SECTION 6

Acute inpatient services

General short-term hospitals
Inpatient psychiatric facilities

Chart 6-1. Urban IPPS hospitals comprised half of short-term acute care hospitals but accounted for over 85 percent of all-payer and Medicare FFS inpatient stays in 2019

	Hospitals		Inpatient stays			
			All payer		Medicare FFS	
Hospital group	Number (in thousands)	Share of total	Number (in millions)	Share of total	Number (in millions)	Share of total
All short-term acute	**4.5**	**100**	**31.5**	**100**	**9.1**	**100**
IPPS	3.1	68	29.7	94	8.6	94
Metropolitan (urban)	2.3	51	27.6	87	7.7	85
Rural micropolitan	0.5	11	1.8	6	0.7	8
Other rural	0.2	5	0.3	1	0.1	1
For profit	0.8	17	4.9	16	1.4	16
Nonprofit	1.9	41	20.9	66	6.1	67
Government	0.5	10	4.0	13	1.0	11
DSH and teaching	1.1	23	18.6	59	5.0	55
DSH only	1.5	34	9.0	29	2.9	31
Teaching only	0.1	2	0.9	3	0.3	3
Neither	0.4	9	1.2	4	0.5	5
Sole community	0.4	8	1.1	4	0.4	5
Medicare dependent	0.1	3	0.2	1	0.1	1
Neither	2.6	57	28.4	90	8.0	88
Critical access	1.3	29	0.6	2	0.3	3
Maryland	<0.1	1	0.5	2	0.2	2

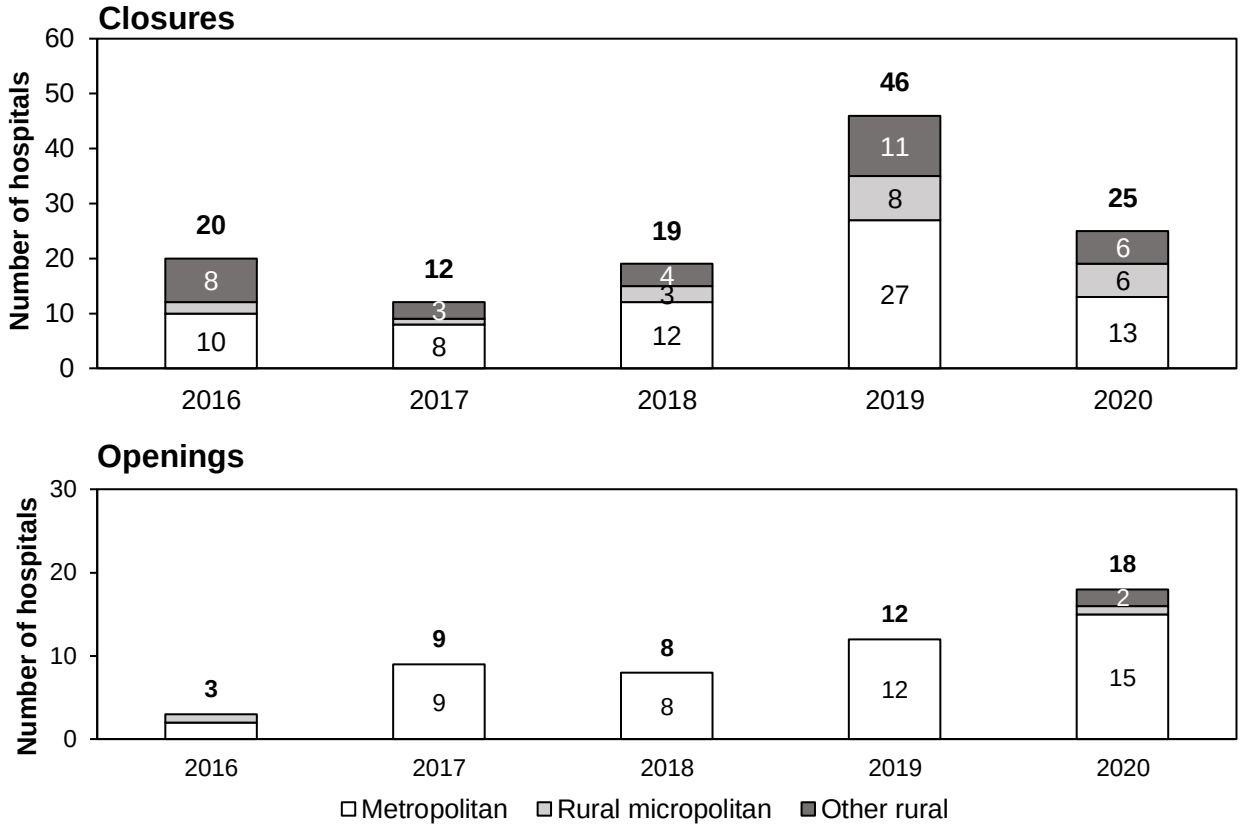
Note: IPPS (inpatient prospective payment system), FFS (fee-for-service), DSH (disproportionate share hospital). Data are for short-term acute care hospitals in the U.S. (excluding territories) that had a cost report with a midpoint in fiscal year 2019. "Number of hospitals" is the number of Medicare provider numbers; a single provider number can represent multiple hospital locations. Metropolitan (urban) counties contain an urban cluster of 50,000 or more people, and rural micropolitan counties contain a cluster of 10,000 to 50,000 people. Components may not sum to totals due to rounding and because children's and cancer hospitals are not listed separately.

Source: MedPAC analysis of hospital cost report data from CMS.

- Estimates of the total number of short-term acute care hospitals differ somewhat, depending on the source of data. Using cost report data, we estimate that there were about 4,500 short-term acute care hospitals participating in the Medicare program in 2019, including 3,100 paid under the inpatient prospective payment system and 1,300 small, rural hospitals designated as critical access hospitals.

- Metropolitan (urban) IPPS hospitals accounted for 51 percent of short-term acute care hospitals but accounted for 87 percent of the 31.5 million all-payer inpatient stays and 85 percent of the 9.1 million Medicare FFS inpatient stays in 2019.

Chart 6-2. Fewer general short-term acute care hospitals closed in 2020 and openings increased



Note: "Closure" refers to a hospital location that ceased inpatient services, while "opening" refers to a new location for inpatient services. The chart does not include the relocation of inpatient services from one hospital to another under common ownership within 10 miles, nor does it include hospitals that both opened and closed within a 5-year time period. Data are for general short-term acute care hospitals in the U.S. paid under the inpatient prospective payment system, designated as critical access hospitals, or covered under the Maryland state waiver. Metropolitan (urban) counties contain an urban cluster of 50,000 or more people, and rural micropolitan counties contain a cluster of 10,000 to 50,000 people. The counts in this chart differ from those previously published for several reasons, such as removing hospitals previously counted as closures but that have since reopened. Year refers to fiscal year.

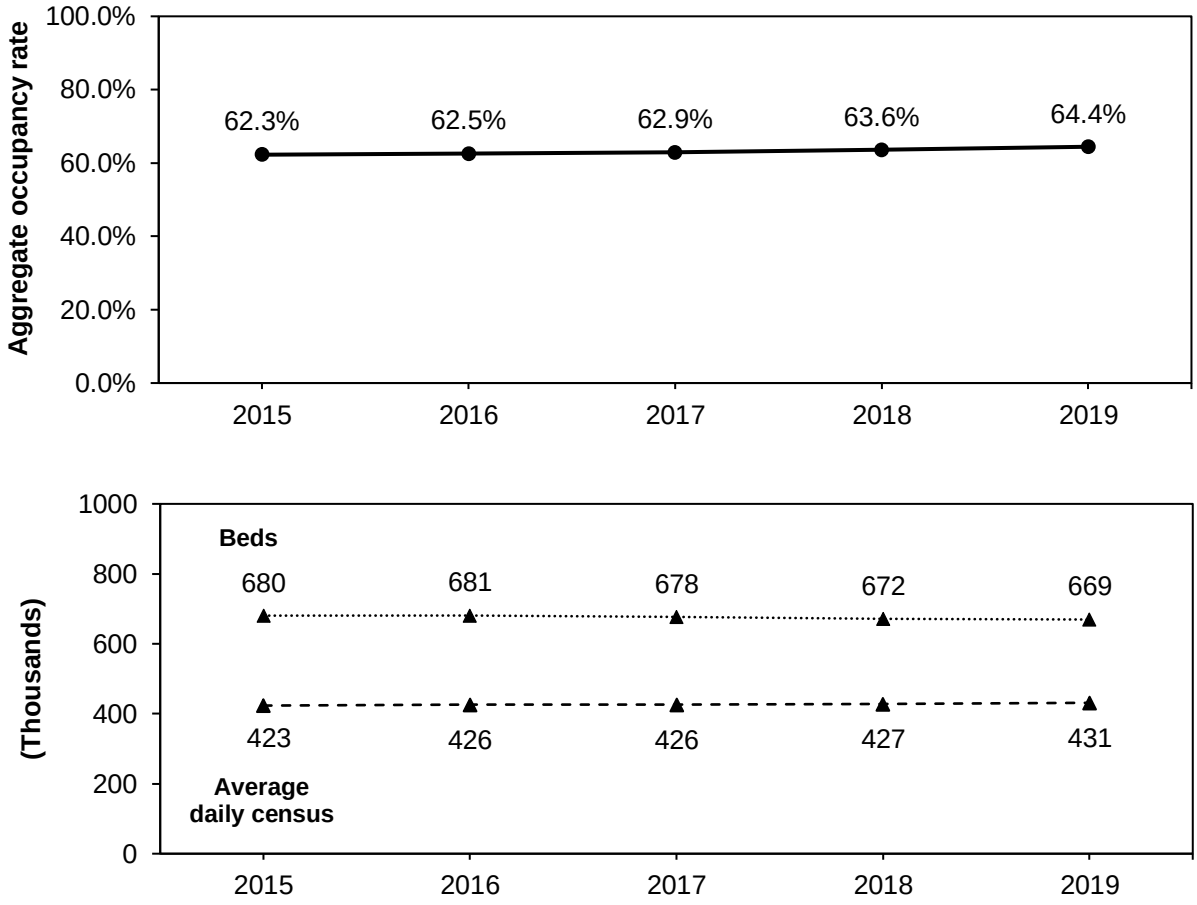
Source: MedPAC analysis of the CMS Provider of Services file, census data on metropolitan and micropolitan areas, internet searches, and personal communication with the Department of Health and Human Services Office of Rural Health Policy.

- In fiscal year 2020, 25 general short-term acute care hospitals participating in the Medicare program closed, and 18 hospitals opened. The number of closures decreased from the peak in 2019, while the number of openings increased.

- Among the 25 hospital closures in 2020, 13 were in metropolitan counties, 6 were in rural micropolitan counties, and 6 were in other rural counties. Similar to prior years, the hospitals that closed in 2020 tended to be small (18 had 100 or fewer beds), had low inpatient occupancy rates (approximately 29 percent, on average), and had poor profitability (all-payer margin of –11 percent, on average, in the year before closure) (data not shown).

- Nearly all of the hospital openings from 2016 to 2020 were in metropolitan counties.

