Demystifying the Medicare Margin

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This presentation is not legal advice.

What we will cover this morning:

I. Why does the Medicare margin need to be demystified?

II. The technicals.

III. Right, wrong, and it depends.

On facts versus beliefs

“Facts are stubborn things; and whatever may be our wishes, our inclinations, or the dictates of our passion, they cannot alter the state of facts and evidence.”

— John Adams, 1770

"The reimbursement from Medicare covers the cost of the hospital to deliver those services."

An excerpt from a dialogue with an expert on healthcare pricing from a generally high-quality podcast show; one that is widely listened to by regulators, policymakers, and thought leaders.

The Groups That Measure

- Hospitals & Health Systems
- Hospital Auditors
- Bond Rating Agencies
- MedPAC
- NASHP

How can both these conversations take place and both be defensible?

Health System C-Suite Meeting

CFO:
*"This report says our overall margin is 3.5%, but my Medicare payer margin is **-40%.** I thought I read this morning in Modern Healthcare that the overall national Medicare margin for hospitals is **-12%.** WTF?*

Director of Reimbursement to CFO:
"Sir, the difference between Washington's calculation and our calculation is driven by large categories of expenses we include but they exclude."

CFO response to Director:
"How do you just get to exclude large categories of expense… there are rules here!

MEDPAC Briefing Congress

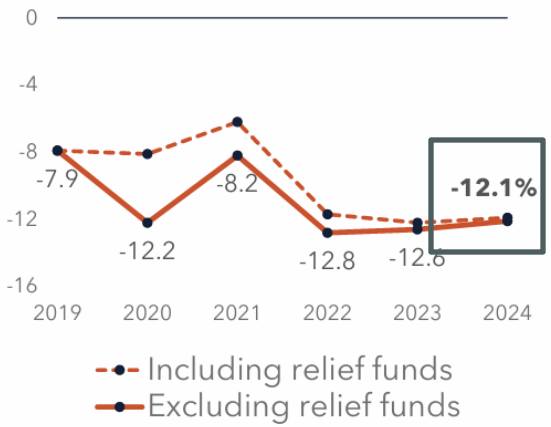
MEDPAC Analyst to Congressional staff:
"The overall Medicare margin for hospitals is -12%, and efficient ones roughly break-even".

Congressional staff to MEDPAC:
"I knew it! It's only the inefficient ones that lose money. I knew the hospitals were lying to me. They told me they are losing 40%!"

The January 2026 MEDPAC View:

Hospitals' FFS Medicare margin remained low but increased in FY 2024, and continued increase projected

FFS Medicare margin low, but slight increase



Slightly negative margin for relatively efficient hospitals

- "Relatively efficient": 13% of hospitals that performed relatively well on both quality and cost, in at least 3 of 4 prior years
- −1% median FFS Medicare margin

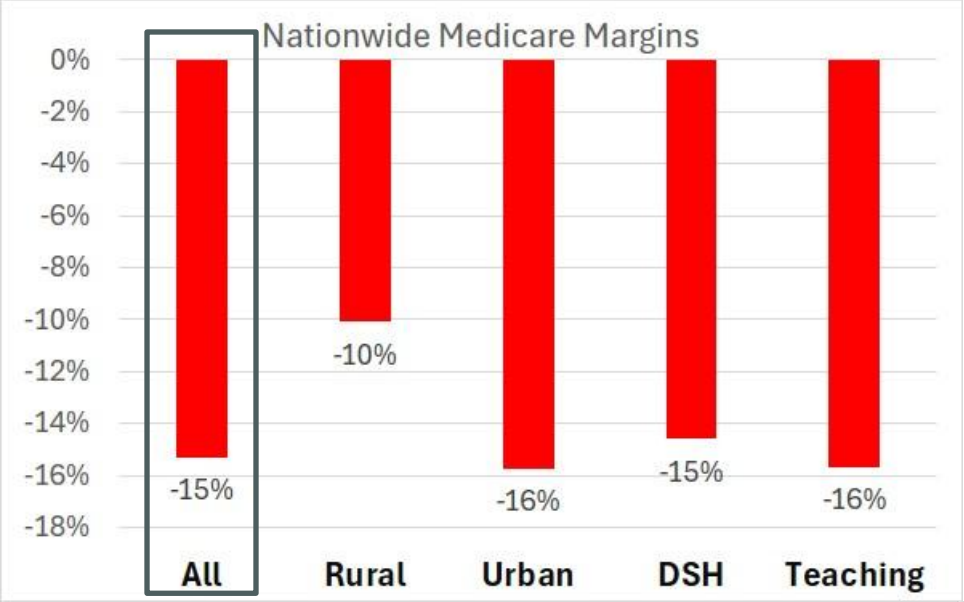
Project margin to increase

- Project increase FFS Medicare margin in FY 2026:
  - −10% in aggregate
  - 1% for median relatively efficient hospital
- Drivers include:
  - $1.8 billion increase in uncompensated care payments
  - Growth in outpatient drugs

