023 report, with $1 billion added to the MSNI pool.

Mandated report: Rural emergency hospitals

The Consolidated Appropriations Act (CAA), 2021, created a new rural emergency hospital (REH) designation, effective January 2023, and requires the Commission to report annually on payments to REHs. During CY 2024, there were 38 REHs, and they received over $100 million in enhanced Medicare payments, almost all of which were from fixed monthly payments intended to help to cover REHs' standby costs.

Medicare should move toward site-neutral payments

The Commission has twice recommended more closely aligning Medicare payment rates for selected services that are safe and appropriate to provide in all settings when doing so does not pose a risk to beneficiary access to care. In CY 2017, CMS began site-neutral payments for hospital outpatient services provided in certain off-campus locations and expanded the scope of these policies in 2019. In 2024, site-neutral policies reduced payments for FFS Medicare outpatient services provided at hospital off-campus locations by $1.2 billion. CMS expanded the scope of site-neutral payments in 2026, which CMS estimated will result in an additional $290 million in savings. However, there remain additional opportunities to expand site-neutral policies to align Medicare's payment rates for similar services across ambulatory settings. Two possibilities that build on CMS's current site-neutral policies include implementing site-neutral payments for clinic services provided in on-campus locations and further expanding site-neutral payments for hospital outpatient services in off-campus locations. Another possible direction for site-neutral payments can be found in our June 2023 recommendation, which aligns payment rates for services across hospital outpatient departments, ambulatory surgical centers, and/or freestanding offices when safe and appropriate and when doing so does not pose a risk to access. ■

As required by law, the Commission annually makes payment-update recommendations for providers paid under Medicare's traditional fee-for-service (FFS) payment systems. Such providers include general acute care hospitals, which primarily provide inpatient medical and surgical care to patients needing an overnight stay and provide outpatient services, including procedures, tests, evaluation and management services, and emergency care.[1]

Background

FFS Medicare makes two payments for hospital inpatient and outpatient services: one to the facility, generally through the inpatient prospective payment systems (IPPS) and the outpatient prospective payment system (OPPS), and the other to the clinicians for their professional services.[2] As with all FFS Medicare payment rates, IPPS and OPPS payment rates have important implications beyond FFS Medicare because Medicare Advantage (MA) and other payers rely upon FFS payment rates in setting their rates (see Chapter 2).

In setting these prospective rates per inpatient stay or primary outpatient service, CMS adjusts IPPS and OPPS national base payment rates for factors generally outside of hospitals' control, such as regional wage rates and patient characteristics. Both the IPPS and OPPS also include other payments not tied to the base payment rates: The IPPS includes uncompensated-care payments (based in part on each hospital's share of uncompensated-care costs), and the OPPS sets payment rates for separately payable drugs and other inputs (based on manufacturers' average sales price for drugs and on hospitals' costs for most other separately payable inputs). (FFS Medicare payments for all drugs and other inputs provided in the inpatient setting and for some drugs and other inputs provided in outpatient settings are bundled with the payment for the inpatient stay or primary outpatient service.[3])

In 2024, the FFS Medicare program and its beneficiaries spent $185 billion on IPPS and OPPS services at general acute care hospitals (Table 3-1). Over $110 billion of this spending was on 6.5 million inpatient stays, including nearly $6 billion in uncompensated-care payments under the IPPS. The other nearly $75 billion

TABLE 3–1

In 2024, FFS Medicare and its beneficiaries spent $185 billion on IPPS and OPPS services at general acute care hospitals

	Medicare payment system	
	IPPS	**OPPS**
Number of hospitals	3,095	3,060
Number of users (in millions)	4.2	15.8
Volume of services (in millions)	6.5	70.8
Total Medicare payments (in billions)	$110.5	$74.8
Payments for base-rate-covered services (in billions)	$104.6	$52.7
Other payments (in billions)	$5.9	$22.0
Beneficiary cost-sharing liability as share of total Medicare payments	7%	17%

Note: FFS (fee-for-service), IPPS (inpatient prospective payment systems), OPPS (outpatient prospective payment system). "General acute care hospitals" refers to hospitals paid under the IPPS (in the case of the IPPS) or Subsection (d) hospitals paid under the OPPS (in the case of the OPPS). "Number of hospitals" is the count of unique provider numbers that provided at least one IPPS or OPPS service; the number of IPPS hospitals is higher than the number of OPPS hospitals primarily because Indian Health Service hospitals are paid under the IPPS but not OPPS. "Volume of services" refers to inpatient stays (in the case of the IPPS) and hospital outpatient encounters (in the case of the OPPS) where Medicare was the primary payer. "Total Medicare payments" includes the program amount and beneficiary cost-sharing liability (which may be paid by the beneficiary or the beneficiary's supplemental insurance, or it may become hospital bad debt). "Other payments" refers to uncompensated-care payments (in the case of the IPPS) and to payments for separately payable drugs, devices, blood products, and brachytherapy sources (in the case of the OPPS). The given year (2024) refers to fiscal year for inpatient services and calendar year for outpatient services, consistent with when CMS updates these payment systems.

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

was for 70.8 million hospital outpatient encounters, including $22 billion for separately payable drugs and other separately payable inputs under the OPPS. FFS beneficiaries' cost-sharing liability totaled 7 percent of IPPS payments and 17 percent of OPPS payments. Over 20 percent of all acute inpatient stays (and days) at hospitals were FFS Medicare stays paid under the IPPS, and 17 percent of all hospital outpatient services (as measured by charges) were FFS Medicare services paid under the OPPS. Together, IPPS and OPPS payments accounted for about 13 percent of hospitals' operating revenue across all service lines (data not shown).[4]

Are FFS Medicare payments adequate in 2026?

Based on the most recently available data, indicators of the adequacy of IPPS and OPPS payments have been mixed. FFS Medicare beneficiaries maintained good access to hospital inpatient and outpatient services: Hospitals continued to have available capacity in aggregate, the supply of hospitals was relatively steady in both fiscal year (FY) 2024 and FY 2025, and FFS Medicare beneficiaries' inpatient stays and hospital outpatient encounters per beneficiary increased. In addition, hospitals' access to capital improved: Hospitals' all-payer operating margin increased to 6.5 percent in 2024, and preliminary data suggest a continued increase in 2025. However, the quality of hospital care was mixed: FFS Medicare beneficiaries' risk-adjusted mortality rate improved in 2024, but their readmission rate worsened, and most patient-experience measures remained stable. Hospitals' FFS Medicare margin remained negative but increased to –12.1 percent in aggregate and to –1 percent for the median relatively efficient hospital. For 2026, we project hospitals' FFS Medicare margin to increase to about –10 percent in aggregate and to 1 percent for the median relatively efficient hospital.

Beneficiaries maintained good access to hospital inpatient and outpatient services in 2024

Indicators of hospital capacity and supply and FFS Medicare beneficiaries' use of services suggest that FFS Medicare beneficiaries maintained good access to hospital inpatient and outpatient services. In FY 2024, hospitals continued to have available capacity in aggregate. The supply of hospitals was also relatively steady in both FY 2024 and FY 2025. Looking more specifically at FFS Medicare beneficiaries, the number of inpatient stays per beneficiary and hospital outpatient encounters per beneficiary both increased.

Hospitals continued to have available capacity

In FY 2024 hospitals continued to have available inpatient capacity in aggregate (Table 3-2). The number of inpatient beds remained relatively stable at about 674,000 in FY 2024. Similarly, hospitals' occupancy rate remained relatively stable at about 71 percent, indicating available inpatient capacity in aggregate. However, as in past years, there was significant variation within these aggregates, with some hospitals having substantially higher available capacity while others faced capacity constraints. For example, in FY 2024, 5 percent of hospitals had an occupancy rate under 13 percent while another 5 percent had an occupancy rate over 90 percent; this variation was similar to FY 2023 (data not shown).

Hospital outpatient capacity is harder to measure, but two measures of timely and effective care suggest hospitals continued to have available emergency department (ED) capacity (Table 3-2). The median time from patients' ED arrival to departure remained stable at about 150 minutes in FY 2024. While the median time is 15 minutes higher than in 2019, it still suggests available ED capacity, especially as the median share of patients who left the ED without being seen has remained steady at 1 percent to 2 percent from calendar year (CY) 2019 through CY 2023 (the most recent year of data currently available for that measure).

Overall hospital employment also continued to increase, reaching 4.8 million full-time-equivalent staff in FY 2024 (Table 3-2).

Supply of hospitals held relatively stable, though slightly more hospitals closed than opened

Since 2021 the supply of hospitals has been relatively stable, with about 4,530 unique provider numbers in FY 2024 (Table 3-3, p. 70). Most hospitals continued to be short-term acute care hospitals, virtually all of which were paid by FFS Medicare under the IPPS and OPPS.[5] However, FFS Medicare beneficiaries also received care at 1,370 critical access hospitals, which are hospitals

TABLE 3–2 **In FY 2024, hospitals continued to have available capacity in aggregate**

	2019	2020	2021	2022	2023	2024
Beds (in thousands)	675	674	677	675	671	674
Occupancy rate	67%	64%	68%	70%	70%	71%
Median time from ED arrival to departure (in minutes)	135	137	147	153	152	150
Median share of patients that left ED without being seen	1%	1%	2%	2%	1%	N/A
Employment (in millions)	4.5	4.5	4.5	4.6	4.6	4.8

Note: FY (fiscal year), ED (emergency department), N/A (not available). "Hospitals" refers to Subsection (d) hospitals as well as critical access hospitals and short-term acute care hospitals in territories. "Beds" refers to inpatient beds, regardless of what share of the time the bed was used for observation or swing-bed services or the share of time the bed was staffed. "Occupancy rate" refers to the share of bed days that were occupied by a patient. "Median time from ED arrival to departure" refers to the median across hospitals' reported median time that patients spent from ED arrival to ED departure for patients who were discharged from the ED. "Median share of patients that left the ED without being seen" is the median across hospitals' reported median share of patients who left the ED without being seen by qualified medical personnel (physician, physician's assistant, or advanced practice nurse) and is reported on a calendar year basis; 2024 data for this measure were not available at the time of our analysis. "Employment" refers to the average number of paid full-time-equivalent employees over hospitals' cost-reporting periods. To account for hospitals that had not yet submitted 2024 cost reports as of the time of our analysis, missing 2024 data were imputed for employment and beds. Data for ED measures include hospitals with a complete cost report in a prior year.

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

with 25 or fewer beds that are generally located in rural areas and paid based on their costs. Additionally, since 2023, FFS Medicare beneficiaries also receive care at a new type of hospital called a "rural emergency hospital" (REH). REHs are required to provide 24/7 ED services but are prohibited from furnishing acute inpatient care (see section at the end of this chapter on REHs, pp. 87–88). The majority of hospitals continued to be located in urban areas and be nonprofit, and the number of nonprofit hospitals has continued to increase.

However, changes in the count of hospital provider numbers that provided FFS Medicare inpatient and outpatient services is an imperfect measure of changes in beneficiary access. For example, decreases in provider numbers can also reflect mergers and acquisitions without any change in the locations where beneficiaries can receive hospital services. On the other hand, hospitals opening new campuses can result in an increase in access without any change in the count of hospital provider numbers.