Chart 6-3. Aggregate occupancy rate at short-term acute care hospitals increased, 2015–2019



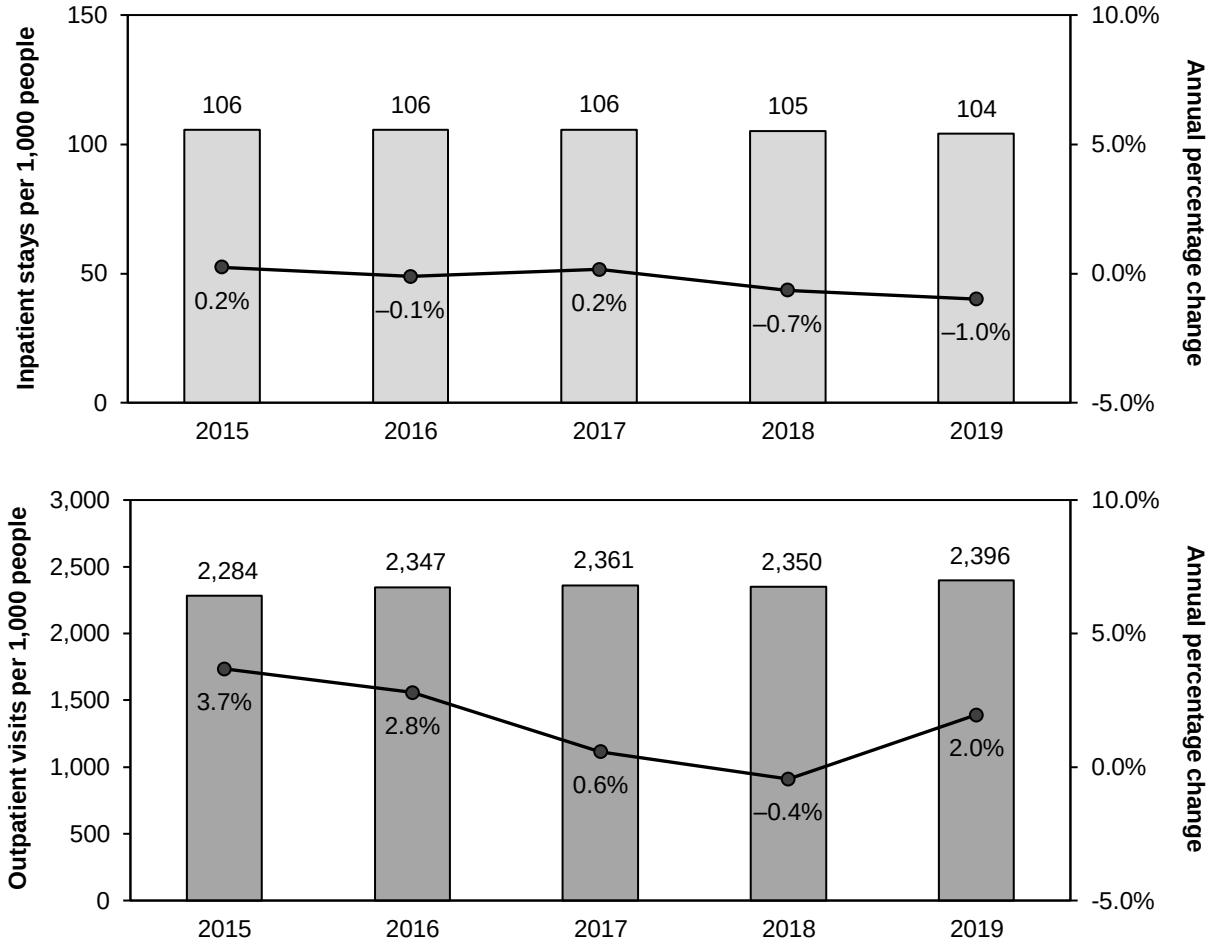
Note: "Aggregate occupancy rate" is calculated as total used bed days (including inpatient, swing, and observation bed days but excluding nursery bed days) divided by total bed days available. "Average daily census" is calculated as total used bed days divided by 365; "beds" refers to total bed days available divided by 365. Data are for short-term acute care hospitals in the U.S. (excluding territories) that had a cost report with a midpoint in fiscal year 2019. Occupancy rates may vary slightly from calculations of components due to rounding.

Source: MedPAC analysis of hospital cost report data from CMS.

- The aggregate occupancy rate at short-term acute care hospitals increased slightly between 2015 and 2019, from 62.3 percent to 64.4 percent. This increase in occupancy rate reflects a combination of an increase in hospitals' average daily inpatient census and a decrease in hospitals' inpatient beds.

- The occupancy rate varied significantly across different groups of hospitals. For example, in 2019, metropolitan (urban) inpatient prospective payment system hospitals had an occupancy rate of 67.6 percent, while critical access hospitals had an occupancy rate of 31.0 percent (data not shown).

Chart 6-4. All-payer inpatient visits per capita decreased while outpatient visits per capita increased, 2015–2019

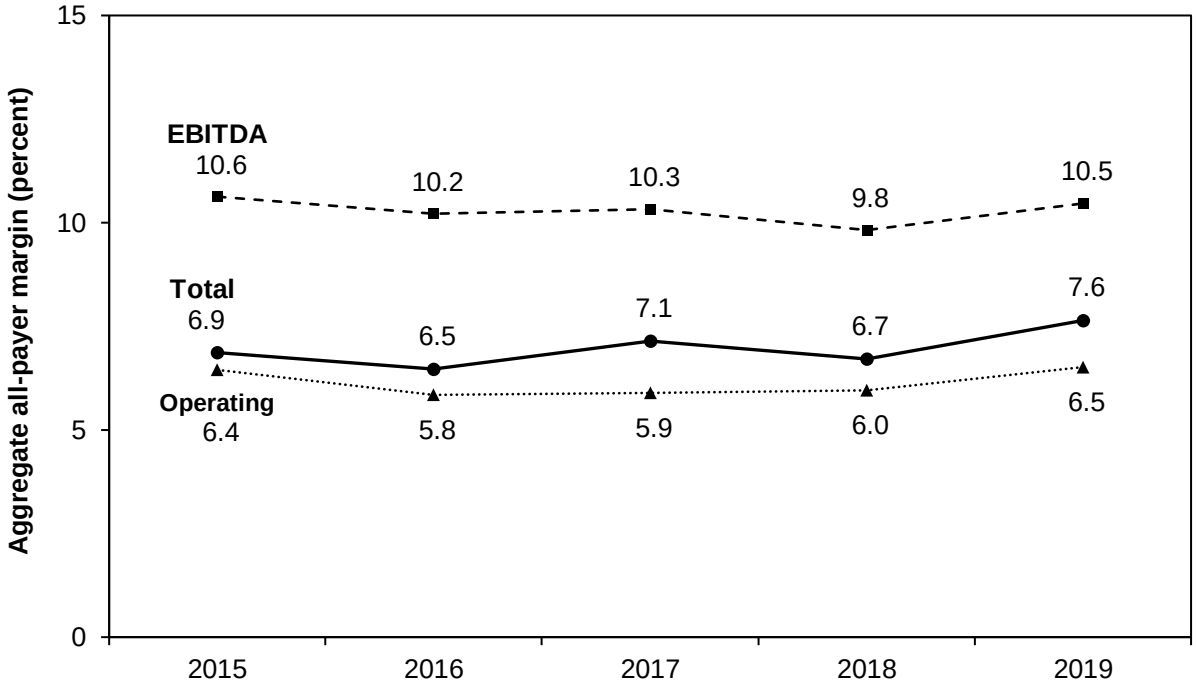


Note: "Outpatient visits" includes all clinic visits, referred visits, observation services, outpatient surgeries, and emergency department visits, regardless of the number of diagnostic and/or therapeutic treatments the patient received during the visit. Data are for community hospitals (nonfederal short-term general and specialty hospitals), estimated from those who responded to the American Hospital Association (AHA) survey. With the 2019 edition of *Hospital Statistics*, the AHA began using a new methodology to classify facilities as hospitals. As a result of the application of the new, broader hospital definition, the number of community hospitals in each year increased by approximately 400.

Source: MedPAC analysis of Hospital Statistics data from the American Hospital Association and CMS National Health Expenditure data.

- From 2015 to 2019, there were divergent trends in all-payer inpatient stays and hospital outpatient visits per capita, with declines in inpatient stays and growth in outpatient visits.
- All-payer inpatient stays per capita held relatively steady from 2015 to 2017, but declined 0.7 percent in 2018 and 1.0 percent in 2019—a cumulative change of –1.6 percent from 2015 to 2019.
- All-payer outpatient visits per capita grew more than 2 percent in each of 2015 and 2016, were steadier in 2017 and 2018, and then returned to 2 percent growth in 2019—a cumulative change of 4.9 percent from 2015 to 2019.

Chart 6-5. IPPS hospitals' aggregate total and operating all-payer margins reached record highs in 2019

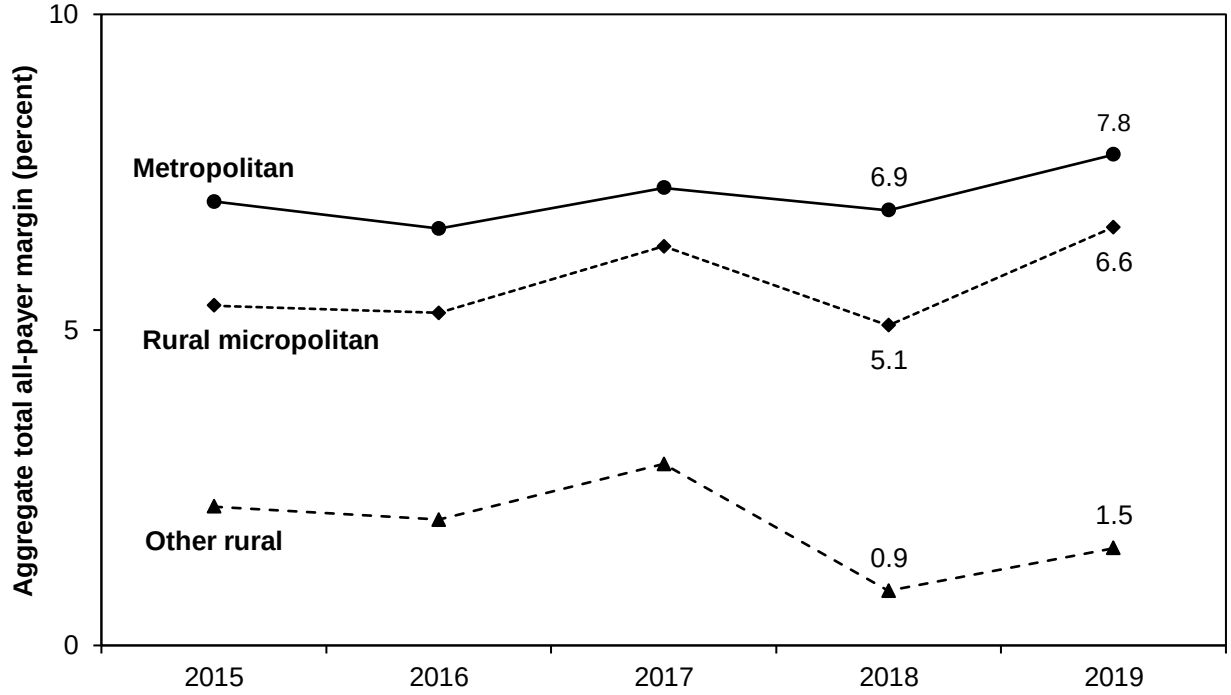


Note: IPPS (inpatient prospective payment system), EBITDA (earnings before interest, taxes, depreciation, and amortization). Hospitals' aggregate margin is calculated as aggregate payments minus aggregate allowable costs, divided by aggregate payments. "All-payer" margin includes payments from all payers. "Total" margin includes investment income; "operating" margin is limited to patient care revenue; and EBITDA margin is a measure of cash flow. Analysis includes short-term acute care hospitals in the U.S. (excluding territories) paid under the IPPS with complete cost report data.

Source: MedPAC analysis of hospital cost report data from CMS.

- Hospitals' aggregate all-payer margin reflects the relationship between hospitals' payments and costs across all payers (Medicare, Medicaid, other government payers, and private payers).
- In 2019, IPPS hospitals' aggregate total all-payer margin (which includes investment income) increased to an all-time high of 7.6 percent. Similarly, IPPS hospitals' aggregate operating margin increased to an all-time high of 6.5 percent, slightly above the prior all-time high in 2015.
- In addition, IPPS hospitals' cash flow margin (which includes earnings before interest, taxes, depreciation, and amortization (EBITDA)) increased to 10.5 percent in 2019, the highest level since 2015.
- Within these aggregate results, there continued to be substantial variation in hospitals' financial performance. For example, in 2019, for-profit IPPS hospitals' all-payer operating margin was 12.5 percent, compared with nonprofit IPPS hospitals' all-payer margin of 7.3 percent (data not shown). In contrast, the all-payer operating margin at rural nonmicropolitan IPPS hospitals was only 1.5 percent in 2019.