Note: FFS (fee-for-service), FY (fiscal year). See December presentation for additional notes.
Source: MedPAC analysis of hospital costs reports, claims data, H-CAHPS survey results, and market basket data.

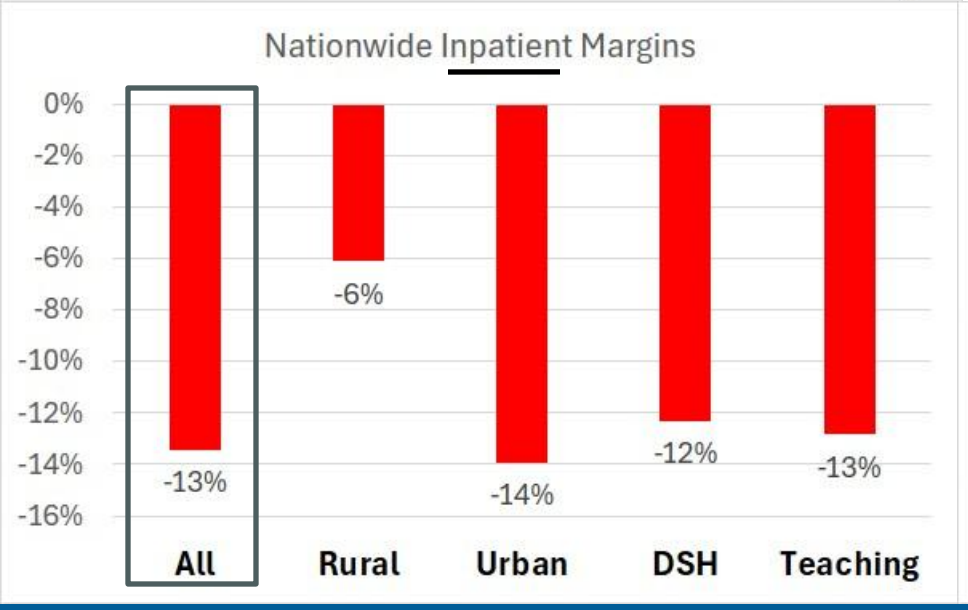
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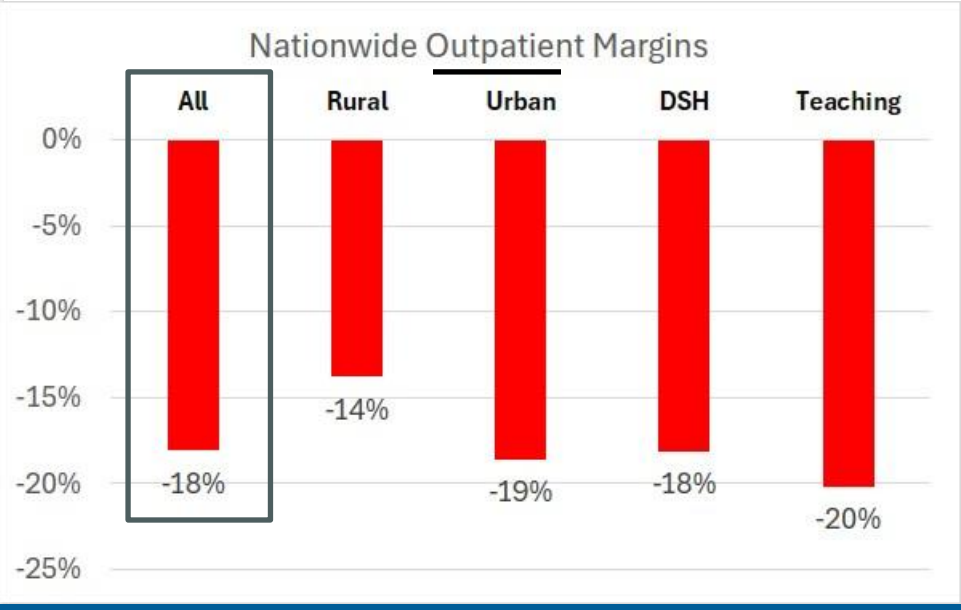
See Sources in Appendix. MEDPAC