We therefore also look at changes in unique hospital locations where beneficiaries can receive hospital inpatient and emergency and other outpatient care; by this metric, eight more hospitals closed than opened in both FY 2024 and FY 2025 (Table 3-4, p. 71). In FY 2024, 5 hospitals opened at some point in the year while 13 closed. Of the five hospitals that opened, four were in metropolitan areas and three were for-profit facilities. Of the 13 hospitals that closed, 7 were in metropolitan areas and 8 were nonprofit facilities. In FY 2025, an additional 10 hospitals opened and 18 closed. Of the 10 hospitals that opened, 9 were in metropolitan areas, none were critical access hospitals, and the distance to the nearest hospital ranged from 1 mile to about 32 miles (some data not shown). Of the 18 hospitals that closed, 14 were located in metropolitan areas, 5 had fewer than 50 beds, and none were critical access hospitals. In addition, 13 of the closures were in 12 hospital systems. The average distance to the next-nearest hospital was 11 miles; three rural closures were at least 25 miles from the next hospital. The ability of hospitals to transition to REHs has likely prevented a number of rural hospital closures since 2023. Among the three rural nonmicropolitan hospitals that closed in FY 2025 (all of which were at least 25 miles from the next hospital), one is working to reopen as an REH, and the other two were not eligible to become an REH because they were not open in December 2020 (a condition for REH eligibility).

TABLE 3–3

In FY 2024, the supply of hospitals held relatively stable

	Unique provider numbers (rounded to nearest 10)						Average annual percent change	
Hospital category	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2019–2023**	**2023–2024**
All	4,620	4,590	4,550	4,550	4,550	4,530	–0.4%	–0.6%
Type								
Short-term acute care	3,280	3,230	3,210	3,200	3,170	3,120	–0.8	–1.7
Critical access	1,350	1,350	1,350	1,350	1,360	1,370	0.2	0.7
Rural emergency	0	0	0	0	20*	40*	N/A	100*
Geography								
Metropolitan	2,780	2,750	2,740	2,730	2,720	2,710	–0.5	–0.4
Micropolitan	820	810	800	800	800	790	–0.5	–0.9
Other rural	1,030	1,020	1,020	1,020	1,040	1,020	0.1	–1.0
Ownership								
For profit	890	860	840	820	800	760	–2.7	–4.6
Nonprofit	2,720	2,710	2,720	2,740	2,750	2,770	0.3	0.7
Government	1,020	1,010	1,000	990	1,000	990	–0.3	–1.1

Note: FY (fiscal year), N/A (not applicable). "Supply 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. "Metropolitan" (urban) counties contain an urban cluster of 50,000 or more people; "micropolitan" rural counties contain a cluster of 10,000 to 50,000 people; all other counties are classified as "other rural." Components may not sum to totals due to rounding. Percentage changes were calculated on unrounded data.
* For unrounded count of REHs on a calendar year basis, see p. 88.

Source: MedPAC analysis of Medicare Provider Analysis and Review, hospital outpatient claims, hospital cost-report, Provider of Services, and census geographic data.

According to hospital press releases and news reports, FFS Medicare payment rates did not appear to be the main contributor to the financial difficulties of the hospitals that closed in 2024 or 2025. Rather, many hospitals that closed cited other financial reasons; low patient volume was the most common.[6]

FFS Medicare beneficiaries' inpatient services per capita increased

In FY 2024, FFS Medicare beneficiaries had 208.3 inpatient stays per 1,000 beneficiaries, an increase of 1.5 percent from 2023 (Table 3-5). (In contrast, the number of inpatient stays by FFS Medicare beneficiaries declined 0.4 percent in FY 2024 because the number of FFS Medicare beneficiaries decreased by more than the number stays per beneficiary increased.) Despite the increase in 2024, the number of inpatient stays per capita remained nearly 15 percent below the level in 2019. About one-quarter of the decline in inpatient stays per capita since 2019 was from the shift of knee and hip replacements from inpatient to outpatient settings after these services were removed from the inpatient-only list in 2018 and 2020, respectively (data not shown).

TABLE 3–4

In both FY 2024 and FY 2025, slightly more hospitals closed than opened

	2019	2020	2021	2022	2023	2024	2025
Net openings	–31	–8	1	2	–9	–8	–8
Openings	12	16	11	17	7	5	10
Metropolitan	12	14	10	13	5	4	9
Rural micropolitan	0	1	0	2	0	1	0
Other rural	0	1	1	2	2	0	1
Closures	43	24	10	15	16	13	18
Metropolitan	25	13	7	10	9	7	14
Rural micropolitan	4	6	1	5	4	1	1
Other rural	14	5	2	0	3	5	3

Note: FY (fiscal year). "Hospital" refers to a Subsection (d), critical access, or rural emergency hospital. "Openings" refers to a new location that provided inpatient and outpatient services, while "closures" refers to a hospital location that ceased inpatient services and did not convert to a rural emergency hospital. "Metropolitan" (urban) counties contain an urban cluster of 50,000 or more people; "micropolitan" rural counties contain a cluster of 10,000 to 50,000 people; all other counties are classified as "other rural." The counts of openings and closures do not include the conversion of a short-term acute care hospital to or from a critical access hospital or rural emergency hospital, the relocation of inpatient services from one hospital to another under common ownership within 10 miles, or hospitals that both opened and closed within a five-year period. The number of hospital openings and closures in a given year can change from prior publications as hospitals reopen and newer data become available.

Source: MedPAC analysis of Provider of Services and census geographic data and internet searches.

The majority of the growth in FFS Medicare inpatient stays per capita in FY 2024 was from stays for infectious and parasitic diseases and for diseases of the kidney and urinary tracts (data not shown). In particular, stays for blood poisoning (septicemia) continued to be the most common type of inpatient patient stay and disproportionately increased relative to other types of stays. Inpatient stays for diseases of the circulatory system continued to be the most common major diagnostic category, but its share of volume declined in 2024, led by a decline in inpatient stays for heart failure. The decrease in the average length of stay in 2024 was driven by a decline in the share of inpatient stays longer than one week (from 18.8 percent of stays in 2023 down to 18.2 percent of stays in 2024).

TABLE 3–5

FFS Medicare beneficiaries' hospital inpatient stays per capita increased in FY 2024

							Average annual percent change	
	2019	2020	2021	2022	2023	2024	2019–2023	2023–2024
Inpatient stays (millions)	9.2	7.9	7.4	7.0	6.9	6.9	–6.9%	–0.4%
Inpatient stays per 1,000 beneficiaries	244.5	213.6	207.7	202.2	205.2	208.3	–4.3	1.5
Average length of stay (days)	4.9	5.1	5.5	5.6	5.3	5.2	1.9	–2.1

Note: FFS (fee-for-service), FY (fiscal year). "Hospital" refers to Subsection (d) hospitals as well as critical access hospitals and short-term acute care hospitals in territories. "Inpatient stays per 1,000 beneficiaries" refers to FFS Medicare inpatient stays divided by all FFS Medicare beneficiaries who resided in the U.S. and had Part A. Percentage changes were calculated on unrounded data.

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

TABLE 3–6 **FFS Medicare beneficiaries' hospital outpatient encounters increased in CY 2024**

	2019	2020	2021	2022	2023	2024	Average annual percent change 2019–2023	Average annual percent change 2023–2024
Outpatient encounters (millions)	93.7	75.7	91.5	82.1	81.0	82.2	–3.6%	1.5%
Outpatient encounters per beneficiary	2.9	2.4	3.0	2.8	2.9	3.0	0.1	4.0

Note: FFS (fee-for-service), CY (calendar year). "Hospital" refers to Subsection (d) hospitals as well as critical access hospitals and short-term acute care hospitals in territories. "Outpatient encounters" are unique combinations of claims, beneficiaries, and providers, where the claim included at least one outpatient-prospective-payment-system (OPPS)-equivalent service. "Outpatient encounters per beneficiary" refers to FFS Medicare outpatient encounters divided by all FFS Medicare beneficiaries who resided in the U.S. and had Part B. Percentage changes were calculated on unrounded data.

Source: MedPAC analysis of hospital outpatient claims, OPPS final rule, and Common Medicare Environment data.

FFS Medicare inpatient stays continued to be predominantly provided by urban hospitals and nonprofit hospitals, and the share of volume provided by these hospitals continued to slowly increase. In FY 2024, nearly 90 percent of FFS Medicare inpatient stays were provided by hospitals located in urban areas (up from 88 percent in 2019). Similarly, in FY 2024, nearly 75 percent of FFS Medicare inpatient stays were provided by nonprofit hospitals (up from 72 percent in 2019).

FFS Medicare beneficiaries' hospital outpatient encounters per capita increased

In CY 2024, FFS Medicare beneficiaries had 3.0 hospital outpatient encounters per beneficiary, an increase of 4.0 percent from 2023 (Table 3-6). (The number of outpatient encounters by FFS Medicare beneficiaries increased by a smaller amount, 1.5 percent because the number of FFS Medicare beneficiaries declined.) In contrast to inpatient stays, the number of outpatient encounters per capita quickly rebounded from the decline in 2020 and in each of 2021 through 2024 was in line with the 2019 level (within 0.1 encounters per beneficiary).

The majority of the growth in FFS Medicare hospital outpatient encounters per capita in CY 2024 was from an increase in evaluation and management services. In particular, clinic services continued to be the most common primary service, and they disproportionately increased relative to other outpatient services. However, all other categories of hospital outpatient services also increased in CY 2024, led by imaging and tests. There was also continued growth in outpatient services per encounter, driven by growth in ancillary services that are always packaged under the OPPS, such as X-rays.

FFS Medicare hospital outpatient encounters continued to be predominantly provided by urban hospitals and nonprofit hospitals, and the share of volume provided at these hospitals continued to slowly increase. In CY 2024, 83 percent of FFS Medicare hospital outpatient encounters were provided by hospitals located in urban areas (up from 82 percent in 2019). Similarly, in CY 2024, 77 percent of FFS Medicare hospital outpatient encounters were provided by nonprofit hospitals (up from 73 percent in 2019).

A growing share of FFS Medicare hospital outpatient encounters occur in off-campus provider-based departments or off-campus emergency rooms—defined as locations not on or within 250 yards of a hospital campus or remote location of a hospital. In CY 2024, nearly 20 percent of FFS Medicare hospital outpatient encounters were provided at off-campus locations (up from 17 percent in 2019).

Quality of hospital care in 2024 was mixed

In FY 2024, the quality of hospital care was mixed relative to 2023. FFS Medicare beneficiaries' risk-

TABLE 3–7

FFS Medicare beneficiaries' risk-adjusted hospital mortality rate improved in FY 2024 and relative to prepandemic level

							Percentage point change	
	2019	2020	2021	2022	2023	2024	2019–2023	2023–2024
Risk adjusted	7.9%	8.4%	8.4%	7.9%	7.6%	7.4%	–0.3	–0.2
Unadjusted	8.2	9.8	11.3	10.6	9.4	9.1	1.2	–0.3

Note: FFS (fee-for-service) FY (fiscal year). "Hospital" refers to hospitals paid under the inpatient prospective payment systems. "Mortality rate" refers to the share of inpatient stays that result in death during or within 30 days after the inpatient stay.

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

adjusted hospital mortality rate improved, while their risk-adjusted readmission rate worsened. Most patient-experience scores remained the same.