Chart 6-6. Urban IPPS hospitals continued to have a higher aggregate total all-payer margin than rural IPPS hospitals, 2015–2019



Note: IPPS (inpatient prospective payment system). Hospitals' aggregate margin is calculated as aggregate payments minus aggregate allowable costs, divided by aggregate payments. "Total all-payer" margin includes payments from all payers and from investments. Metropolitan (urban) counties contain an urban cluster of 50,000 or more people, and rural micropolitan counties contain a cluster of 10,000 to 50,000 people; all other counties are classified as "other rural." Analysis includes short-term acute care hospitals in the U.S. (excluding territories) paid under the IPPS with complete cost report data.

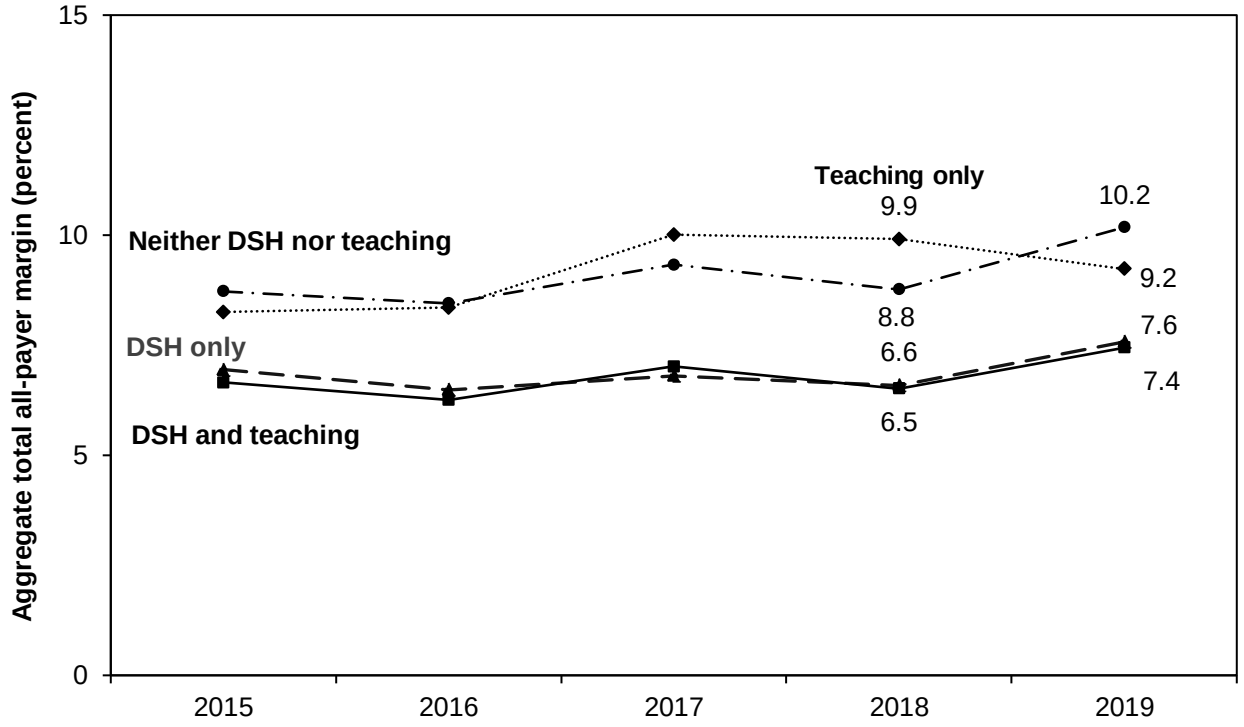
Source: MedPAC analysis of hospital cost report data from CMS.

- Metropolitan (urban) IPPS hospitals continued to have a higher aggregate total all-payer margin than rural micropolitan or other rural IPPS hospitals in 2019. (In contrast, rural IPPS hospitals had a higher aggregate overall Medicare margin, see Chart 6-11.)

- From 2018 to 2019, the aggregate total all-payer margin for metropolitan IPPS hospitals increased from 6.9 percent to a relative high of 7.8 percent, while the margin for rural micropolitan IPPS hospitals increased from 5.1 to a relative high of 6.6 percent. These 2019 margins were the highest since the late 1990s (data not shown). From 2018 to 2019, the aggregate all-payer total margin for other rural IPPS hospitals also increased, from 0.9 to 1.5 percent, but remained below 2015 to 2017 levels.

- From 2018 to 2019, the aggregate all-payer total margin for critical access hospitals also increased, from a relative low of 2.8 percent to 3.6 percent (data not shown).

Chart 6-7. IPPS hospitals, including those that treat a disproportionate share of low-income patients, reached record highs in aggregate total all-payer margin, 2019



Note: IPPS (inpatient prospective payment system), DSH (disproportionate share hospital). Hospitals' aggregate margin is calculated as aggregate payments minus aggregate allowable costs, divided by aggregate payments. "Total all-payer" margin includes payments from all payers and from investments. Analysis includes short-term acute care hospitals in the U.S. (excluding territories) paid under the IPPS with complete cost report data.

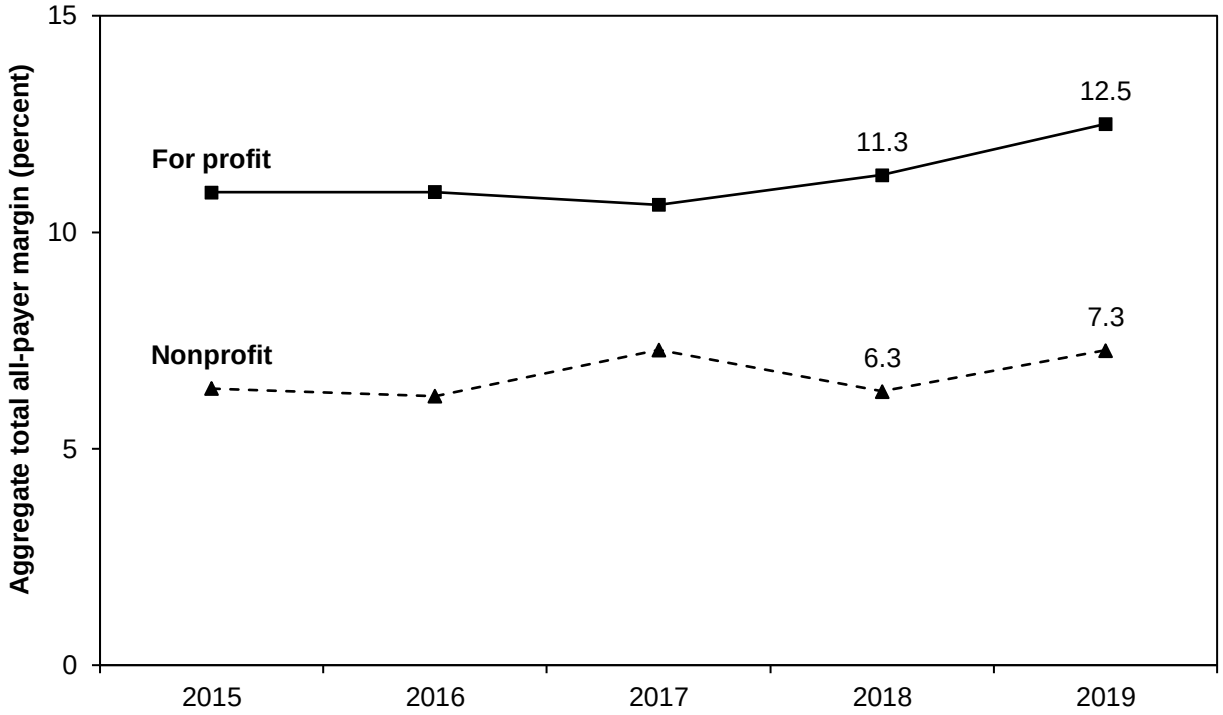
Source: MedPAC analysis of hospital cost report data from CMS.

- IPPS hospitals that treated a disproportionate share of low-income patients (DSHs) continued to have a lower aggregate total all-payer margin than non-DSH hospitals, regardless of whether the hospital was a teaching hospital. (In contrast, DSHs had a higher aggregate overall Medicare margin than other hospitals; see Chart 6-12.)

- From 2018 to 2019, the aggregate total all-payer margin for DSHs and teaching IPPS hospitals increased from 6.5 percent to 7.4 percent, with a similar increase among DSHs but non-teaching hospitals (from 6.6 percent to 7.6 percent)—all-time highs since the late-1990s in both categories (data not shown).

- Over this same time period, IPPS hospitals that were neither DSHs nor teaching hospitals experienced a larger increase in aggregate total all-payer margin, from 8.8 percent to 10.2 percent—an all-time high since the late-1990s (data not shown). In contrast, the aggregate total all-payer margin at the smaller number of teaching but non–disproportionate share hospitals decreased from 9.9 percent to 9.2 percent.

Chart 6-8. For-profit IPPS hospitals' aggregate total all-payer margin reached an all-time high in 2019

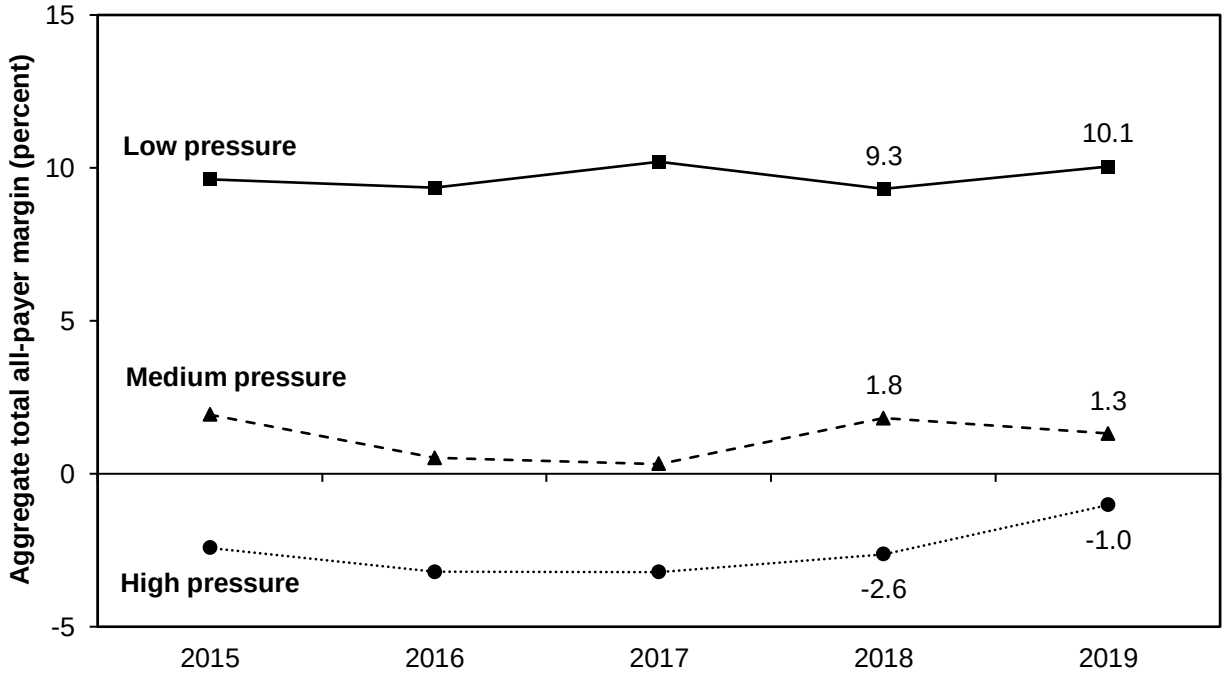


Note: IPPS (inpatient prospective payment system). Hospitals' aggregate margin is calculated as aggregate payments minus aggregate allowable costs, divided by aggregate payments. "Total all-payer" margin includes payments from all payers and from investments. Analysis includes short-term acute care hospitals in the U.S. (excluding territories) paid under the IPPS with complete cost report data.

Source: MedPAC analysis of hospital cost report data from CMS.

- For-profit IPPS hospitals continued to have a higher aggregate total all-payer margin than nonprofit IPPS hospitals. (For-profit IPPS hospitals also have a higher overall Medicare margin; see Chart 6-13.)
- From 2018 to 2019, for-profit hospitals' aggregate total all-payer margin increased from 11.3 percent to 12.5 percent. This was the highest level since the late-1990s (data not shown).
- Over this same period, nonprofit IPPS hospitals' aggregate total all-payer margin increased from 6.3 percent to 7.3 percent, returning to the level in 2017. The 2017 and 2019 total all-payer margins were the highest since an all-time high of 7.4 percent in 2014 (data not shown).