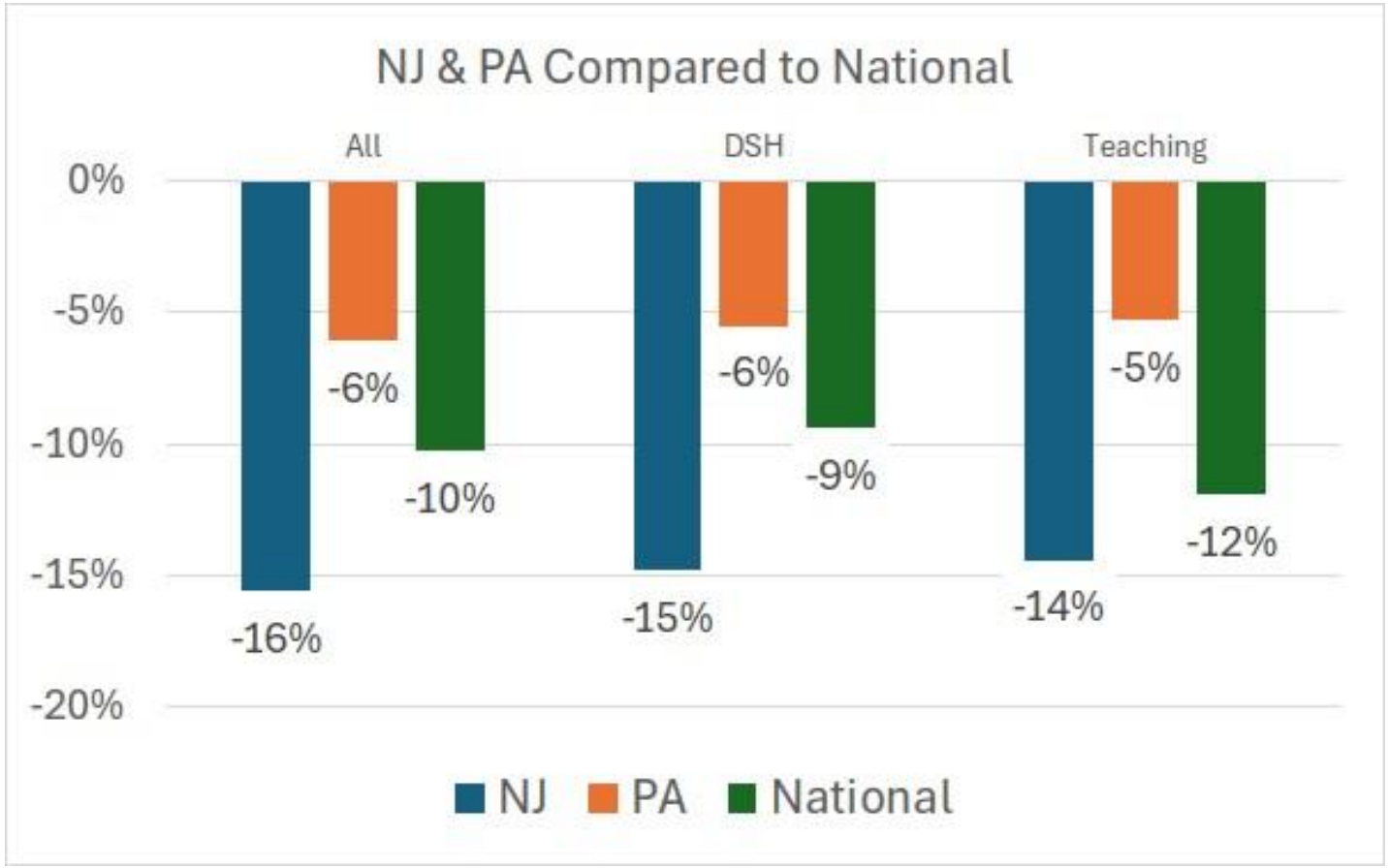
Direction, order of magnitude… we can roughly replicate MEDPAC's methodology. The roughly 3-point gap could be partially due to:

- MedPAC trimmed their data to remove extreme values, and we lacked sufficient information to replicate those trims.
- We excluded hospitals that were in the dataset with less than a full cost report year.
- HCRIS dataset contains multiple entries for some hospitals so timing of when data is extracted could materially impact the calculation.