Hospital mortality rate improved

Mortality during or soon after a hospital stay (e.g., within 30 days) is an outcome measure that provides information about important aspects of hospital care, such as prevention of and response to complications, emphasis on patient safety, and the timeliness of care. It also encourages hospitals to effectively discharge plan and coordinate with post-acute care providers. Risk-adjusted mortality can be determined with a high degree of accuracy through claims, reducing administrative burden on providers.

In FY 2024, FFS Medicare beneficiaries' risk-adjusted hospital mortality rate—defined as the share of inpatient stays that result in death during or within 30 days after the inpatient stay—improved to 7.4 percent, 0.2 percentage points lower than the level in 2023 and 0.5 percentage points lower than in 2019 (Table 3-7). Both unadjusted and risk-adjusted hospital mortality rates for FFS Medicare beneficiaries have improved since 2021.

FFS Medicare beneficiaries' mortality rate continued to vary across hospital categories. In FY 2024, hospitals in rural nonmicropolitan areas continued to have a higher risk-adjusted mortality rate (9.2 percent) compared with hospitals in rural micropolitan (8.1 percent) and hospitals in urban areas (7.3 percent) (data not shown). When stratifying results by bed size, smaller hospitals (those with fewer than 100 beds) also continued to have the highest risk-adjusted mortality rate (7.8 percent), while larger hospitals (those with more than 250 beds) had the lowest risk-adjusted mortality rate (7.3 percent) in 2024. In 2024, for-profit hospitals continued to have higher risk-adjusted mortality rates (7.6 percent) than nonprofit hospitals (7.3 percent), and major teaching hospitals continued to have higher risk-adjusted mortality rates (7.5 percent) than nonteaching hospitals (7.1 percent).

Hospital-readmission rate worsened

Acute, unplanned hospital readmissions are disruptive to patients and caregivers, costly to the health care system, and put patients at additional risk of health care–associated infections and complications. Such readmissions can also be a major source of patient and family stress and may contribute substantially to loss of functional ability, particularly in older adults. Measuring hospitals' readmission rates holds hospitals accountable for ensuring that beneficiaries have the discharge information they need and encourages hospitals to coordinate with other providers. Like the mortality measure, the readmission measure is important to and understandable by beneficiaries and can be calculated through claims data, reducing administrative burden on providers.

TABLE 3–8

FFS Medicare beneficiaries' risk-adjusted hospital readmission rate worsened in FY 2024 but remained better than prepandemic level

							Percentage point change	
	2019	2020	2021	2022	2023	2024	2019–2023	2023–2024
Risk adjusted	15.5%	15.0%	14.7%	14.6%	15.1%	15.4%	–0.4	0.3
Unadjusted	15.7	15.5	15.8	15.6	15.7	15.9	0.0	0.2

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

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

In FY 2024, FFS Medicare beneficiaries' risk-adjusted hospital-readmission rate worsened (increased) by 0.3 percentage points to 15.4 percent; however, it remained 0.1 percentage points lower than in 2019 (Table 3-8). (For information on our risk-adjustment methodology, see Chapter 1 of MedPAC's June 2018 report to the Congress.) The unadjusted readmission rate increased by 0.2 percentage points from 2023 to 2024.

FFS Medicare beneficiaries' readmission rate continued to vary across hospital categories. In 2024, hospitals in urban areas continued to have a higher risk-adjusted readmission rate (15.5 percent) compared with hospitals in rural micropolitan and nonmicropolitan areas (14.7 percent) (data not shown). When stratifying results by bed size, larger hospitals continued to have the highest risk-adjusted readmission rates (15.6 percent), while small hospitals had the lowest risk-adjusted readmission rate (14.4 percent). In 2024, for-profit hospitals continued to have higher risk-adjusted readmission rates (16.1 percent) than nonprofit hospitals (15.3 percent), and nonteaching hospitals continued to have higher risk-adjusted readmission rates (16.0 percent) than major teaching hospitals (15.1 percent).

Most patient-experience measures remained stable

Hospitals collect Hospital Consumer Assessment of Healthcare Providers and Systems (H–CAHPS) surveys from a sample of admitted patients, which CMS uses to calculate results for 10 measures of patient experience included in hospitals' overall ratings. The H–CAHPS measures key components of quality by assessing whether something that should happen during a hospital stay (such as clear communication) actually happened or how often it happened.

Almost all hospital patient-experience measures remained stable from FY 2023 to FY 2024, but performance remained at least 1 percentage point below prepandemic levels for almost all measures (Table 3-9). In FY 2024, 72 percent of surveyed patients rated their overall hospital experience a 9 or 10 on a 10-point scale, consistent with FY 2023 but still a percentage point below 2019.[7] Receipt of discharge information had the highest score: 86 percent of surveyed patients answered with the most positive response. The care-transition measure continued to get the lowest score, with only 52 percent of surveyed patients "strongly agreeing" that they understood their care plan when they left the hospital.

Hospitals' patient-experience performance continued to vary across hospital categories. Hospitals in rural areas have better (higher) H–CAHPS results than hospitals in urban areas (HCAHPS Online 2025). For example, 75 percent of surveyed patients who received care in a rural hospital rated their overall hospital experience a 9 or 10, while 70 percent of surveyed patients who received care in an urban

TABLE 3–9

Most hospital patient-experience measures remained the same in FY 2024 but below prepandemic levels

H–CAHPS measure	2019	2020	2021	2022	2023	2024	Percentage point change 2019–2023	Percentage point change 2023–2024
Share of patients rating the hospital a 9 or 10 out of 10	73%	72%	72%	70%	72%	72%	–1	0
Share of patients who would definitely recommend the hospital	72	71	71	69	70	70	–2	0
Share of patients giving top ratings for:								
Communication with nurses	81	80	80	79	80	80	–1	0
Communication with doctors	82	81	80	79	80	80	–2	0
Responsiveness of hospital staff	70	67	67	65	66	66	–4	0
Communication about medicines	66	63	63	61	62	62	–4	0
Cleanliness of hospital environment	76	73	73	72	73	74	–3	1
Quietness of hospital environment	62	63	63	62	62	62	0	0
Understanding their care when they left the hospital (care transitions)	54	52	52	51	52	52	–2	0
Share of patients who received discharge information	87	86	86	86	86	86	–1	0

Note: FY (fiscal year). "Patient-experience measures" refers to measures in the Hospital Consumer Assessment of Healthcare Providers and Systems (H–CAHPS) survey, a standardized 29-item survey of patients' evaluations of hospital care. The survey items are combined to calculate measures of patient experience for each hospital. The H–CAHPS measures included in the table are "top box," or the most positive, response to H–CAHPS survey items. Each year's results are based on a sample of surveys of hospitals' patients from October to September. Results in 2020 include surveys only from patients discharged July to December 2020 rather than the customary full year. These results encompass H–CAHPS survey responses from inpatient prospective payment systems hospitals (that are penalized if they do not participate) as well as critical access hospitals, cancer hospitals, and Veterans Affairs or Department of Defense hospitals that voluntarily participate. National H–CAHPS response rates from 2019 to 2024 ranged from 23 percent to 26 percent.

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

hospital rated their overall hospital experience highly (data not shown). Nonprofit hospitals have modestly higher H–CAHPS results than for-profit hospitals on most measures, other than the respective measures of cleanliness and quietness in the hospital. In FY 2024, smaller hospitals (based on number of beds) consistently had better H–CAHPS results than larger hospitals, as did nonteaching hospitals (compared with major teaching hospitals).

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

Medicare should move toward a single value-based incentive payment program

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—that is, the hospital value

TABLE 3–10

Hospitals' all-payer operating margin increased across all hospital categories in FY 2024, though substantial variation persisted

Margin type and hospital category	2019	2020	2021	2022	2023	2024
Excluding relief funds						
All	6.7%	2.0%	7.4%	1.9%	4.9%	6.4%
Ownership						
For profit	12.3	10.7	14.3	12.4	13.3	14.5
Nonprofit	6.2	1.2	6.9	0.1	4.1	5.8
Geography						
Metropolitan	6.8	2.1	7.5	2.1	5.1	6.5
Micropolitan	5.0	1.2	6.4	–0.7	2.5	5.1
Other rural	1.3	–1.8	2.9	–2.5	–1.3	1.3
Including relief funds						
All	6.7%	5.5%	8.8%	2.7%	5.2%	6.5%
Ownership						
For profit	12.3	13.0	15.4	12.8	13.5	14.5
Nonprofit	6.2	4.8	8.3	0.9	4.4	5.9
Geography						
Metropolitan	6.8	5.5	8.8	2.8	5.4	6.6
Micropolitan	5.0	5.7	8.8	1.2	2.9	5.3
Other rural	1.3	3.9	7.8	0.9	–0.7	1.5

Note: FY (fiscal year). "Hospitals" refers to hospitals paid under the inpatient prospective payment systems. "All-payer operating margin" excludes reported investment and donation income. "Relief funds" refers to federal or other coronavirus relief funds. "Metropolitan" (urban) counties contain an urban cluster of 50,000 or more people; "micropolitan" rural counties contain a cluster of 10,000 to 50,000 people; all other counties are classified as "other rural." Government-owned hospitals operate in a different financial context from other hospitals, so their margin is not necessarily comparable; therefore, data for government-owned hospitals are not reported separately or included in the ownership rows (but are included in other rows). Results differ from those published last year in part because of newer data.

Source: MedPAC analysis of hospital cost-report and census geographic data.

incentive program (HVIP)—which balances rewards and penalties and has the potential to drive further improvement in hospital quality (Medicare Payment Advisory Commission 2019). A single HVIP would also reduce complexity and overlap between existing Medicare hospital quality programs and would reduce the reporting burden for providers.

Hospitals' access to capital improved in 2024

Hospitals access to capital—which can be used to maintain, modernize, and expand their facilities—improved in FY 2024, and preliminary data suggest continued improvement in 2025. Other measures of hospitals' access to capital also improved or remained positive in both FY 2024 and FY 2025.

Hospitals' all-payer margin increased

Hospitals' all-payer operating margin (including coronavirus relief funds) increased 1.3 percentage points in FY 2024, to 6.5 percent, indicating that hospitals had net operating profits that could be used for hospital capital projects (Table 3-10).[8] (See the text box in Chapter 2 on the different margin measures MedPAC uses to assess provider profitability.) The 6.5 percent operating margin in 2024 was near the level in the immediate prepandemic period (6.7 percent in 2019). As in prior years, there was significant variation within this aggregate. In FY 2024, a quarter of hospitals

had an all-payer operating margin below –2 percent, while another quarter had a margin above 12 percent; both of these levels were about 2 percentage points higher than in 2023 (data not shown).

Several factors contributed to the 1.3 percentage point increase in hospitals' all-payer operating margin in FY 2024, including a one-time increase in revenue and slower growth in hospitals' labor costs. A subset of hospitals received $9 billion in 340B remedy payments from Medicare in 2024 to offset lower Medicare payment rates for drugs obtained through the 340B Drug Pricing Program from CY 2018 to CY 2021; we estimate that about half of the increase in hospitals' operating margin in 2024 was from these one-time remedy payments. (The payment reduction to offset higher Medicare payments for nondrug services in CY 2018 through CY 2022 began in CY 2026 and so is not reflected in hospitals' 2024 margin.) Another contributing factor to the increase in margin was slower growth in hospitals' labor costs in 2024 (less than 2 percent growth in 2024 vs. about 9 percent growth in 2023); this slower growth was driven by an $8 billion decrease in hospitals' spending on direct patient-care contract labor (a decline of about 25 percent from 2023). One partially offsetting factor putting downward pressure on hospitals' all-payer operating margin was a $0.8 billion decrease in coronavirus relief funds (from $3 billion in 2023 to $2.2 billion in 2024).