Chart 6-9. IPPS hospitals under low fiscal pressure continued to have a higher aggregate total all-payer margin than those under higher fiscal pressure, 2015–2019



Note: IPPS (inpatient prospective payment system). Hospitals' aggregate margin is calculated as aggregate payments minus aggregate allowable costs, divided by aggregate payments. "Total all-payer" margin includes payments from all payers and from investments. "High-pressure" hospitals are defined as those with a median non-Medicare profit margin of 1 percent or less over five years and a net worth (assets minus liabilities) that would have grown by less than 1 percent per year over that period if the hospital's Medicare profits had been zero. "Low-pressure" hospitals are defined as those with a median non-Medicare profit 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 Medicare profits had been zero. "Medium-pressure" hospitals are those that fit into neither the high- nor the low-pressure categories. Analysis includes short-term acute care hospitals in the U.S. (excluding territories) paid under the IPPS with complete cost report data.

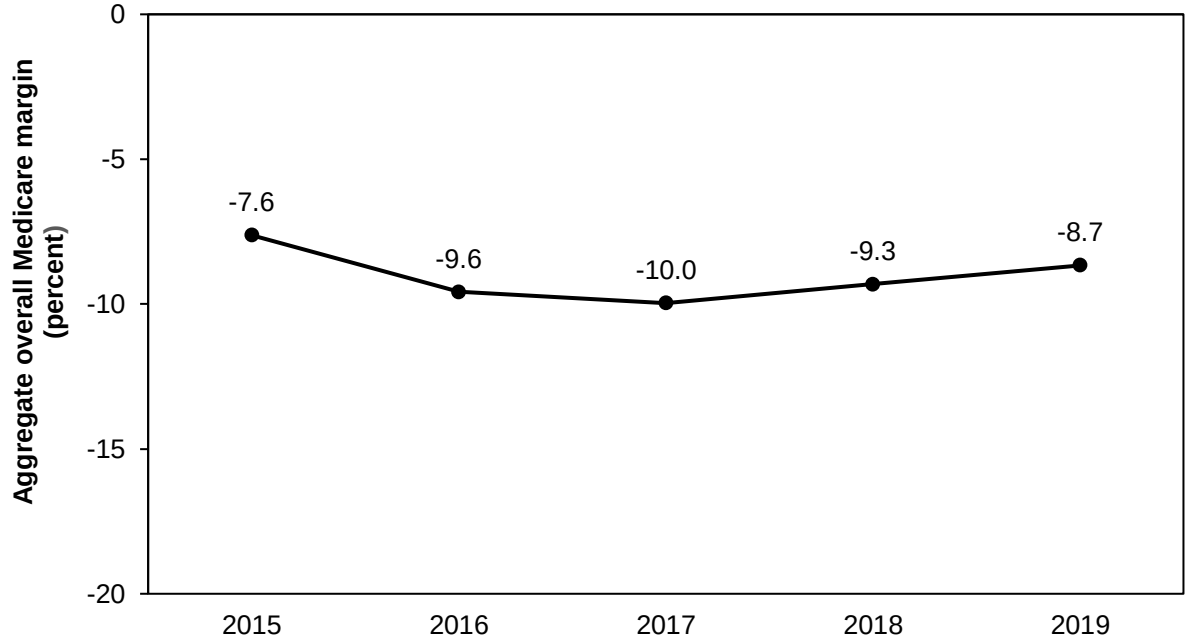
Source: MedPAC analysis of hospital cost report data from CMS.

- IPPS hospitals' total all-payer margin varied depending on their level of fiscal pressure. IPPS hospitals under the highest fiscal pressure—defined as those with a median non-Medicare profit margin of 1 percent or less and lacking material growth in net worth—continued to have a lower aggregate total all-payer margin than hospitals under less fiscal pressure. (IPPS hospitals under fiscal pressure have a higher overall Medicare margin, see Chart 6-14.)

- IPPS hospitals under low fiscal pressure maintained a strong and steady aggregate total all-payer margin, including an increase to an all-time high of 10.1 percent in 2019.

- In contrast, hospitals under high fiscal pressure maintained a negative aggregate total all-payer margin, though it increased to a relative high of –1 percent.

Chart 6-10. IPPS hospitals' aggregate overall Medicare margin remained negative, but increased in 2019



Note: IPPS (inpatient prospective payment system). Hospitals' Medicare margin is calculated as aggregate Medicare payments minus aggregate allowable Medicare costs, divided by aggregate Medicare payments. "Overall Medicare margin" refers to the aggregate margin across hospital service lines (including inpatient, outpatient, swing bed, skilled nursing, rehabilitation, psychiatric, and home health services), as well as supplemental payments not tied to the provision of services (such as direct graduate medical education and uncompensated care payments) and bad debt payments. Analysis includes short-term acute care hospitals in the U.S. (excluding territories) paid under the IPPS with complete cost report data.

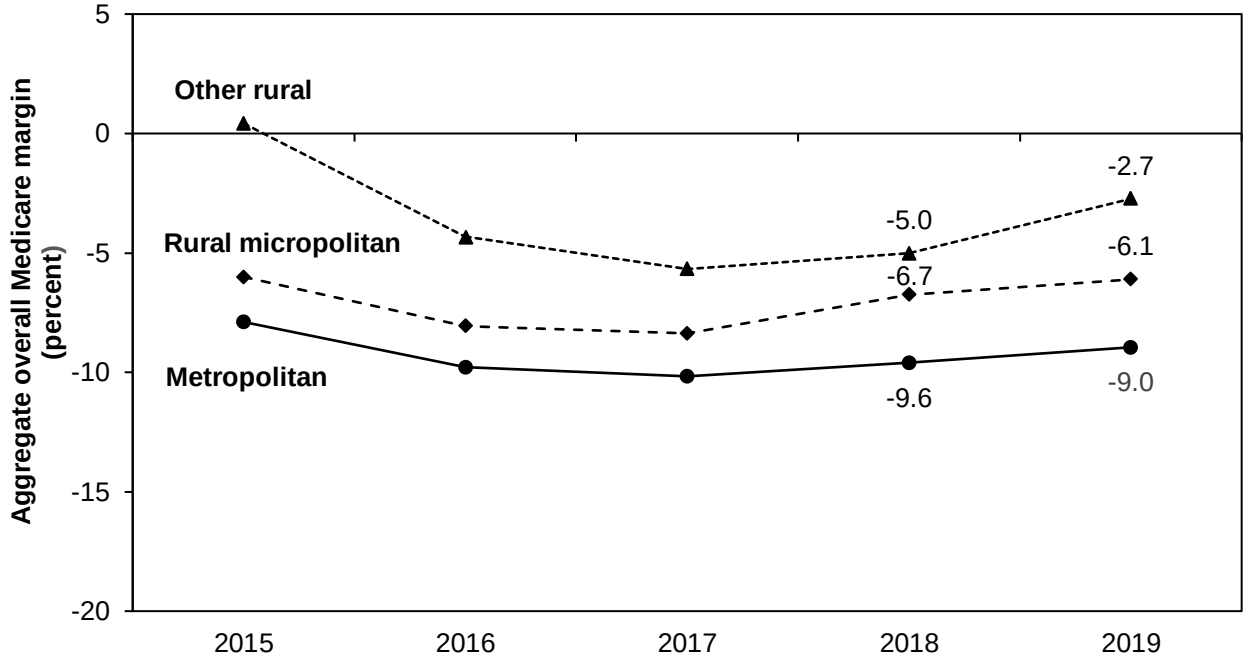
Source: MedPAC analysis of hospital cost report data from CMS.

- Hospitals' aggregate overall Medicare margin reflects the relationship between hospitals' Medicare fee-for-service payments and Medicare-allowable costs across inpatient, outpatient, and other services, as well as supplemental Medicare payments not tied to the provision of services (such as uncompensated care and direct graduate medical education payments).

- From 2018 to 2019, IPPS hospitals' aggregate overall Medicare margin increased from –9.3 percent to –8.7 percent. However, the margin remains well below pre-2014 levels (data not shown), when Congress reduced DSH payments and added uncompensated care payments proportional to the decline in the national uninsured rate (see Chart 6-18).

- The range of overall Medicare margins at individual IPPS hospitals varied substantially. For example, in 2019, 25 percent of hospitals had an overall Medicare margin of 3 percent or higher, and another 25 percent had a margin of –18 percent or lower (data not shown).

Chart 6-11. Rural IPPS hospitals continued to have a higher aggregate overall Medicare margin than urban IPPS hospitals, 2015–2019



Note: IPPS (inpatient prospective payment system). Hospitals' Medicare margin is calculated as aggregate Medicare payments minus aggregate allowable Medicare costs, divided by aggregate Medicare payments. "Overall Medicare margin" refers to the aggregate margin across hospital service lines (including inpatient, outpatient, swing bed, skilled nursing, rehabilitation, psychiatric, and home health services), as well as supplemental payments not tied to the provision of services (such as direct graduate medical education and uncompensated care payments) and bad debt payments. Metropolitan (urban) counties contain an urban cluster of 50,000 or more people, and rural micropolitan counties contain a cluster of 10,000 to 50,000 people; all other counties are classified as "other rural." Analysis includes short-term acute care hospitals in the U.S. (excluding territories) paid under the IPPS with complete cost report data.

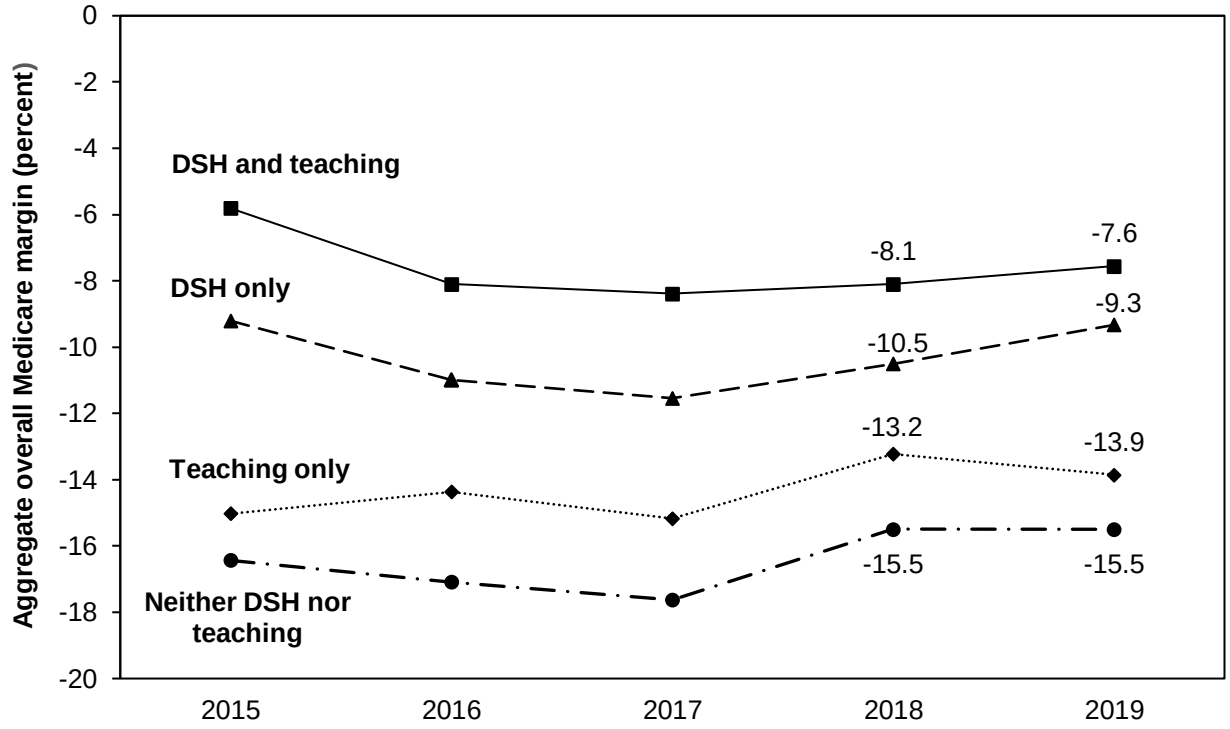
Source: MedPAC analysis of hospital cost report data from CMS.