Zero in: NJ vs. PA Medicare Margin



So… we can get relatively close to MEDPAC's analysis. Does that mean the right answer is -12% to -15% negative margin?

- It depends on the perspective.
- For example, third-party financial auditors of hospitals (e.g., KPMG, EY, Deloitte, PWC) would never allow the cost accounting methodology used here to pass audit, as it excludes significant expenses incurred by the hospital, thus overstating the hospital's financial health.
  - The auditor would conclude the hospital *understated* its expenses and require the hospital to reissue the financial statements including the *fully incurred expenses* following GAAP principles.
  - If you have a payer profitability report at your hospital, you will see margins for Medicare that are substantially worse than percentage you would under this methodology.
- However, MEDPAC isn't attempting to perform a financial audit. It is strictly evaluating *IPPS and OPPS* payment systems for Medicare relative to *allowable costs* of hospitals, as defined under Federal law and regulation.
- So, a hospital's actual GAAP margin calculation for Medicare (whether completed by hospital, bond agency, auditor) will be different than MEDPAC's, **as each party intentionally includes/excludes certain buckets of expenses allocable to Medicare patients.**

Demystifier #1: **Allowable Costs**

- Yes, “marketing and lobbying” are not allowable costs under CMS rules.
- Though these are the easiest sound bites for allowable costs, these are not the drivers in the disparity on the margin calculations.
- The single greatest cost that is considered non-allowable are hospital subsidies to their physician groups to cover the physician group’s financial shortfall.
- This “subsidy” is a real expense that the hospital must report in it’s audited financials, but CMS requires be excluded from allowable costs. This expense can be single digit millions to hundreds of millions.

How significant is this “allowable cost” discrepenacy in the margin analysis?

Health Financial Systems [redacted] In Lieu of Form CMS-2552-10

ADJUSTMENTS TO EXPENSES | Provider CCN: [redacted] | Period: From 01/01/2024 To 12/31/2024 | Worksheet A-8 | Date/Time Prepared: 9/2/2025 11:24 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
39.10	REMOVE MARKETING-ADVERTISING - NOI	A	-838,961	CENTERS OTHER NONREIMBURSABLE COST CENTERS			
39.11	REMOVE MARKETING-ADVERTISING - NOI	A	-5	EMPLOYEE BENEFITS DEPARTMENT			
39.12	REMOVE MARKETING-ADVERTISING - NOI	A	-224,374	ADMINISTRATIVE AND GENERAL			
39.13	REMOVE MARKETING-ADVERTISING -	A	-558,364	ADMIN & GENERAL - PATIENT			

Marketing

10.00	Provider-based physician adjustment	A-8-2	-144,907,241				0	10.00

Subsidy to cover physician group shortfalls

Demystifier #2: **"Related Organizations"** make even the concept of calculating the hospital facility Medicare margin a bit ridiculous and outdated. Who holds what portion of every category of expense… and what does it matter if the hospital has a -12% Medicare margin if the physician group is -80% margin?





How significant is the “related organization” discrepenacy in the margin analysis?

Health Financial Systems [redacted] In Lieu of Form CMS-2552-10

ADJUSTMENTS TO EXPENSES | Provider CCN: [redacted] | Period: From 01/01/2024 To 12/31/2024 | Worksheet A-8 | Date/Time Prepared: 9/2/2025 11:24 pm

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		1.00	2.00	3.00	4.00	5.00	
12.00	(Chapter 23) Related organization transactions (chapter 10)	A-8-1	-97,960,123			0	12.00
12.00	Related organization transactions (chapter 10)	A-8-1	120,515,230			0	12.00

Demystifier #3: Graduate Medical Education

- MEDPAC excludes Direct GME costs and payments from the calculation of Medicare margin because DGME is not paid through the IPPS or OPPS pricer.
- However, without GME programs, there are no physicians.
- Medicare payment for Medicare's allocable share of DGME expenses is well below the fully-loaded cost, similar to the overall Medicare payment system.
- The GAAP accounting rules require hospitals to include these expenses at their full cost no different than any other expense.