Hospitals' all-payer operating margin continued to vary across hospital categories (Table 3-10). For-profit hospitals' all-payer operating margin continued to be much higher than nonprofit hospitals' margin (14.5 percent vs. 5.9 percent, including relief funds). One factor contributing to for-profit hospitals' higher all-payer operating margin is their lower average hourly wage. The all-payer operating margin also continued to be higher at urban hospitals than at hospitals in rural nonmicropolitan areas (6.6 percent vs. 1.5 percent, respectively).

While cost reports were complete only through FY 2024, financial statements from large hospital systems suggest that hospitals' all-payer operating margin continued to gradually increase in FY 2025. The all-payer operating margin among three for-profit and five nonprofit hospital systems—which together represented over 20 percent of hospitals—increased by about 1 percentage point in 2025. Among the three largest for-profit health systems, the increase in all-payer operating margin varied from a 0.5 percentage point increase to a 2.5 percentage point increase (Community Health Systems 2025, HCA Healthcare 2025, Tenet Health 2025). The weighted average operating margins for these three for-profit systems was 12.8 percent during the first nine months of 2025. To explain what drove their improved margin, these for-profit systems cited reasons such as higher patient volume, increased payment rates, higher supplemental revenues, and lower contract-labor costs. Among the five selected large nonprofit hospital systems, the all-payer operating margin increased by about 1 percentage point in aggregate from July 30, 2024, to July 30, 2025 (the most recent period available), though again the experience of the individual systems varied (ranging from a 2.0 percentage point decrease to a 3.3 percentage point increase) (Advocate Health Care 2025, Ascension 2025, CommonSpirit 2025, Providence 2025, Trinity Health 2025). On a weighted average basis, these nonprofit systems had an operating profit margin of 0.3 percent during the period ending June 30, 2025. To explain what improved their margin, these systems primarily cited higher patient volume. To explain downward pressures on their margin, they cited inflation and the absence of the previous year's 340B settlement.

Other indicators of access to capital improved or remained positive

A second way hospitals access capital is through income from investments and donations, and such income increased in FY 2024. In FY 2024, hospitals reported over $18 billion in investment income on their cost reports, an increase of nearly 40 percent, consistent with the U.S. stock market surging to record highs. Hospitals also reported $2 billion in donation income, an increase of 3 percent. Together these components led hospitals' all-payer total margin to increase 1.5 percentage points (more than their operating margin), up to 7.9 percent. (See the text box in Chapter 2 on the different margin measures MedPAC uses to assess provider profitability.) Moreover, despite some volatility, in FY 2025, the U.S. stock market rose to even higher levels, suggesting hospitals' investment income further increased in 2025.

A third way hospitals access capital is by issuing bonds, and hospitals' borrowing costs held stable in FY 2024

and FY 2025 while investors' risk premium on hospitals decreased, suggesting that investors see little risk of hospital defaults on their bonds (relative to the U.S. government). In FY 2024, hospitals' borrowing costs held stable: The yield on hospital municipal bonds remained about 4.4 percent on average in each of FY 2023, FY 2024, and FY 2025 (S&P Global 2025). Over this same period, the spread between hospitals' borrowing costs and borrowing costs in the general market declined slightly—falling from an average of 0.6 percentage points above the yield of 10-year treasury bonds in 2023 to about 0.2 percentage points in 2024 and 0.1 percentage points in 2025.

Hospital mergers and acquisitions also continued in FY 2024 and FY 2025, indicating that investors—including hospital systems—continue to be willing to put capital into acquiring hospitals. About 50 hospital deals were announced in FY 2024 and 35 in FY 2025 (Irving Levin Associates LLC 2025).

FFS Medicare payments to hospitals were lower than hospitals' costs in aggregate but near hospitals' costs for the median relatively efficient hospital

In FY 2024, FFS Medicare payments for inpatient and outpatient services continued to be well below hospitals' costs in aggregate: Hospitals' FFS Medicare margin was −12.1 percent. However, among a group of hospitals that historically achieved relatively low costs while maintaining relatively high quality (a group we refer to as "relatively efficient" hospitals), the median FFS Medicare margin increased to −1 percent. For 2026, we project hospitals' FFS Medicare margin to increase to about −10 percent in aggregate and to 1 percent for the median relatively efficient hospital.

Hospitals' FFS Medicare margin increased but remained negative

In FY 2024, hospitals' FFS Medicare margin increased to −12.1 percent (Table 3-11). (See the text box in Chapter 2 on the different margin measures MedPAC uses to assess provider profitability.) Consistent with the methodological updates implemented last year (see March 2025 Chapter 3, pp. 79–80), hospitals' FFS Medicare margin is limited to a comparison of their payments and costs for services paid under the IPPS and OPPS.[9] We focus our discussion on hospitals' FFS Medicare margin exclusive of coronavirus relief funds; however, we also report a version including the FFS Medicare share of coronavirus relief funds because these funds were intended to cover lost revenue and higher costs—including those related to FFS Medicare patients. The 2024 FFS Medicare margin does not reflect the $9 billion in one-time payments that Medicare paid hospitals in 2024 to offset lower payments for drugs acquired through the 340B Drug Pricing Program from 2018 to 2021. If we had included this $9 billion, we estimate hospitals' 2024 FFS Medicare margin would have been −6.5 percent, or 5.4 percentage points higher. (The payment reduction to offset higher Medicare payments for nondrug services in CY 2018 through CY 2022 began in CY 2026 and so is not reflected in hospitals' 2024 margin.) As in prior years, there was significant variation within this aggregate. In FY 2024, a quarter of hospitals had a FFS Medicare margin below −21 percent, while another quarter had a margin above 3 percent (data not shown); both of these levels were slightly higher than in 2023. A higher FFS Medicare margin can reflect higher FFS Medicare payments and/or lower costs.

The 0.5 percentage point increase in hospitals' FFS Medicare margin in FY 2024 reflects several partially offsetting factors. Factors that put upward pressure on hospitals' FFS Medicare margin include growth in the share of FFS Medicare revenue from profitable separately payable drugs and the slower growth in hospitals' labor costs. These upward pressures on hospitals' FFS Medicare margin were partially offset by an about $1 billion decline in uncompensated-care payments. While there are analytic challenges to calculating FFS Medicare margins separately for services paid under the IPPS and OPPS, we approximate that, after excluding uncompensated-care payments, hospitals' FFS Medicare margin in 2024 was roughly similar for FFS Medicare patients across inpatient and outpatient settings.[10]

Hospitals' FFS Medicare margin continued to vary across hospital categories (Table 3-11). For-profit hospitals' FFS Medicare margin remained slightly positive and substantially higher than nonprofit hospitals' margin (1.1 percent vs. −13.4 percent, respectively), primarily because they have been able to constrain their labor and other costs (including having a lower average hourly wage). Rural hospitals' FFS Medicare margin also continued to exceed urban hospitals' margin, especially for rural hospitals in nonmicropolitan areas (−3.4 percent vs. −12.6 percent, respectively), primarily

TABLE 3–11

Hospitals' FFS Medicare margin increased in FY 2024 but remained substantially negative, and substantial variation across hospitals persisted

Margin type and hospital category	2019	2020	2021	2022	2023	2024
Excluding relief funds						
All	–7.9%	–12.2%	–8.2%	–12.8%	–12.6%	–12.1%
Ownership						
For profit	1.3	1.9	4.2	0.3	0.4	1.1
Nonprofit	–9.4	–14.6	–10.1	–14.6	–14.2	–13.4
Geography						
Metropolitan	–8.3	–12.7	–8.6	–13.0	–12.9	–12.6
Micropolitan	–4.5	–7.6	–4.6	–10.7	–10.4	–7.3
Other rural	0.3	–0.6	2.6	–3.6	–4.7	–3.4
Fiscal pressure						
Low pressure	–10.9	–14.7	–10.5	–14.7	–14.5	–13.9
Medium pressure	–4.5	–8.9	–4.9	–9.3	–9.6	–9.1
High pressure	3.7	0.9	2.4	–4.8	–5.6	–6.6
Including relief funds						
All	–7.9	–8.1	–6.2	–11.7	–12.2	–11.9
Ownership						
For profit	1.3	4.6	5.7	0.8	0.7	1.6
Nonprofit	–9.4	–10.1	–8.1	–13.4	–13.7	–13.2
Geography						
Metropolitan	–8.3	–8.7	–6.8	–12.1	–12.5	–12.3
Micropolitan	–4.5	–2.5	–1.4	–8.1	–9.8	–7.1
Other rural	0.3	5.4	8.0	0.6	–3.8	–3.1
Fiscal pressure						
Low pressure	–10.9	–11.1	–8.8	–13.8	–14.2	–13.7
Medium pressure	–4.5	–4.4	–2.7	–8.0	–9.1	–8.8
High pressure	3.7	6.9	5.8	–3.2	–4.8	–6.2

Note: FFS (fee-for-service), FY (fiscal year). "Hospitals" refers to hospitals paid under the inpatient prospective payment systems. "FFS Medicare margin" is limited to revenue and costs for services included under the inpatient or outpatient prospective payment systems, including uncompensated-care payments and revenue and costs of separately payable drugs, including any reported discounts to drug costs under the 340B Drug Pricing Program. The FFS Medicare margin does not include remedy payments hospitals received in 2024 to offset lower payments for 340B drugs acquired in 2018 through 2021; but it does include the higher payments for drugs on reprocessed claims in 2022. "Relief funds" refers to FFS Medicare's share of federal and other coronavirus relief funds (with the share based on FFS Medicare's share of 2019 all-payer operating revenue). "Metropolitan" (urban) counties contain an urban cluster of 50,000 or more people; "micropolitan" rural counties contain a cluster of 10,000 to 50,000 people; all other counties are classified as "other rural". "Low [fiscal] pressure" hospitals are defined as those with a median non–FFS Medicare margin greater than 5 percent over five years and a net worth that would have grown by more than 1 percent per year over that period if the hospital's FFS Medicare profits had been zero. "High [fiscal] pressure" hospitals are defined as those with a median non–FFS Medicare margin of 1 percent or less over five years and a net worth that would have grown by less than 1 percent per year. All other hospitals with complete data are classified as "medium pressure." Government-owned hospitals operate in a different financial context from other hospitals, so their margin is not necessarily comparable; therefore, data for government-owned hospitals are not reported separately or included in the ownership rows (but are included in other rows). Results differ from those published last year in part because of newer data.