- IPPS hospitals in rural micropolitan and other rural areas continued to have higher aggregate overall Medicare margins than metropolitan (urban) IPPS hospitals. (The reverse holds for the total all-payer margin; see Chart 6-6.) The higher margins at IPPS rural hospitals were in large part attributable to the additional IPPS payments many rural hospitals received for their inpatient services through the sole community hospital, Medicare-dependent hospital, and low-volume hospital designations (see Chart 6-17).

- From 2018 to 2019, the overall Medicare margin increased for urban, rural micropolitan, and other rural hospitals. However, the increase was largest for IPPS hospitals in rural nonmicropolitan ("other rural") areas (from –5.0 percent to –2.7 percent, the highest level since 2015).

- From 2018 to 2019, the overall Medicare margin for critical access hospitals remained steady, near –2 percent (data not shown).

Chart 6-12. IPPS hospitals that treat a disproportionate share of low-income patients or are teaching hospitals continued to have higher aggregate overall Medicare margins than other hospitals, 2015–2019



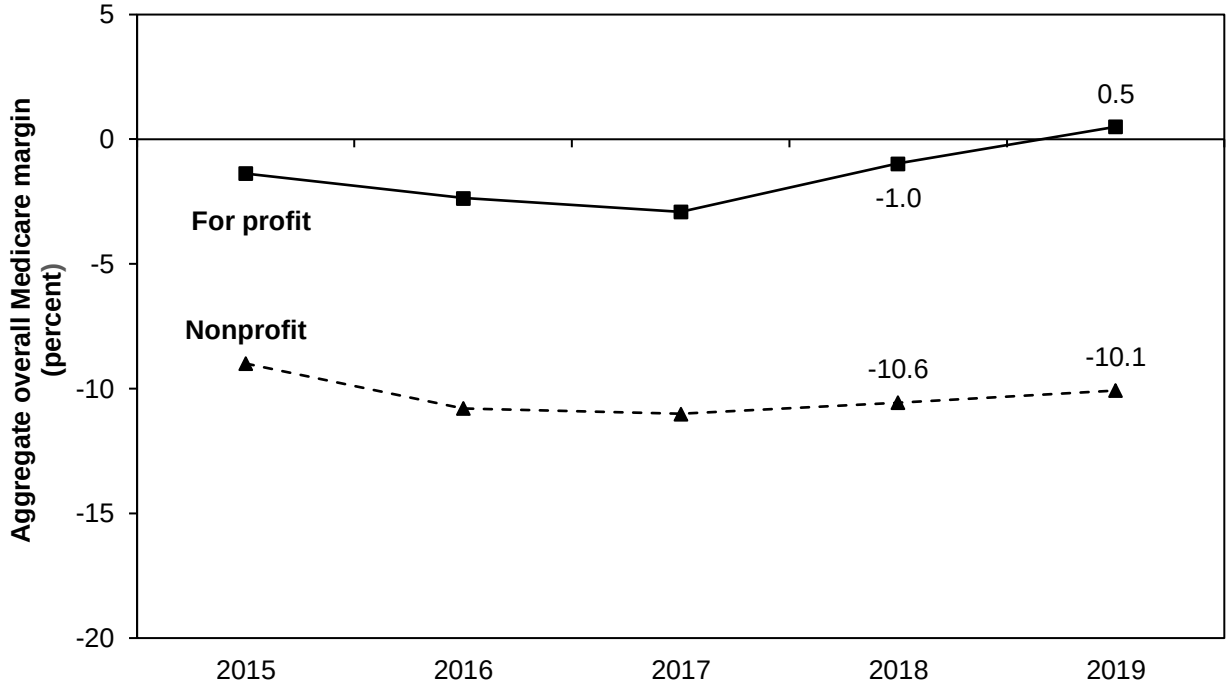
Note: IPPS (inpatient prospective payment system), DSH (disproportionate share hospital). Hospitals' Medicare margin is calculated as aggregate Medicare payments minus aggregate allowable Medicare costs, divided by aggregate Medicare payments. "Overall Medicare margin" refers to the aggregate margin across hospital service lines (including inpatient, outpatient, swing bed, skilled nursing, rehabilitation, psychiatric, and home health services), as well as supplemental payments not tied to the provision of services (such as direct graduate medical education and uncompensated care payments) and bad debt payments. Analysis includes short-term acute care hospitals in the U.S. (excluding territories) paid under the IPPS with complete cost report data.

Source: MedPAC analysis of hospital cost report data from CMS.

- IPPS hospitals that treat a disproportionate share of low-income patients (DSHs) or are teaching hospitals continued to have a higher aggregate overall Medicare margin than other IPPS hospitals. (The reverse holds for the total all-payer margin; see Chart 6-7.) The higher margins at DSH and teaching IPPS hospitals were in large part attributable to the additional IPPS payments DSH and teaching hospitals received for inpatient services (see Chart 6-17), as well as supplemental uncompensated care payments.

- From 2018 to 2019, the aggregate overall Medicare margin increased for DSH hospitals—both those that were and were not also teaching hospitals—driven by higher uncompensated care payments (see Chart 6-18).

Chart 6-13. For-profit IPPS hospitals continued to have a higher aggregate overall Medicare margin than nonprofit IPPS hospitals and increased to a positive margin in 2019

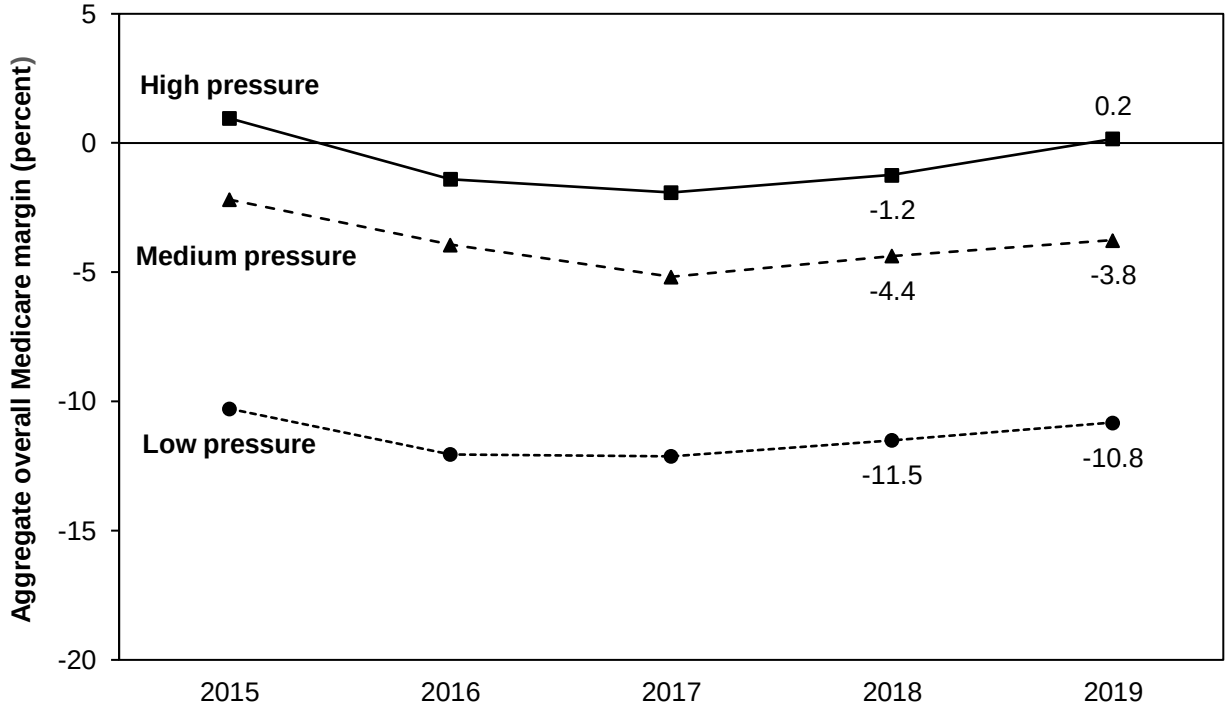


Note: IPPS (inpatient prospective payment system). Hospitals' Medicare margin is calculated as aggregate Medicare payments minus aggregate allowable Medicare costs, divided by aggregate Medicare payments. "Overall Medicare margin" refers to the aggregate margin across hospital service lines (including inpatient, outpatient, swing bed, skilled nursing, rehabilitation, psychiatric, and home health services), as well as supplemental payments not tied to the provision of services (such as direct graduate medical education and uncompensated care payments) and bad debt payments. Analysis includes short-term acute care hospitals in the U.S. (excluding territories) paid under the IPPS with complete cost report data.

Source: MedPAC analysis of hospital cost report data from CMS.

- For-profit IPPS hospitals continued to have a higher aggregate overall Medicare margin than nonprofit hospitals.
- From 2018 to 2019, for-profit IPPS hospitals' aggregate overall Medicare margin increased from –1.0 to 0.5 percent. This was the highest level since 2014 (data not shown).
- From 2018 to 2019, nonprofit IPPS hospitals' aggregate overall Medicare margin also increased, but by a smaller amount.

Chart 6-14. IPPS hospitals under high fiscal pressure continued to have a higher aggregate overall Medicare margin than those under medium and low fiscal pressure, 2015–2019



Note: IPPS (inpatient prospective payment system). Hospitals' Medicare margin is calculated as aggregate Medicare payments minus aggregate allowable Medicare costs, divided by aggregate Medicare payments. "Overall Medicare margin" refers to the aggregate margin across hospital service lines (including inpatient, outpatient, swing bed, skilled nursing, rehabilitation, psychiatric, and home health services), as well as supplemental payments not tied to the provision of services (such as direct graduate medical education and uncompensated care payments) and bad debt payments. "High-pressure" hospitals are defined as those with a median non-Medicare profit margin of 1 percent or less over five years and a net worth (assets minus liabilities) that would have grown by less than 1 percent per year over that period if the hospital's Medicare profits had been zero. "Low-pressure" hospitals are defined as those with a median non-Medicare profit 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 Medicare profits had been zero. "Medium-pressure" hospitals are those that fit into neither the high- nor the low-pressure categories. Analysis includes short-term acute care hospitals in the U.S. (excluding territories) paid under the IPPS with complete cost report data.

Source: MedPAC analysis of hospital cost report data from CMS.

- IPPS hospitals under the highest fiscal pressure—defined as those with a median non-Medicare profit margin of 1 percent or less and a lack of material growth in worth—continued to have a higher aggregate overall Medicare margin than hospitals under less fiscal pressure. (In contrast, IPPS hospitals under fiscal pressure have a lower total all-payer margin; see Chart 6-9.)

- From 2018 to 2019, high-pressure IPPS hospitals' aggregate overall Medicare margin increased from –1.2 to 0.2 percent, the highest level since 2015.

- From 2018 to 2019, the aggregate overall Medicare margin among IPPS hospitals under medium and low fiscal pressure also increased, but by a smaller amount.