Demystifier #4. Reasonable humans can disagree on what proportion of hospital facilities are efficient. However, even MEDPAC estimates that their identified **efficient hospitals** are losing -1% (again, that is without including hospital subsidies to physician shortfalls).

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.

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. ■

Demystifier #5. How can MEDPAC and/or regulators suggest Medicare payments to providers are **adequate** if they don't even cover allowable costs, even for efficient providers?

Adequate can mean different things to different people. Every year in the MEDPAC report, something like this:

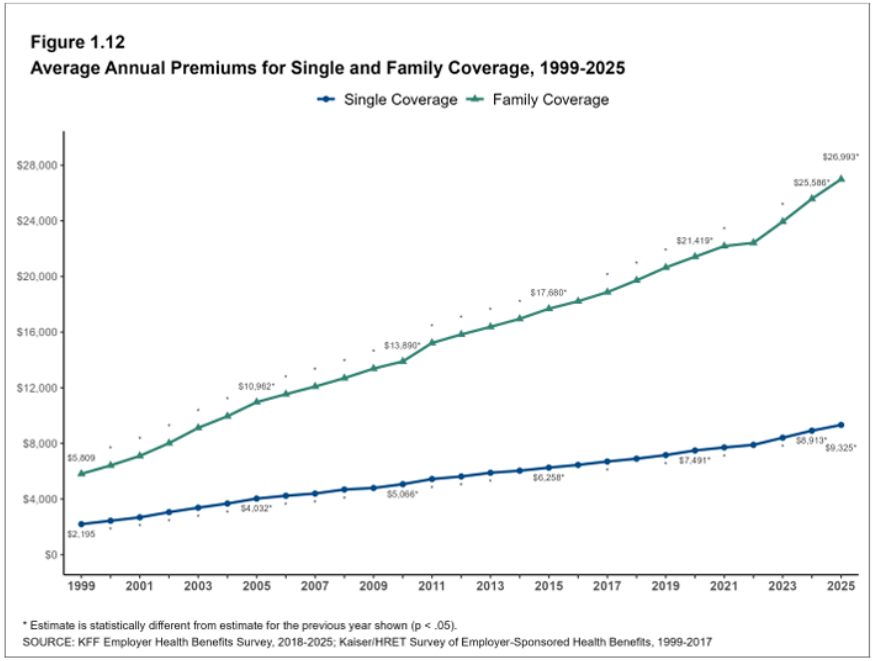
In this chapter

- Are FFS Medicare payments adequate in 2026?

Beneficiaries' access to care—In the Commission's 2025 survey, Medicare beneficiaries reported access to clinician services that was generally better than that of privately insured people. Our findings are consistent with findings of other national surveys, which have found that people ages 65 and older (almost all of whom have Medicare coverage) report better access to care than younger adults; Medicare beneficiaries of any age are also more likely than privately insured people to rate their insurance coverage positively.

Other surveys indicate that the share of clinicians accepting Medicare is comparable with the share accepting private insurance, despite private health insurers' higher payment rates. And almost all clinicians who bill Medicare accept PFS amounts as payment in full and do not seek to increase total payments for fee schedule services by balance-billing beneficiaries up to a limiting charge as "nonparticipating" providers. In addition, very few clinicians forgo all Medicare payments by electing to "opt out" of the program; these clinicians may collect the full amount they charge to patients.

The downside of not assessing adequacy on cost coverage w/ margin for the average hospitals, is that someone else must pick up that cost.



Source: 2025 Employer Health Benefits Survey

Where do we go from here?

- We need to get the facts straight to identify the underlying issues and policy solutions. This applies to all parties… hospitals, think tanks, advisory groups, etc.

- HFMA GREC should consider partnering with MEDPAC and other stakeholders to educate policymakers and regulators on the margin calculations and why they are different.

- Health systems need to up their game on cost-accounting and transparency. AI and overall computing power improvements should make this easier.

- MEDPAC does not report a Medicare margin for the Medicare Physician Fee Schedule because physicians and physician groups don't report their costs to Medicare the way facilities do.
  - Not suggesting we have physician cost reports!!!
  - Therefore, its less clear to policymakers that Medicare physician payments are far below costs to physicians, thus necessitating large subsidies from other parts of the system.
  - Put together **infographics** demonstrating this issue when your Government Affairs people meet with policy makers.

MedPac Sources

- Chapter 3: March 2026 Report to the Congress: Medicare Payment Policy
- Tab-D-Hospital-update-Jan-2026.pdf