Source: MedPAC analysis of hospital cost-report and census geographic data.

because most rural hospitals benefit from one or more special designations that provide additional FFS Medicare payments above standard IPPS and/or OPPS payments.[11] In addition, hospitals under higher fiscal pressure, and therefore under more pressure to constrain their costs, continued to have an FFS Medicare margin over 7 percentage points higher than hospitals under low pressure.[12]

Relatively efficient hospitals, which historically have had higher quality and lower costs, continued to have higher margins

As part of our assessment of payment adequacy, the Commission calculates a median FFS Medicare margin in a performance year for a group of hospitals that has historically performed relatively well on a set of quality metrics (measures of mortality and readmissions) while keeping unit costs relatively low. We refer to the group of hospitals identified by our method as "relatively efficient" because these hospitals historically performed better than other hospitals on selected measures of quality and cost for inclusion. Under this concept, "efficiency" refers to the level of resources needed to provide a certain quality and quantity of services. While our method is one way of identifying relatively efficient hospitals, it does not seek to identify all hospitals that efficiently deliver hospital care. For example, we exclude from our analysis hospitals that have few Medicare or Medicaid patients or do not have sufficient baseline or performance-year data, even though these hospitals may be relatively efficient. In addition, our method does not seek to identify hospitals that performed relatively well in all possible quality and cost metrics. For example, the use of other quality and cost measures (e.g., hospital-acquired conditions, transition to post-acute care, or spending per episode) to identify relative efficiency likely would yield a different set of hospitals. Still, the median margin for our group of relatively efficient hospitals provides one source of information about whether FFS Medicare payments are adequate to cover the costs of providing hospital care efficiently.

We first published a "relatively efficient hospital" analysis as a way to identify lower-cost hospitals that maintained quality in 2009 (Medicare Payment Advisory Commission 2009). Since then, as we annually review our methods and results, we have refined our analysis and updated data sources. For example, we have (1) incorporated hospital outpatient costs to obtain a more complete picture of hospitals' costs, (2) refined quality measure thresholds, and (3) explored incorporating additional hospital factors that drive costs (Medicare Payment Advisory Commission 2024, Medicare Payment Advisory Commission 2011). In each year since 2009, the group of hospitals that we identified as relatively efficient in a historical baseline period had higher quality and lower standardized costs than other hospitals in the performance year.

This year, we continued to refine our method for identifying relatively efficient hospitals (see text box on our refined methods, pp. 82–83). In past years, we identified relatively efficient hospitals as those that consistently met performance criteria in all three historical years before the performance year. This year, to allow for the possibility of some year-to-year variation in performance measurement, we relaxed our requirements such that relatively efficient hospitals must meet criteria in at least three of the four years (2020, 2021, 2022, and 2023) before our 2024 performance year. About 13 percent of eligible hospitals met these criteria for costs and quality; in contrast, we had identified only 6 percent of hospitals as relatively efficient using the prior criteria last year.[13]

Among the 13 percent of hospitals that we identified as relatively efficient, the median hospital continued to have higher quality and lower costs in FY 2024 than the comparison group (Table 3-12). In terms of quality, the relatively efficient hospitals had lower median mortality and readmission rates (90 percent of the national median and 95 percent, respectively) and slightly higher median shares of patients highly rating the hospital. They also had lower standardized FFS Medicare costs per unit, at 89 percent of the national median. These lower standardized costs resulted in a higher FFS Medicare margin than the comparison group. The median relatively efficient hospital in 2024 had a FFS Medicare margin of –1 percent, an increase from –2 percent last year (latter data not shown). The median relatively efficient hospital also had a higher all-payer operating margin than the median other hospital, though the spread was narrower than the FFS Medicare margin.[14]

As in past years, relatively efficient hospitals were spread across the country and included various categories of hospitals. Relatively efficient hospitals were more likely to be in urban areas and were slightly larger in terms of bed size compared with other hospitals (data not shown). Among teaching and nonteaching hospitals, the shares of hospitals categorized as relatively efficient were similar. The share of relatively efficient hospitals was slightly higher among hospitals under low fiscal pressure than those under high fiscal pressure. Finally, the share of relatively efficient hospitals was slightly higher among for-profit hospitals than nonprofit hospitals; generally, for-profit hospitals tend to have lower standardized

TABLE 3–12

Relatively efficient hospitals performed better than other hospitals but still had a slightly negative median FFS Medicare margin in FY 2024

	Relatively efficient hospitals	Other hospitals
Number of hospitals	270	1,875
Share of hospitals in our study sample	13%	87%
Historical performance, average over 2020–2023 (median)		
FFS Medicare mortality rate (relative to national)	89%	102%
FFS Medicare readmission rate (relative to national)	93	102
Standardized FFS Medicare costs per unit (relative to national)	91	102
Current year performance, 2024 (median)		
FFS Medicare mortality rate (relative to national)	90%	101%
FFS Medicare readmission rate (relative to national)	95	101
Share of patients rating the hospital a 9 or 10 (out of 10) (relative to national)	101	100
Standardized FFS Medicare costs per unit (relative to national)	89	102
FFS Medicare margin	–1	–10
All-payer operating margin	9	4

Note: FFS (fee-for-service), FY (fiscal year). "Relatively efficient" and "other" hospitals were identified based on their performance during 2020 to 2023. (For more details, see text box on our identification methodology, pp. 82–83.) "Hospitals" refers to hospitals paid under the inpatient prospective payment systems. The "all-payer operating margin" excludes reported investment and donation income. The "FFS Medicare margin" is limited to revenue and costs for services included under the inpatient or outpatient prospective payment systems, including uncompensated-care payments and revenue and costs of separately payable drugs (and any reported discounts to drug costs under the 340B Drug Pricing Program) and is reported without FFS Medicare's share of federal or other coronavirus relief funds (which were small in 2024).

Source: MedPAC analysis of hospital cost-report, claims, inpatient and outpatient prospective payment system final rules, and Common Medicare Environment data and CMS's summary of H–CAHPS survey-results tables.

costs and nonprofit hospitals tend to have higher quality metrics (see quality section, pp. 72–76).

FFS Medicare margin is projected to increase in 2026

We project that hospitals' FFS Medicare margin in FY 2026 will be about –10 percent, about 2 percentage points higher than the level in 2024 exclusive of coronavirus relief payments. Similarly, we project the median FFS Medicare margin among relatively efficient hospitals to increase to 1 percent. These projections are based on actual payments and costs in the most recent year of complete data (2024), FFS Medicare payment policies for 2025 and 2026, and environmental changes that took place in 2025 and are anticipated in 2026.

Our projected increase in hospitals' FFS Medicare margin in 2026 reflects several partially offsetting pressures. One key factor that will put upward pressure on hospitals' FFS Medicare margin is the $1.8 billion dollar increase in FFS Medicare's uncompensated-care payments (from $5.9 billion in 2024 to $7.7 billion in 2026), driven by CMS's estimated increase in the percentage of individuals without insurance and in FFS Medicare inpatient volume. Another key factor that we project will put upward pressure on hospitals' FFS Medicare margin is the projected continued growth in the share of hospitals' FFS Medicare revenue from separately payable drugs, for which FFS Medicare payments are above hospitals' average acquisition costs. We project these upward pressures will be

Identifying relatively efficient hospitals

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

- hospitals must perform relatively well on both quality and cost metrics, and
- the performance must be generally consistent and not due to random variation.

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

Updates to the method for categorizing hospitals as relatively efficient

Due to concerns about the increasingly small share of hospitals identified as relatively efficient in our analysis, this year we relaxed our consistency requirement such that relatively efficient hospitals must meet quality and cost criteria in three of four baseline years (instead of three out of three). Under this updated requirement, a hospital could have lower quality or higher costs in one of the four baseline years and still be identified as a relatively efficient hospital. This update balances our principles of consistently meeting relatively higher performance thresholds with acknowledging that in any particular year a relatively high-performance hospital may experience a negative shock. Indeed, recent years were likely a more difficult time for hospitals to perform consistently well because of the coronavirus pandemic and its impacts. Our quality and cost criteria that relatively efficient hospitals had to meet—now in three of four baseline years—remained the same:[15]

- Either fee-for-service (FFS) Medicare risk-adjusted mortality rates or standardized inpatient and outpatient cost per unit was among the best one-third of hospitals and
- FFS Medicare risk-adjusted mortality rates, risk-adjusted readmission rates, and standardized costs per unit were not in the bottom third of all hospitals.[16]

We also made other methodological refinements, such as improving the data sources used for standardizing hospitals' FFS Medicare costs per unit and using more current wage indexes to standardize for labor costs.[17]

(continued next page)

partially offset by other factors. One of these is the temporary 0.5 percentage point decrease in the update to the OPPS base rate, which CMS is implementing to offset the increased Medicare payments for nondrug items and services made in CY 2018 through CY 2022.

Like all projections, ours are subject to uncertainty. For example, actual inflation in FY 2026 is unknown. In addition, it is uncertain how hospitals will respond to legislative changes passed in 2025 and policy changes in 2026, such as expanded site-neutral payment policies and the phase-out of the inpatient-only list.

Looking forward to 2027, there are additional uncertainties. Most notably, we do not yet know what the uncompensated-care pool will be in 2027. However, while there is more uncertainty, we expect hospitals' 2027 FFS Medicare margin to be slightly higher than in 2026. We will update data on actual experience in our next recommendation cycle.

The Commission-developed Medicare Safety-Net Index should be used to target hospitals most in need of Medicare funds

In the Commission's March 2023, 2024, and 2025 reports, we recommended transitioning existing hospital payments to payments based on this new metric—the Medicare Safety-Net Index (MSNI)—to improve targeting Medicare safety-net payments toward hospitals that

Identifying relatively efficient hospitals (cont.)

The collective effect of these method changes increased the share of hospitals we identify as relatively efficient. In 2024, the updated method resulted in approximately double the share of hospitals identified as relatively efficient compared with last year. Not surprisingly, among this larger group, the median relatively efficient hospital had slightly lower quality and higher costs than if we had continued with our stricter criteria. Had we continued to require that relatively efficient hospitals meet quality and cost criteria in three out of three baseline years, the median FFS Medicare margin in 2024 would have been slightly higher, at 0 percent. We also found that requiring three of four baseline years last year would have yielded a similar FY 2023 median FFS Medicare margin among hospitals identified as relatively efficient as was reported last year. Overall, our findings indicate an improvement in 2024 in the median FFS Medicare margin among relatively efficient hospitals.

Implications

There is no single way to identify hospitals that are operating efficiently, and we do not seek to identify all efficient hospitals, nor do we conclude that all hospitals that did not meet our criteria are inefficient. For example, lower-volume hospitals have more variation in their costs, volume, and mix of patients and therefore may be more likely to experience a shock and have inconsistent performance during the baseline years. It is also important to note that there is substantial variation in performance among both the relatively efficient hospitals and the other hospitals. Still, the median FFS Medicare margin among the set of hospitals we identified as relatively efficient provides some insight about whether FFS Medicare payments to hospitals are adequate to cover the cost of providing inpatient and outpatient hospital care efficiently. This analysis is one of many metrics we use to assess the adequacy of FFS payments. ■

provide care to large shares of low-income Medicare beneficiaries (Medicare Payment Advisory Commission 2025, Medicare Payment Advisory Commission 2024, Medicare Payment Advisory Commission 2023b, Medicare Payment Advisory Commission 2022). The MSNI was developed with the Commission's principle that Medicare safety-net payments should be used primarily to support hospitals that provide care to large shares of Medicare beneficiaries, and in particular low-income Medicare beneficiaries, and are therefore hospitals particularly vulnerable to unforeseen circumstances (such as misestimates of input price inflation). (The calculation of each hospital's MSNI value is described in the text box on p. 85.) This measure of "safety-net" status is Medicare-centric by design; safety-net definitions used by Medicaid and other payers would likely differ. Currently, Medicare payments to support safety-net hospitals are composed of disproportionate-share (DSH) and uncompensated-care payments.[18] However, unlike those funds, payments based on the Commission's MSNI would be:

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

We have found that the MSNI was an important predictor of hospitals' all-payer margins and risk of closure—and a better predictor than the metric used in determining current DSH payments. This finding continued to be true in 2024: Hospitals with higher values on the MSNI had lower all-payer operating margins (Table 3-13, p. 84). Hospitals in the highest MSNI quartile had an all-payer operating margin of 4.3 percent compared with 8.6 percent among hospitals in the lowest MSNI quartile. The spread in margin between hospitals in the highest and lowest MSNI quartiles is even larger when looking at the all-payer operating margin exclusive of payments from state

TABLE 3–13 **Hospitals with higher MSNI values had lower all-payer operating margins in FY 2024**

	MSNI quartile			
	Lowest	2nd	3rd	Highest
All-payer operating margin	8.6%	6.3%	6.6%	4.3%
FFS Medicare margin	–16.1	–14.6	–10.7	–4.8

Note: MSNI (Medicare Safety-Net Index), FY (fiscal year), FFS (fee-for-service). "Hospitals" refers to hospitals paid under the inpatient prospective payment systems. The "all-payer operating margin" excludes reported investment and donation income. The "FFS Medicare margin" is limited to revenue and costs for services included under the inpatient or outpatient prospective payment systems, including uncompensated-care payments and revenue and costs of separately payable drugs (and any reported discounts to drug costs under the 340B Drug Pricing Program) and is reported without FFS Medicare's share of federal or other coronavirus relief funds (which were small in 2024).