Chart 6-15. Financial pressure led to lower hospital costs per discharge in 2019

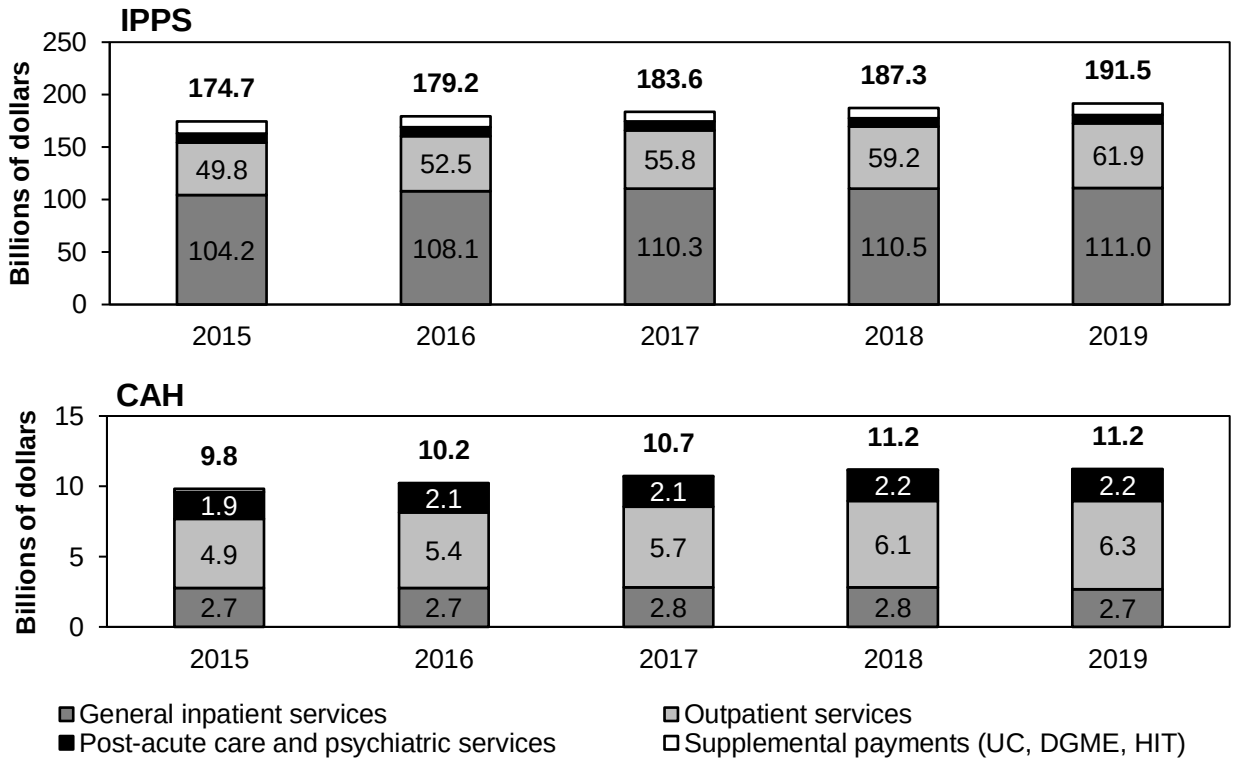
	Level of financial pressure, 2014–2018		
	High pressure (non-Medicare margin ≤ 1%)	Medium pressure	Low pressure (non-Medicare margin > 5%)
Number of hospitals	480	265	1,329
Financial characteristics, 2019 (medians)			
Non-Medicare margin (private, Medicaid, uninsured)	–3%	3%	14%
Standardized cost per Medicare discharge (as a share of the national median)			
For-profit and nonprofit hospitals	0.95	1.00	1.04
Nonprofit hospitals	0.97	1.01	1.06
For-profit hospitals	0.88	0.93	0.96
Annual growth in cost per discharge, 2016–2019	2%	2%	2%
Overall 2019 Medicare margin	0%	–2%	–9%
Patient characteristics (medians)			
Total hospital discharges in 2019	3,287	5,655	8,503
Medicare share of inpatient days	37%	35%	35%
Medicaid share of inpatient days	6%	6%	6%
Medicare case-mix index	1.46	1.57	1.69

Note: Standardized costs are adjusted for hospital case mix, wage index, outliers, transfer cases, interest expense, and the effects of teaching and low-income Medicare patients on hospital costs. The sample includes short-term acute care hospitals paid under the inpatient prospective payment system with over 500 discharges that had complete cost reports on file with CMS by October 2020. "High-pressure" hospitals are defined as those with a median non-Medicare profit margin of 1 percent or less over five years and a net worth (assets minus liabilities) that would have grown by less than 1 percent per year over that period if the hospital's Medicare profits had been zero. "Low-pressure" hospitals are defined as those with a median non-Medicare profit 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 Medicare profits had been zero. "Medium-pressure" hospitals are those that fit into neither the high- nor the low-pressure categories.

Source: MedPAC analysis of hospital cost report data and claims files from CMS.

- Hospitals under high financial pressure had 5 percent lower standardized costs per discharge than the national median. For-profit hospitals tended to constrain their costs more than nonprofit hospitals. The median for-profit hospital had costs that were 4 percent below the median even when they were not under financial pressure.
- Hospitals with lower volume, lower case mix, and higher Medicare shares of discharges are more likely to be under financial pressure.
- One limitation of this analysis is that it measures only hospital inpatient costs. To the extent that hospitals with strong profit margins direct their resources toward non-inpatient expenditures (such as the purchase or subsidization of physician practices), those costs would not be included in our standardized costs per discharge.

Chart 6-16. Medicare FFS payments for inpatient services were the largest component of payments to IPPS hospitals but not to CAHs, 2015–2019



Note: FFS (fee-for-service), IPPS (inpatient prospective payment system), CAH (critical access hospital), UC (uncompensated care), DGME (direct graduate medical education), HIT (health information technology). Medicare-designated CAHs are limited to 25 beds and primarily operate in rural areas; Medicare pays these hospitals based on their reported costs. Analysis includes short-term acute care hospitals in the U.S. (excluding territories) paid under the IPPS or CAH payment system with complete cost report data. Components may not sum to totals due to rounding and components with values not shown.

Source: MedPAC analysis of hospital cost report data from CMS.

- In fiscal year 2019, IPPS hospitals received $191.5 billion in Medicare FFS payments, including $111.0 billion for general inpatient services and $61.9 billion for outpatient services. From 2015 to 2019, IPPS hospitals' Medicare FFS inpatient payments increased at an average annual rate of 1.6 percent, while outpatient payments increased 5.6 percent. These increases were driven by increases in payments per service (data not shown).
- In fiscal year 2019, CAHs received $11.2 billion in Medicare FFS payments, including $2.7 billion for general inpatient services, $6.3 billion for outpatient services, and $2.2 billion in post-acute care services (mainly provided in swing beds). From 2015 to 2019, CAHs' Medicare FFS inpatient payments held relatively steady, while outpatient revenue increased 6.4 percent, and post-acute care revenue increased 3.7 percent. These increases were driven by increases in payments per service (data not shown).

Chart 6-17. About 15 percent of IPPS payments were from adjustments and additional payments, 2019

Hospital group	Share of IPPS payments					
	Base PPS	Low income (DSH)	Teaching (IME)	Outliers	Rural and/or Isolated	Quality
All IPPS	84.9%	3.2%	6.5%	4.7%	1.4%	–0.8%
Metropolitan (urban)	85.0	3.3	6.9	4.9	0.7	–0.8
Micropolitan	84.3	2.4	2.1	2.3	9.4	–0.5
Other rural	80.1	2.3	0.5	1.3	16.2	–0.3
For profit	90.0	3.4	3.6	3.0	1.0	–1.2
Nonprofit	85.1	3.1	6.5	4.5	1.4	–0.7
Government	77.5	4.0	9.8	7.2	2.1	–0.8
DSH and teaching	81.4	3.7	9.7	5.4	0.6	–0.8
DSH only	91.2	3.2	0.0	3.2	3.2	–0.8
Teaching only	88.4	0.1*	6.3	4.7	0.9	–0.4
Neither	93.9	0.1*	0.0	2.8	3.4	–0.4
Sole community	79.1	2.2	2.4	2.4	14.3	–0.4
Medicare dependent	83.3	1.9	0.4	1.1	13.7	–0.4
Low volume	79.1	2.0	0.5	1.4	17.4	–0.2

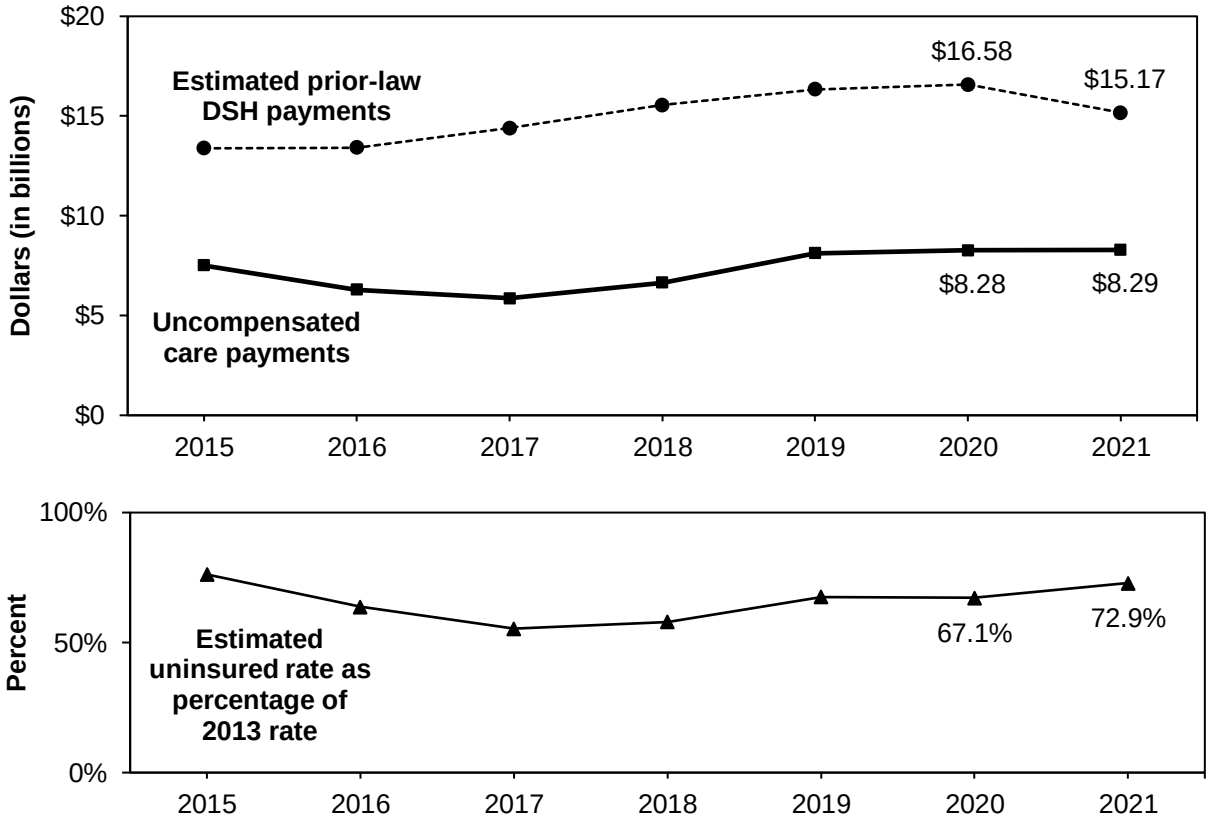
Note: IPPS (inpatient prospective payment system), DSH (disproportionate share hospital), IME (indirect medical education). Payments are shares of total inpatient operating and capital PPS payments, and exclude uncompensated care, direct graduate medical education, Medicare Advantage IME, and other pass-through payments outside of the IPPS. "Rural and/or isolated" includes additional payments to sole community hospitals, Medicare-dependent hospitals, and low-volume hospitals; while sole community and Medicare-dependent hospitals that are paid on their hospital-specific rate do not technically receive any base PPS payments or adjustments, the "Rural and/or Isolated" column includes only the amount by which their rate exceeds the otherwise applicable IPPS payments. "Quality" includes payments and penalties from the Value-Based Purchasing Program, Hospital Readmissions Reduction Program, and Hospital Acquired Conditions Reduction Program. Metropolitan (urban) counties contain an urban cluster of 50,000 or more people; rural micropolitan counties contain a cluster of 10,000 to 50,000 people; all other counties are classified as "other rural." Analysis limited to IPPS hospitals in the U.S. with a complete cost report having a midpoint in fiscal year 2019. Components may not sum to totals due to rounding and because other types of payments, such as new technology payments, are not included in the table.
* DSH group defined as receiving inpatient operating DSH payments, while DSH payments column includes both inpatient operating and capital DSH payments. All urban hospitals with more than 100 beds are eligible for inpatient capital DSH payments.

Source: MedPAC analysis of hospital cost report data from CMS.

- Base payments accounted for about 85 percent of IPPS payments to hospitals for inpatient services provided to Medicare FFS beneficiaries, while low-income and teaching adjustments, outlier payments, rural and/or isolated payments, and quality payments and penalties accounted for the remaining 15 percent.