Source: MedPAC analysis of hospital cost-report, claims, Medicare Advantage encounters, and Common Medicare Environment data, and H–CAHPS survey results.

and local governments, as reported on Medicare cost reports (8.6 percent vs. 1.2 percent) (data not shown). We also found that the MSNI continued to be a better predictor of hospitals' all-payer operating margin than the current DSH metric. For example, in 2024 the spread in all-payer operating margin between the lowest and highest MSNI quartile (4.4 percentage points) was wider for the MSNI than the DSH metric (2.4 percentage points) (data not shown).[19]

Consistent with prior years, the FFS Medicare margin continued to be higher among hospitals with higher values on the Commission-developed MSNI (Table 3-13). This finding primarily reflects how, in aggregate, these hospitals disproportionately receive additional FFS Medicare payments from existing DSH and uncompensated-care payments. However, as we noted previously, the MSNI would better target scarce Medicare resources to hospitals that treat large shares of low-income Medicare beneficiaries. Additionally, our proposed mechanism for distributing MSNI safety-net payments would have other advantages, including direct payments to hospitals for both their FFS and MA patients (Medicare Payment Advisory Commission 2024, Medicare Payment Advisory Commission 2023b, Medicare Payment Advisory Commission 2022).[20]

In our simulations of replacing current DSH and uncompensated-care payments with payments based on the MSNI, some hospitals would receive higher payments and others would receive lower payments. Rural hospitals would tend to receive more payments under the MSNI than under the current DSH and uncompensated-care payments (since they treat large shares of Medicare beneficiaries and receive a relatively small share of these existing payments) while government hospitals would tend to receive less (since they receive large amounts of current DSH and uncompensated-care funds). Phasing in changes would help ease the transition for hospitals that would receive lower safety-net payments under the MSNI.

How should FFS Medicare payments change in 2027?

Under current law, CMS sets the percentage update to IPPS and OPPS payment rates based on its forecasts of market basket increases less a forecasted increase in productivity, as well as any other statutory or policy updates. The final hospital updates for 2027 will not be set until the IPPS and OPPS final rules in summer and fall 2026, respectively. However, based on current CMS forecasts through the third quarter of 2025 and current CMS policies, the 2027 updates would include:

- a 2.3 percent increase in the IPPS operating rate (resulting from a 3.1 percent increase in the market basket less a 0.8 percentage point productivity adjustment);

Calculating each hospital's Medicare Safety-Net Index value

Each hospital's Medicare Safety-Net Index (MSNI) value is calculated as the sum of three components: low-income share of Medicare volume, uncompensated-care costs as a share of hospital revenues, and Medicare share of all-payer volume (divided by two). These components were selected for their importance in identifying hospitals that would be more in need of Medicare safety-net funds. For more details on development of the MSNI, see our March 2023 report to the Congress, Chapter 3, Table 3A-1 (p. 97) (Medicare Payment Advisory Commission 2023b).

This year, we continued to incorporate additional data sources so that the MSNI calculation is based on both inpatient and outpatient data and on fee-for-service (FFS) and Medicare Advantage (MA) beneficiaries. The MSNI is calculated using 2022 Medicare hospital cost-report, enrollment, FFS claims, and MA encounter data for inpatient and outpatient services as follows:

- Low-income share of Medicare volume: We identified the share of hospitals' inpatient stays and outpatient encounters that were for patients eligible for the Part D low-income subsidy or dually eligible for Medicare and Medicaid during the year. We included both FFS and MA patients.[21]
- Uncompensated-care costs as share of all-payer revenue: We calculated uncompensated-care cost shares as non-Medicare bad debt and charity care divided by all-payer revenue as reported in hospitals' cost reports.
- Medicare share of all-payer volume: To measure Medicare share of volume, we calculated Medicare (FFS and MA) inpatient and outpatient charges as a share of total charges, as reported by hospital's cost reports.[22] We divided this share by two so that it received a lower weight in the calculation of the MSNI than the other two components (per findings during the development of the MSNI that showed that Medicare share had lower importance compared with the other two components).

Higher values on the MSNI indicate higher financial need for Medicare safety-net payments. As discussed in the March 2023 report, we bounded MSNI payments so that hospitals in the lowest 10th percentile would not receive any safety-net funds and capped MSNI values at the 95th percentile value. ■

- a 3.1 percent increase in the IPPS capital base rate (resulting from a 2.8 percent increase in the capital input price index plus a 0.3 percentage point forecast-error adjustment for FY 2025); and
- a 2.3 percent increase in the OPPS base rate (resulting from the same market basket and productivity adjustment as used for the IPPS operating rate).

Since 2006, the Commission has made a single update recommendation for FFS Medicare's payment rates for services provided under the IPPS and OPPS. Primarily we do so because we cannot adequately apply some of the Commission's payment-adequacy indicators separately for hospital inpatient and outpatient services since hospitals typically provide both types of services. Allocating costs to inpatient and outpatient services is conceptually challenging and subject to data limitations and variation in hospitals' accounting practices. Access to capital is also fundamentally a hospital-specific, not service line–specific, measure. Moreover, at this time we do not see evidence of significant differences between inpatient and outpatient settings in FFS Medicare beneficiaries' access to care or hospitals' FFS Medicare margins.[23]

That said, the Commission has long recognized that Medicare's payments in any sector should reflect the potential to deliver the service in other settings, suggesting the importance of considering the relationship of prices across sectors. That work, such as the Commission's recommendation for site-neutral payments, raises complex issues beyond the scope of our update criteria. For that reason, we address such issues separately. (However, we provide an overview of existing site-neutral policies and potential expansions at the end of this chapter; see pp. 88–91.)

Our hospital payment-adequacy indicators were mixed and suggest that FFS Medicare payments for inpatient and outpatient services were well below costs in aggregate; however, the FFS Medicare margin for the median relatively efficient hospital was –1 percent in FY 2024, and we project it will increase to 1 percent in FY 2026.

In considering how hospital base payment rates should change in 2027, the Commission contends that scarce Medicare resources should be used efficiently. To meet this goal, Medicare should aim to balance several objectives:

- support hospitals with payments high enough to ensure beneficiaries' access to care,
- maintain payments close to hospitals' cost of providing high-quality care efficiently to ensure value for taxpayers and beneficiaries,
- maintain fiscal pressure on hospitals to constrain costs, and
- limit the need for large across-the-board payment-rate increases by better targeting Medicare funds to safety-net hospitals that treat large shares of vulnerable Medicare patients.

Balancing these objectives continues to be difficult.

RECOMMENDATION 3

The Congress should:

- **for 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.**

RATIONALE 3

Our indicators of the adequacy of FFS Medicare payments to hospitals continued to be mixed, though several measures improved relative to last year, and we project further improvement. In 2024, beneficiaries maintained good access to hospital care, hospitals' access to capital improved, and the FFS Medicare margin for the median relatively efficient hospital increased to –1 percent. However, indicators of the quality of care experienced by patients continued to be mixed, and FFS Medicare payments continued to be well below hospitals' costs in aggregate. Looking forward, there continues to be uncertainty, including how hospitals will respond to legislative changes passed in 2025 and policy changes in 2026, each of which may have factors that could improve or worsen some of our FFS Medicare payment-adequacy indicators. However, preliminary data suggest hospitals' access to capital improved in 2025, and we project that hospitals' FFS Medicare margin will increase in 2026 and 2027 under current law. Therefore, for 2027, the Commission recommends increasing hospital inpatient and outpatient base rates by current law.

However, there continued to be substantial variation within the aggregates in each of our payment-adequacy indicators; in particular, hospitals that treat larger shares of low-income Medicare patients continue to face larger financial challenges. Therefore, for 2027, the Commission reiterates our recommendation from March 2023 that the Congress implement the MSNI, which would better target limited Medicare resources toward those hospitals that are key sources of care for low-income Medicare beneficiaries and are facing financial challenges. As specified in more detail in our March 2023 report, implementing the MSNI would involve:

- a transition from DSH and uncompensated-care payments to payments through the MSNI;
- scaling FFS–MSNI payments in proportion to each hospital's MSNI value and distributing the funds through a percentage add-on to payments under the inpatient and outpatient prospective payment systems;[24]
- paying commensurate MSNI amounts for services furnished to MA enrollees directly to hospitals and excluding them from MA benchmarks; and

- expanding the MSNI pool in future years—for example, the pool could be expanded by the same rate as Medicare's base payment rates to hospitals.

As we previously noted, our definition of "Medicare safety-net hospital" used for the purpose of supporting hospitals that are key sources of care for low-income Medicare beneficiaries is Medicare-centric by design; safety-net definitions used for other purposes by Medicaid and other payers would likely differ. For example, DSH computations could still be made to determine eligibility for certain programs, such as the 340B program.

Given that current law has already increased uncompensated-care payments in 2026 by $1.8 billion relative to 2024, this year's recommendation would increase the MSNI pool by $1 billion dollars (to be distributed across hospitals' FFS and MA patients), less than our recommendation in prior years.

A current-law update to hospital base rates would affect all hospitals equally; however, implementing the MSNI and adding $1 billion to the MSNI pool would have distributional impacts, with some hospitals receiving more than current law and others less than current law. We estimate that about half of the $1 billion would be used for hospitals' FFS Medicare patients and, compared with current law, would increase hospitals' FFS Medicare margin by less than 1 percentage point, both in aggregate and for the median relatively efficient hospital.

There would also be variation in the impacts across categories of hospitals. We estimate that the recommendation would increase the FFS Medicare margin among hospitals in the highest MSNI quartile by about 3 percentage points. We also estimate the recommendation would increase rural hospitals' FFS Medicare margin by about 3 percentage points over current law because they tend to have larger Medicare shares and larger shares of low-income Medicare patients. In contrast, we estimate that the recommendation would decrease government hospitals' FFS Medicare margin by about 3 percentage points relative to current law because some large government hospitals have relatively few Medicare patients and, currently, very high uncompensated-care payments.[25] However, these are aggregate estimated impacts, and there would be substantial variation within categories of hospitals as well.

We anticipate that a 2027 update to hospital payment rates equal to current law and a transition to the MSNI would generally be adequate to maintain FFS beneficiaries' access to hospital inpatient and outpatient care and to raise hospital payment rates close to the cost of delivering high-quality care efficiently.

IMPLICATIONS 3

Spending

- This recommendation would increase spending relative to current law by $750 million to $2 billion in one year and by $5 billion to $10 billion over five years.

Beneficiary and provider

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

Mandated report: Rural emergency hospitals

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

- do not furnish inpatient care,
- have an emergency department that is staffed 24/7,

- receive fixed monthly payments from Medicare,
- are paid 105 percent of standard OPPS rates for emergency and outpatient services, and
- meet other criteria (e.g., have a transfer agreement with a Level I or II trauma center).

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

The CAA, 2021, requires the Commission to report annually on payments to REHs. In its March 2024 report to the Congress, the Commission described the historical context that led to the creation of REHs and the characteristics of the first cohort of REHs (Medicare Payment Advisory Commission 2024). In our March 2025 report, we provided updated information on the number of REHs, the fixed payments REHs received from Medicare, and FFS Medicare payments to REHs for outpatient services in the first full year that the designation was available.

In the first year of eligibility, CY 2023, 21 hospitals converted to REHs. In 2024, the number of REHs increased to 38, and the count further increased to 44 in 2025. These REHs were located in 18 states, including at least 4 in each of Arkansas, Mississippi, Oklahoma, and Texas.

In CY 2024, REHs received over $100 million in enhanced Medicare payments, almost all of which were from fixed monthly payments. In CY 2024, fixed payments were about $276,000 per month per REH, and we estimate that, in aggregate, the 38 REHs received about $100 million in fixed payments. The other type of enhanced Medicare payment is the FFS Medicare program's payment of 105 percent of its share of the standard OPPS rates for services that a non-REH would be paid under the OPPS. In CY 2024, REHs received about $24 million for OPPS-equivalent services, which was $1.2 million higher than the amount would have been using standard OPPS rates. The OPPS-equivalent services that accounted for the highest share of spending at REHs were ED visits, observation visits, and partial-hospitalization mental health services.

The Commission continues to monitor the uptake of the REH designation and important policy issues surrounding it. For example, in our hospital site visits and interviews in the last few years, rural hospitals reported that MA plans tend to match FFS's claims-based payment rates for REHs but (as expected) do not pay REHs fixed monthly payments. However, Medicare's fixed monthly payments to REHs are included in MA benchmarks. In our March 2024 report to the Congress, we noted that excluding REH fixed payments from MA benchmarks would promote equity between FFS and MA because plans would not be paid (through higher benchmarks) for doing something they are not expected to do (i.e., match the fixed payments to REHs) (Medicare Payment Advisory Commission 2024).

Medicare should move toward more site-neutral payments

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

Since the Commission's 2014 recommendation, Medicare has implemented some site-neutral payments for off-campus outpatient services. The Bipartisan Budget Act (BBA) of 2015 required CMS to implement site-neutral payment rates for services provided in certain off-campus outpatient departments beginning in 2017. In 2019, CMS extended site-neutral payment rates to clinic visits provided in almost all off-campus

outpatient departments, and, for 2026, expanded site-neutral payment rates to drug-administration services. However, there remain additional opportunities to expand site-neutral policies across ambulatory settings.

Starting in 2017, Medicare began site-neutral payments for outpatient services provided in some off-campus locations

In response to Section 603 of the BBA of 2015, Medicare began aligning FFS payment rates across ambulatory settings. Specifically, the Act stated that, starting January 1, 2017, applicable outpatient services provided to FFS Medicare beneficiaries in off-campus outpatient departments that are not excepted from site-neutral payments shall no longer be paid under the OPPS and instead under another FFS Medicare payment system.[26] Services provided at off-campus outpatient departments that were established before the Act were excepted from the payment changes.

To satisfy the requirements in the BBA of 2015, CMS reduced payment rates for most outpatient services provided in nonexcepted off-campus provider-based departments (PBDs) to levels that approximate those under the Medicare physician fee schedule (PFS). Specifically, CMS established a PFS relativity adjuster of 40 percent, which reflected the estimated overall difference between OPPS and PFS payments for most affected services.[27] CMS provided a two-year transition to this policy, paying 50 percent of standard OPPS rates in 2017 and then, starting in 2018, 40 percent of the standard OPPS payment rates, and did so in a non-budget-neutral manner.

In the years immediately following the implementation of site-neutral payments under the BBA of 2015, the number of nonexcepted off-campus PBDs, as well as the volume of affected services and site-neutral payments grew rapidly. More recently, the number of nonexcepted off-campus PBDs has been stable, though the volume of off-campus services and site-neutral payments have continued to climb. In CY 2024, about 1,100 hospitals had one or more nonexcepted off-campus PBDs that provided a service subject to site-neutral payments, similar to the number in 2023. The policy applied to 6.3 million FFS Medicare services, a nearly 30 percent increase from 2023. FFS Medicare and its beneficiaries paid about $465 million for these services, and we estimate that this policy reduced FFS Medicare payments by about $700 million in CY 2024.

Starting in 2019, CMS began site-neutral payments for clinic visits in excepted off-campus locations

In 2019, CMS phased in an expansion of the site-neutral payment rates (i.e., 40 percent of OPPS rates) to clinic visits provided in off-campus PBDs that were excepted from the BBA of 2015 (referred to as "excepted" off-campus PBDs).[28]

As the implementation of this policy was phased in, the number of clinic services provided to FFS Medicare beneficiaries in these settings declined. Since then, the volume has been more stable. In CY 2024, about 1,000 hospitals had one or more excepted off-campus PBDs that provided a clinic service subject to this site-neutral policy, and the policy applied to 6.8 million clinic visits by FFS Medicare beneficiaries, both slightly below the levels in 2023. FFS Medicare and its beneficiaries paid about $350 million for these visits, and we estimate that this policy reduced FFS Medicare payments by about $520 million in 2024.

Starting in 2026, CMS expanded site-neutral payments to drug-administration services in excepted off-campus locations

In the CY 2026 OPPS/ASC rule, CMS asserted that the effect of hospital–physician vertical integration and increased volume of outpatient services extends beyond clinic visits and includes drug-administration services. In particular, CMS stated that the high volume of drug-administration services and the magnitude of the FFS Medicare payment differential between settings creates an incentive for these services to migrate to the higher-paying HOPD setting. Both MedPAC and CMS have found increases in both the volume of drug-administration services billed under the OPPS and the volume of services provided per beneficiary, as well as significant volume growth for some individual codes within the drug-administration ambulatory-payment classifications (Centers for Medicare & Medicaid Services 2025, Medicare Payment Advisory Commission 2023a). As a result, starting in 2026, CMS expanded site-neutral payments (i.e., 40 percent of OPPS rates) to drug-administration services provided at excepted off-campus PBDs.[29]

In CY 2024, about 740 hospitals had one or more excepted off-campus PBDs that provided 3.1 million separately payable drug-administration services. FFS Medicare and its beneficiaries paid about $410 million

for these services, and we estimate that, if the 2026 site-neutral policy had been in place in 2024, FFS Medicare payments would have been reduced by about $250 million. Looking forward to the proposed first year of implementation, CMS estimates slightly larger reductions: about $290 million in CY 2026 (Centers for Medicare & Medicaid Services 2025).

Additional possible site-neutral expansions

There remain additional opportunities to expand site-neutral policies to align Medicare's payment rates for similar services across ambulatory settings. Two possibilities that build on CMS's current site-neutral policies include implementing site-neutral payments for clinic services provided in on-campus locations and further expanding site-neutral payments for outpatient services in off-campus locations. Another possible direction for site-neutral policies is our June 2023 recommendation.

Expanding site-neutral payments to clinic visits provided in on-campus locations

On-campus HOPDs are the most common outpatient setting where FFS Medicare beneficiaries receive clinic visits: In CY 2024, FFS Medicare beneficiaries received 15.6 million clinic visits in on-campus HOPDs (or off-campus EDs), with payments of $1.8 billion.[30] We estimate that expanding site-neutral payments (i.e., 40 percent of OPPS rates) to these 15.6 million clinic visits would have decreased FFS Medicare payments by about $1.1 billion in CY 2024. Consistent with the volume of these services, the vast majority of the savings would be from clinic visits provided at urban metropolitan hospitals and nonprofit hospitals. As a percentage of hospitals' total FFS Medicare revenue for hospital outpatient OPPS and site-neutral services (including separately payable drugs and other inputs), the impacts would be slightly larger for hospitals designated as Medicare-dependent hospitals (2.4 percent), rural micropolitan hospitals (2.1 percent), and government hospitals (2.1 percent).

Expanding site-neutral payments to outpatient services provided in excepted off-campus locations

As noted above, CMS has implemented site-neutral payment rates for two types of outpatient services provided in excepted off-campus locations: clinic visits and drug-administration services. Policymakers could also consider expanding site-neutral payments to other outpatient services provided in excepted off-campus locations.

In CY 2024, FFS Medicare beneficiaries received 13.2 million OPPS services in excepted off-campus PBDs (inclusive of the drug-administration services), with payments of $3.5 billion.[31] We estimate that expanding site-neutral payments (i.e., 40 percent of OPPS rates) to these 13.2 million services would have decreased FFS Medicare payments by about $2.1 billion in CY 2024. This $2.1 billion reduction would have been equivalent to a 4.2 percent reduction in payments for remaining OPPS services; therefore, applying a budget-neutral adjustment would require a uniform increase of 4.2 percent to the payment rates for all remaining OPPS services. After applying a budget-neutrality adjustment, there would be no change in aggregate FFS Medicare payments for hospital outpatient services if volume remained the same, but there would be distributional effects (Table 3-14). For example, urban and nonprofit hospitals would lose a small amount of revenue while rural hospitals and for-profit hospitals would gain a small amount.

Implementing site-neutral payments consistent with MedPAC's June 2023 recommendation

The Commission acknowledges that there are different approaches to implementing site-neutral payments across ambulatory settings.

In our June 2023 report to the Congress, we recommended aligning payment rates across ambulatory settings when safe and appropriate and when doing so does not pose a risk to access (Medicare Payment Advisory Commission 2023b, Medicare Payment Advisory Commission 2014). In general, the Commission maintains that Medicare should base payment rates on the resources needed to treat patients in the most efficient setting. However, Medicare should be selective about which services should have payment rates aligned across settings, as many ambulatory services cannot be safely or appropriately provided in freestanding offices in the majority of circumstances.

We discussed a method to identify the services for which it might be appropriate to align payment rates across hospital outpatient departments, ASCs, and/or freestanding offices, aligning payment rates in higher-

TABLE 3–14

Expanding site-neutral payments to outpatient services in excepted off-campus PBDs would have had varying effects, CY 2024

Hospital category	After budget-neutrality adjustment	
	Dollar change in FFS Medicare payments (in millions)	Percent change
All	$0	0.0%
Ownership		
For profit	140	2.0
Nonprofit	–110	–0.2
Government	–30	–0.2
Geography		
Metropolitan	–50	–0.1
Micropolitan	30	0.4
Other rural	20	2.4

Note: PBD (provider-based department), CY (calendar year), FFS (fee-for-service). "Site-neutral payments" estimated as 40 percent of outpatient prospective payment system (OPPS) rates. "Outpatient services" refers to services covered under the OPPS in 2024, inclusive of drug-administration services, but exclusive of separately payable drugs and other separately payable inputs. "Excepted off-campus PBDs" are those not affected by the Balanced Budget Act of 2015. "Percent change" refers to the dollar change in FFS Medicare payments divided by total OPPS and site-neutral payments (including for separately payable drugs and other separately payable inputs). "Metropolitan" (urban) counties contain an urban cluster of 50,000 or more people; "micropolitan" rural counties contain a cluster of 10,000 to 50,000 people; all other counties are classified as "other rural."