- The share of IPPS payments from different payment types varied substantially across different groups of hospitals. For example, while special payments to rural or isolated hospitals accounted for 1.4 percent of all IPPS payments to hospitals, they accounted for over 13 percent of payments to hospitals designated as sole community, Medicare dependent, and/or low-volume hospitals.

Chart 6-18. Medicare's uncompensated care payments to IPPS hospitals have increased from a relative low in 2017

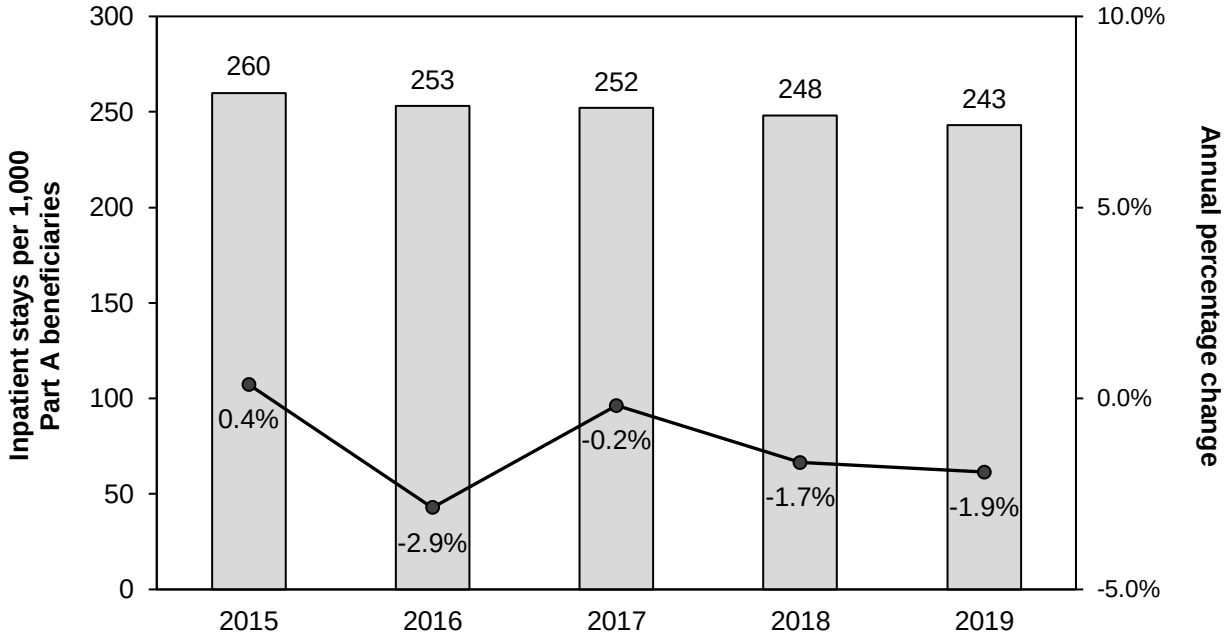


Note: IPPS (inpatient prospective payment system), DSH (disproportionate share). Uncompensated care payments are post-sequestration. Chart does not include capital DSH payments.

Source: CMS IPPS final rules.

- In addition to IPPS payments for fee-for-service Medicare beneficiaries' inpatient stays, the Medicare program makes uncompensated care payments to IPPS hospitals to help cover their costs of treating uninsured patients. Pursuant to a provision in the Affordable Care Act of 2010, beginning in 2014, each eligible hospital receives (1) a reduced operating DSH payment and (2) an uncompensated care payment. Under the revised operating DSH payment equation, hospitals receive 25 percent of the DSH funds they would have received under prior law. Second, each hospital receives uncompensated care payments equal to its share of a fixed pool of dollars, defined as 75 percent of estimated aggregated operating DSH payments under the prior-law DSH formula multiplied by the national uninsured rate as a percentage of the uninsured rate in 2013. Therefore, when the rate of uninsured individuals increases and hospitals have greater losses on uncompensated care, CMS gives hospitals higher uncompensated care add-on payments to their IPPS rates.
- Between 2019 and 2021, Medicare's uncompensated care payments were relatively steady. This reflected three factors roughly offsetting each other in those years: the change in estimated prior-law DSH payments, the change in the national uninsured rate, and the portion of the year that Medicare sequestration was suspended.

Chart 6-19. Medicare FFS inpatient stays per capita decreased, 2015–2019

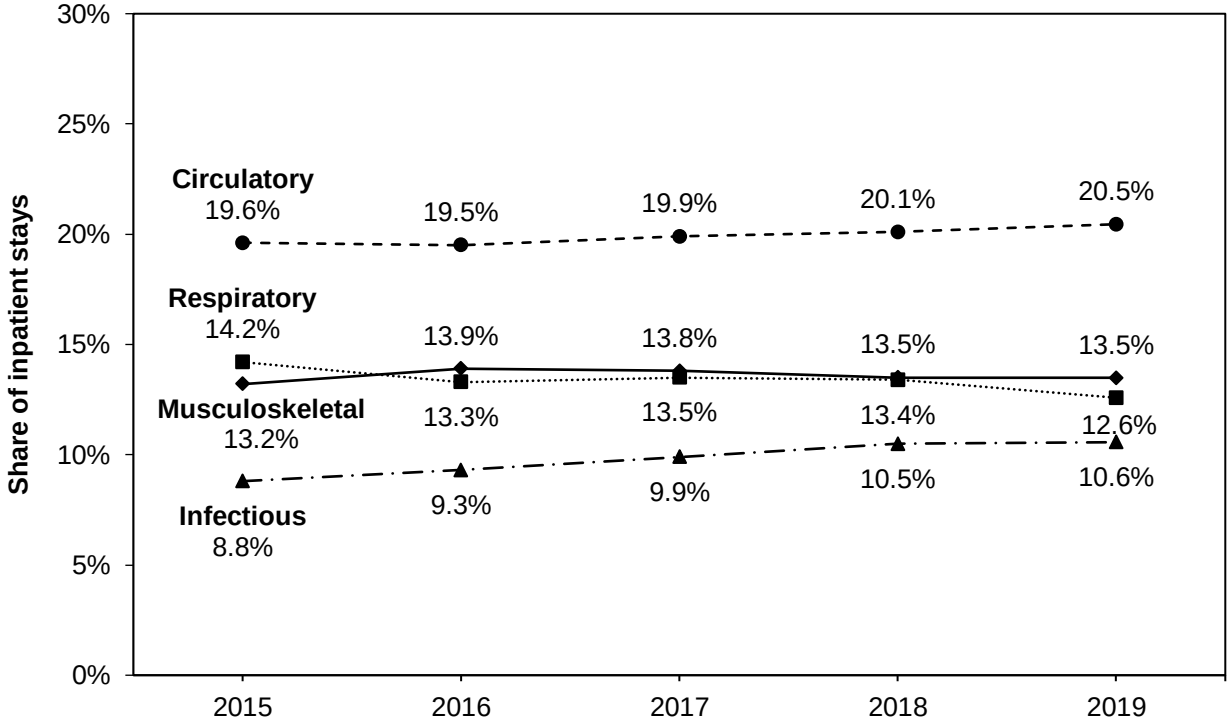


Note: FFS (fee-for-service). Data are for short-term acute care hospitals in the U.S. (exclusive of territories).

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

- The number of inpatient stays per 1,000 Medicare FFS beneficiaries decreased from 260 in 2015 to 243 in 2019. This is a slower decline than earlier in the decade (data not shown) but is still a faster decline than all-payer inpatient stays per capita (see Chart 6-4).
- The magnitude of the decrease in Medicare FFS inpatient stays per capita varied across types of hospitals. For example, from 2018 to 2019, the number of inpatient stays per capita fell 1.6 percent at hospitals located in metropolitan (urban) areas, 3.8 percent at those in rural micropolitan areas, and 6 percent at those located in other rural areas (data not shown).

Chart 6-20. Four major diagnostic categories accounted for over half of all Medicare FFS inpatient stays at short-term acute care hospitals, 2015–2019



Note: FFS (fee-for-service). Data are for short-term acute care hospitals in the U.S. (exclusive of territories).

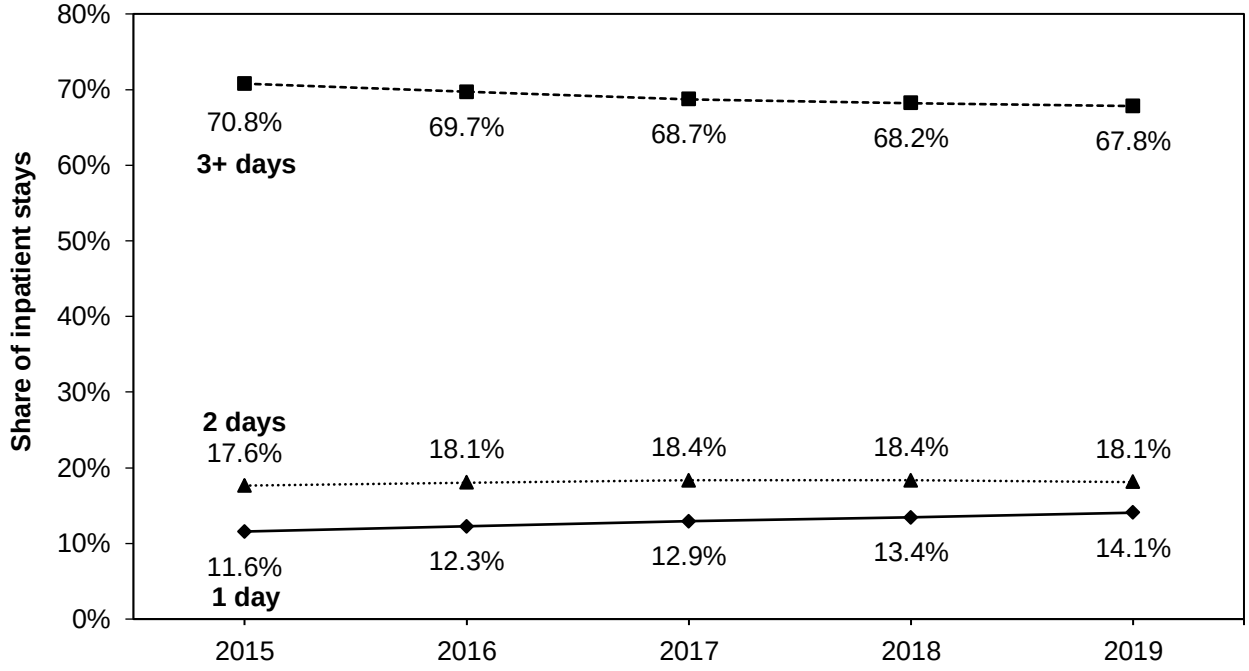
Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS.

- Over half of all Medicare FFS inpatient stays at short-term acute care hospitals were for beneficiaries with a primary diagnosis in one of four major diagnostic categories: circulatory, musculoskeletal, respiratory, or infectious diseases.

- The most common major diagnostic category of Medicare FFS inpatient stays is diseases of the circulatory system, such as heart failure and cardiac arrhythmia. After a relative low in 2016, its share increased to over 20 percent in 2019.

- Of the four most common major diagnostic categories, the one with the largest increase from 2015 to 2019 was infectious and parasitic diseases, such as septicemia. This rise continued a longer term trend, with the share of Medicare FFS beneficiaries' inpatient stays for infectious diseases doubling since 2010 (data not shown).

Chart 6-21. Share of one-day stays among Medicare FFS beneficiaries at short-term acute care hospitals increased, 2015–2019



Note: FFS (fee-for-service). Data are for short-term acute care hospitals in the U.S. (exclusive of territories). Components may not sum to 100 percent due to rounding.