Source: MedPAC analysis of hospital outpatient claims, outpatient provider–specific, OPPS final-rule, census geographic, and hospital cost-report data.

cost settings to the setting that had the highest volume. For example, if ASCs had the highest volume for a service, we aligned the OPPS payment rate (in both on- and off-campus settings) with the ASC payment rate and left the PFS payment rate unchanged.

We also noted the benefits of making budget-neutral adjustments for some OPPS services in conjunction with site-neutral payments. For example, applying a budget-neutral payment adjustment with a site-neutral policy would increase OPPS payment rates for other services, including emergency department visits, which would support hospitals' emergency care and standby capacity. Further, CMS could augment the aligned payment rates when one of the aligned services is provided as part of a visit for emergency care. Finally, CMS should closely monitor the effect that payment rate alignment has on beneficiary access to the services that have aligned payment rates. ■

Endnotes

1 This chapter uses the term "general acute care hospital" or just "hospital" to refer to short-term acute care hospitals paid under the inpatient prospective payment systems and/or outpatient prospective payment system, and the term "inpatient services" and "outpatient services" to refer to services paid under these systems. However, in some instances we use these terms to refer to a broader set of hospitals that provide similar services (but that fee-for-service Medicare pays for under alternative methodologies); the precise definition used in each table is specified in the table note.

2 Clinicians who provide inpatient and outpatient services at hospitals are paid separately under the Medicare physician fee schedule. FFS Medicare uses other payment systems for certain types of hospitals, such as critical access hospitals, hospitals participating in demonstrations, and hospitals that provide care to a specific population (e.g., children's hospitals) or, for inpatient services, a limited set of diagnoses (e.g., psychiatric hospitals, rehabilitation hospitals, and long-term care hospitals). An assessment of the adequacy of these payment systems is beyond the scope of this chapter.

3 A more detailed description of the IPPS and OPPS can be found in our *Payment Basics* series at https://www.medpac.gov/document-type/payment-basic/.

4 The share of hospitals' operating revenue from FFS Medicare across all service lines, such as physician services, is higher.

5 Examples of short-term acute care hospitals not paid by FFS Medicare under the IPPS and OPPS include hospitals in Maryland, which are paid under a state total cost of care waiver, and Indian Health Service hospitals, which are paid under the IPPS for inpatient services but receive an all-inclusive rate for outpatient services.

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

7 The H–CAHPS national response rate for 2024 was 23 percent. The response rate for other provider-focused CAHPS surveys is similar (e.g., the Home Health CAHPS response rate was 23 percent, and the Hospice CAHPS response rate was 28 percent).

8 The all-payer operating margin excludes investment and donation income reported on the indicated cost report lines for these values. However, some hospitals appear to report investment and/or donation income on nonstandard lines; therefore, our calculated operating margin still includes the subset of investment and/or donation income that is reported outside of the indicated cost-report lines.

9 The payments and costs for IPPS and OPPS services include those for services determined by IPPS and OPPS base rates as well as uncompensated-care payments made under the IPPS and payments and costs for separately payable drugs under the OPPS. The FFS Medicare margin does not include FFS Medicare payments and costs for hospital outpatient services provided in off-campus locations paid at site-neutral rates since these are not considered OPPS services and are not included on hospitals' cost reports; for more information on site-neutral payments, see section at the end of this chapter, pp. 88–91.

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

11 A subset of rural hospitals can use inpatient beds as "swing beds" and provide skilled nursing services. If we had included swing-bed services in our FFS Medicare margin, rural nonmicropolitan hospitals' margin would have been about 2 percentage points lower.

12 In 2024, about 13 percent of hospitals in our FFS Medicare margin analysis met the definition of "high fiscal pressure" (those with a median non–FFS Medicare margin of 1 percent or less over five years and a net worth that would have grown by less than 1 percent per year if the hospital's FFS Medicare profits had been zero) and about 48 percent met the criteria of "low fiscal pressure" (those with a median non–FFS Medicare margin greater than 5 percent over five years and a net worth that would have grown by more than 1 percent per year over that period if the hospital's FFS Medicare profits had been zero). That is, hospitals under high fiscal pressure generate lower profits from "other payers"

which include a mix of commercial, Medicaid, uninsured, and Medicare Advantage patients. This fiscal pressure gives them pressure to constrain costs. Lower non-FFS margins could be related to payer mix, possibly having fewer patients covered by commercial insurance plans (which tend to pay higher prices). We continue to find that hospitals under high pressure have higher FFS Medicare margins, stemming from lower costs.

13 Hospitals identified as relatively efficient constituted about 13 percent of inpatient beds in FY 2024.

14 The 2024 FFS Medicare and all-payer operating margins for relatively efficient hospitals were higher than those in 2023 even when applying the same methods in both years.

15 Our other eligibility criteria also remained the same. Relatively efficient hospitals must also have at least half of the hospitals' patients rating it a 9 or 10 on the 10-point scale in the previous year (per the Hospital Consumer Assessment of Healthcare Providers and Systems survey). We exclude from our analyses all hospitals in the lowest 1 percentile of FFS Medicare inpatient stays or outpatient services in the year (but do not adjust our costs per unit for economies of scale). We also exclude hospitals with low shares of Medicaid inpatient days (lower than 5 percent).

16 We risk adjust our mortality and readmission rates but do not adjust for patient income, consistent with the Commission's prior recommendations. We standardize inpatient and outpatient costs per unit by (1) average patient severity; (2) relative labor costs; (3) low-income status (as measured by the share of FFS Medicare patients who received the Part D low-income subsidy or were eligible for Medicaid); (4) teaching intensity; and (5) a portion of a hospital's outlier index (as measured by FFS Medicare outlier payments' share of total FFS base payments) since high outlier costs can indicate either unmeasured differences in illness severity or high cost structures. On the outpatient side, we calculate outpatient cost per encounter, excluding separately payable drugs. We exclude the costs for these drugs because factors besides hospital efficiency, such as participation in the 340B drug program and market power can substantially affect hospitals' drug costs, and we are unable to accurately standardize drug costs.

17 We previously used Medicare's annual outpatient Limited Data Set (LDS) to calculate standardized outpatient costs per service, which is based on cost reports and outpatient claims data that are necessarily lagged. This year, we did not use the outpatient LDS; instead, we directly aligned cost reports with corresponding outpatient claims, providing a more accurate calculation of standardized outpatient costs per encounter each year. We also replaced the MedPAC wage index (calculated from 2019 data) with the annually updated CMS geographic wage index (before reclassifications and floors). Other minor improvements were made as a result of our regular methodology review.

18 Under current policy, hospitals whose Medicaid and Supplemental Security Income (SSI) patient shares are over a certain percentage receive DSH and uncompensated-care payments determined by CMS each year. CMS calculates a "traditional DSH" payment using a formula based on each hospital's share of Medicaid and SSI patients (i.e., the disproportionate patient percentage). Each hospital receives 25 percent of these "traditional DSH" payments (called the "empirically justified" Medicare DSH payment amount). Hospitals then receive uncompensated-care payments calculated as a share of the remaining 75 percent of the aggregated "traditional DSH payments" adjusted by the national uninsurance rate and each hospital's share of uncompensated costs across all DSH hospitals. For more information see https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/disproportionate-share-hospital-dsh.

19 The 4.4 percentage point spread in the all-payer operating margin in 2024 between the lowest and highest MSNI quartile appears different than in Table 3-13 (8.6 percent – 4.3 percent) because the difference was calculated on unrounded components. The 2.4 percentage point spread the all-payer operating margin among the hospitals in the lowest and the highest DSH quartile reflects the spread from 7.9 percent in the lowest quartile to 5.5 percent in the highest. These results also indicate that hospitals in the highest MSNI quartile are more financially vulnerable than those in the highest DSH quartile.

20 Currently, interim uncompensated-care payments are incorporated into the IPPS Pricer software. Most MA plans use this software to pay for enrollees' inpatient stays; therefore, the payment that hospitals receive for most MA patients' inpatient stays include interim uncompensated-care payments (Berenson et al. 2015, Centers for Medicare & Medicaid Services 2013, Maeda and Nelson 2017). On our hospital site visits in recent years, we have also continued to hear that most MA plans payments to hospitals for inpatient services are similar to FFS rates inclusive of DSH and uncompensated-care payments. However, we have shown that this method may lead to inequities in payments depending on the hospitals' MA shares (Medicare Payment Advisory Commission 2023b). In addition, it is uncertain that MA plans will continue to use the IPPS Pricer. Direct payments would ensure that hospitals receive the intended amount of safety-net funds for both their FFS and MA patients.

21 Last year, we calculated hospitals' shares of services that were for low-income patients using FFS and MA inpatient stays and FFS outpatient services. This year, we have incorporated MA enrollees' outpatient encounters in determining each hospital's low-income shares.

22 Since cost reports do not separately report MA outpatient charges, we inflated FFS Medicare inpatient and outpatient charges by the MA-to-FFS inpatient-day ratio to approximate total Medicare inpatient and outpatient charges. We then divided this amount by each hospital's total all-payer charges.

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

24 As we previously noted, separately payable Part B drugs would not be eligible for MSNI add-on payments. In addition, 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.

25 While government hospitals would see a decline in FFS payments in aggregate, it is possible that they could see an increase in MA revenues if MA plans are currently not fully paying uncompensated care payments or are taking hospitals with high uncompensated care add-on payments out of their network.

26 Under Sections 1833(t)(1)(B)(v) and 1833(t)(21) of the Social Security Act, the affected services are no longer considered HOPD services for the purpose of payment under the OPPS. "Off-campus" was defined as a department of a provider that is not on within 250 yards of a hospital campus or a remote location of a hospital facility.

27 CMS did not apply the PFS relativity adjuster to separately payable drugs, which were already paid at the average sales price plus 6 percent in both hospital outpatient and physician office settings; other separately payable inputs (e.g., devices, blood, or brachytherapy), which continued to be paid based on costs; or partial-hospitalization program services, which were aligned with rates paid to community mental health centers (Centers for Medicare & Medicaid Services 2016). Starting in CY 2024, CMS also excepted inpatient cardiac rehabilitation services from the lower site-neutral rate (Centers for Medicare & Medicaid Services 2023).

28 "Clinic visits" refers to services billed using Healthcare Common Procedure Coding System code G0463, which is used for all clinic visits under the OPPS and is assigned to ambulatory payment classification 5012. In 2023, CMS modified this policy to except off-campus PBDs of sole-community hospitals that are designated as rural for payment purposes.

29 Similar to the clinic visit policy, CMS excepts drug-administration services provided at sole-community hospitals that are designated as rural for payment purposes.

30 This amount excludes services provided at sole-community hospitals that are designated as rural for payment purposes.

31 This amount excludes separately payable OPPS inputs, such as drugs, that CMS excepts from current site-neutral policies.

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