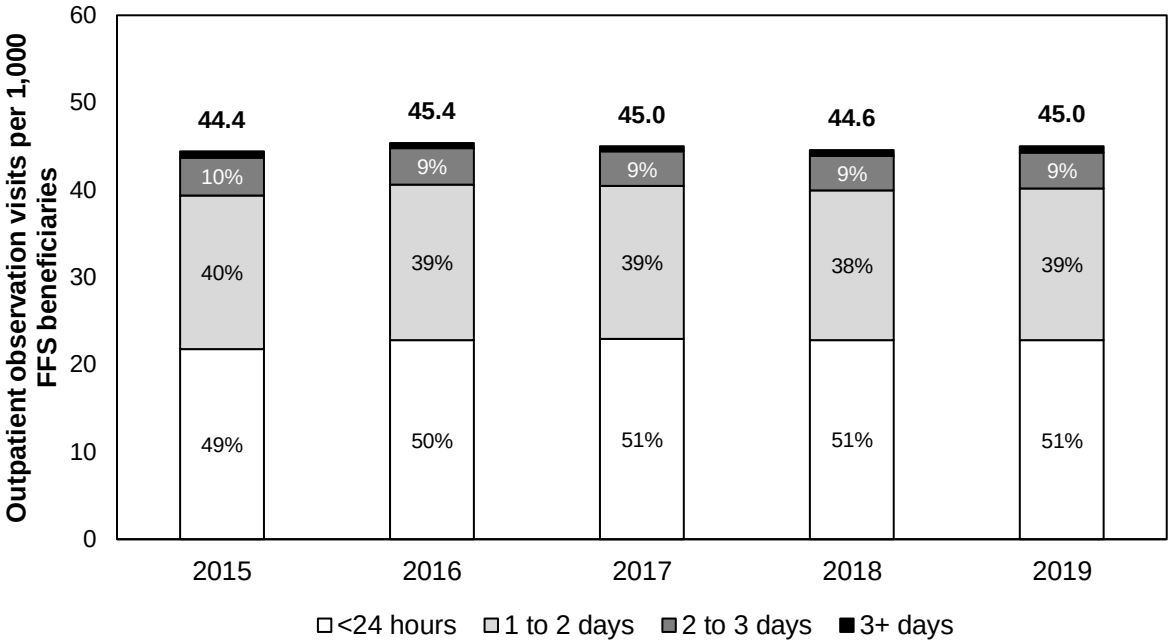
Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS.

- The share of Medicare FFS beneficiaries' inpatient stays at short-term acute care hospitals that were only one day long increased from 2015 to 2019. This reversed the prior trend of declining one-day stays from 2010 to 2014 (data not shown). As the Commission has previously noted, growth in the number of one-day stays starting in 2015 could be due to the reduced likelihood that CMS's recovery audit contractors (RACs) would deny payment for one-day stays. In 2015, CMS ceased patient status reviews (which previously resulted in challenges to one-day stay claims). The result was that from 2014 to 2015, claims challenged by the RACs as overpayments fell by 91 percent (data not shown).

- From 2015 to 2019, there was also a slight increase in the share of stays that were two days long and a decrease in the share of stays three days or longer.

- Together, these changes correspond to a 1.9 percent decrease in the average length of stay, from 5.05 days in 2015 to 4.95 days in 2019 (data not shown). Over 90 percent of Medicare FFS beneficiaries' inpatient stays in 2019 were 10 days or fewer; however, a small share (0.66 percent) of stays lasted over a month (data not shown).

Chart 6-22. Number of Medicare FFS outpatient observation visits per capita remained relatively steady, and nearly half were longer than 24 hours, 2015–2019



Note: FFS (fee-for-service). Observation visits are separately payable visits with a length of stay of at least eight hours. Data for outpatient observation visits include short-term acute care hospitals in the U.S. (exclusive of territories) paid under the inpatient prospective payment system or under the Maryland state waiver. "Outpatient observation visits per capita" refers to outpatient observation visits—that is, observation visits that did not result in an inpatient admission—per Medicare FFS Part B beneficiary. Years are calendar years. Components may not sum to 100 percent due to rounding and component values not shown.

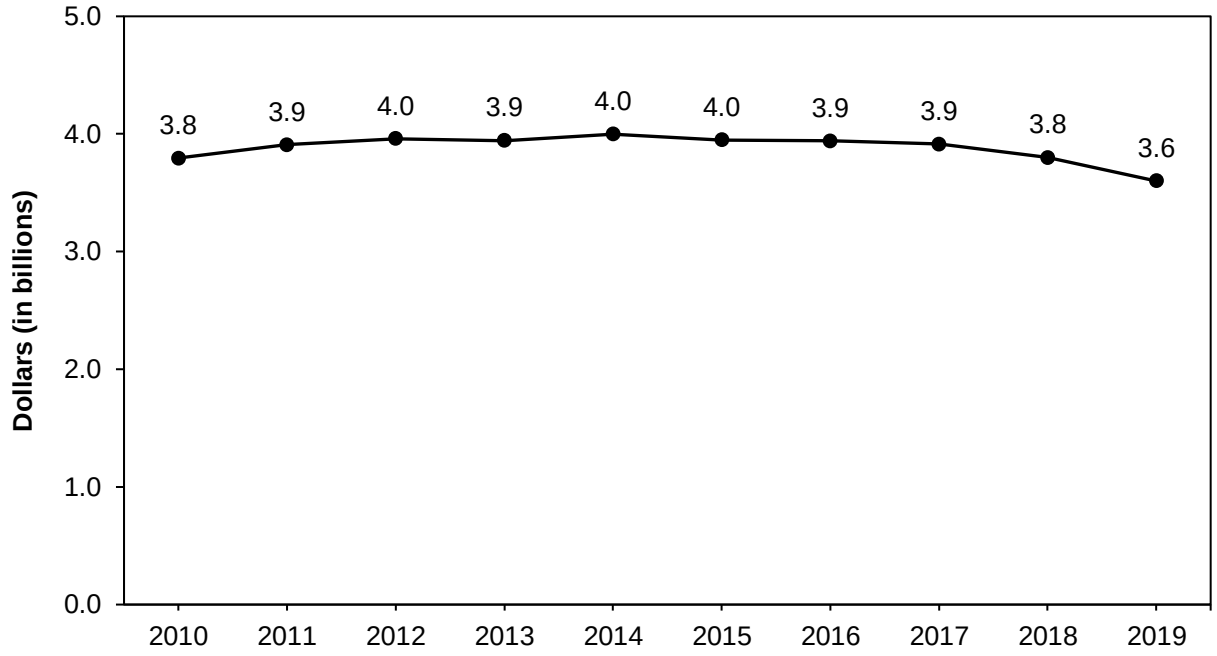
Source: MedPAC analysis of outpatient standard analytical file data from CMS.

- Hospitals sometimes use observation care to determine whether a patient should be hospitalized for inpatient care, transferred to an alternative treatment setting, or sent home. On April 1, 2002, Medicare began providing separate payments to hospitals for some observation services. Previously, the observation services were packaged into the payments for the emergency department or clinic visits that occurred with observation care.

- The number of Medicare FFS outpatient observation visits per capita remained relatively steady from 2015 to 2019, at about 45 visits per 1,000 beneficiaries.

- The decision on whether to discharge or admit a patient can usually be made in less than 24 hours; however, the Medicare benefit does not limit the length of outpatient observation stays. In each year from 2015 to 2019, nearly half of outpatient observation visits were longer than 24 hours, including 9 to 10 percent that spanned more than 2 days and 1 to 2 percent that spanned more than 3 days.

Chart 6-23. Medicare FFS payments to inpatient psychiatric facilities decreased in 2019



Note: FFS (fee-for-service). These fiscal year–incurred data represent only program spending; they do not include beneficiary cost sharing. Spending for inpatient psychiatric care furnished in scatter beds in acute care hospitals (and paid for under the acute care inpatient prospective payment system) is not included in this chart.

Source: CMS Office of the Actuary.

- Medicare pays for inpatient psychiatric facility (IPF) care under the IPF prospective payment system.
- Payments have been relatively steady at about $4 billion since 2012.
- However, since 2017, Medicare's payments to IPFs have declined about 9 percent, consistent with a 13 percent decrease in IPF stays (data not shown).

Chart 6-24. The share of for-profit Medicare-certified inpatient psychiatric facilities increased, 2012–2019

Type of IPF	2012	2015	2018	2019	Average annual change 2012–2015	Average annual change 2015–2018	Average annual change 2018–2019
All	1,568	1,576	1,584	1,530	0.2%	0.2%	–3.4%
Urban	1,241	1,245	1,254	1,225	0.1	0.2	–2.3
Rural	326	330	327	303	0.4	–0.3	–7.3
Freestanding	450	483	524	527	2.4	2.8	0.6
Hospital-based units	1,118	1,093	1,060	1,003	–0.8	–1.0	–5.4
Nonprofit	762	726	723	682	–1.6	–0.1	–5.7
For profit	436	503	523	522	4.9	1.3	–0.2
Government	370	347	338	326	–2.1	–0.9	–3.6

Note: IPF (inpatient psychiatric facility). Data are from facilities that submitted valid Medicare cost reports in the given fiscal year. Components may not sum to totals due to missing data.

Source: MedPAC analysis of hospital cost report data from CMS.

- Between 2012 and 2015, the number of IPFs that filed Medicare cost reports grew, on average, 0.2 percent per year. Similarly, between 2015 and 2018, the supply of IPFs increased slightly, growing, on average, 0.2 percent per year. However, in 2019, the number of IPFs fell by 3.4 percent.

- A growing share of Medicare IPF users receive care in for-profit facilities. Between 2012 and 2015, the number of for-profit IPFs grew 4.9 percent per year, on average. Over the same period, the number of nonprofit IPFs fell more than 1 percent per year, on average. The number of for-profit IPFs continued to grow through 2018, while the number of nonprofit IPFs slightly declined. From 2018 to 2019, the number of for-profit IPFs remained relatively stable, while the number of nonprofit facilities decreased by 5.7 percent.

Chart 6-25. Almost three-quarters of Medicare FFS beneficiaries' stays at IPFs were for psychosis, 2019

MS–DRG	Diagnosis	Share
885	Psychosis	73.4%
884	Organic disturbances and mental retardation	7.0
057	Degenerative nervous system disorders without MCC	5.5
897	Alcohol/drug abuse or dependency, no rehabilitation, without MCC	4.4
881	Depressive neurosis	3.2
895	Alcohol/drug abuse or dependency with rehabilitation, without MCC	1.6
882	Neurosis except depressive	1.3
880	Acute adjustment reaction and psychosocial dysfunction	0.9
883	Disorders of personality and impulse control	0.7
056	Degenerative nervous system disorders with MCC	0.5
894	Alcohol/drug use—left AMA	0.4
886	Behavioral and developmental disorders	0.2
896	Alcohol/drug abuse or dependency without rehabilitation, with MCC	0.1
876	OR procedure with principal diagnosis of mental illness	0.1
887	Other mental disorders	0.1
081	Nontraumatic stupor and coma without MCC	<0.1
080	Nontraumatic stupor and coma with MCC	<0.1
	Nonpsychiatric MS–DRGs	0.8
	Total	100.0

Note: FFS (fee-for-service), IPF (inpatient psychiatric facility), MS–DRG (Medicare severity–diagnosis related group), MCC (major comorbidity or complication), AMA (against medical advice), OR (operating room). Total may not sum to 100 percent due to rounding.

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

- Medicare patients in IPFs are generally assigned 1 of 17 psychiatric MS–DRGs.
- The MS–DRG system does not differentiate well among Medicare beneficiaries in IPFs. The most frequently occurring IPF diagnosis—psychosis—accounted for about 73 percent of IPF discharges in 2019. This broad category includes patients with principal diagnoses of schizophrenia, bipolar disorder, and major depression.
- In 2019, the next most common discharge diagnosis, accounting for 7 percent of IPF cases, was organic disturbances and mental retardation.

Chart 6-26. The majority of Medicare FFS beneficiaries who received IPF services were under the age of 65, 2019

Characteristic	Share of all IPF users	Share of IPF users with more than one IPF stay
Current eligibility status		
Aged	43.3%	30.5%
Disabled	56.6	69.4
ESRD only	0.1	0.1
Age		
<45	23.6	31.8
45–64	32.5	36.9
65–79	30.0	23.9
80+	14.0	7.4
All	100.0	27.5

Note: FFS (fee-for-service), IPF (inpatient psychiatric facility), ESRD (end-stage renal disease). The "aged" category includes beneficiaries ages 65 and older without ESRD. The "disabled" category includes beneficiaries under age 65 without ESRD. The "ESRD only" category includes beneficiaries with ESRD, regardless of age. Components may not sum to totals due to rounding.

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

- Of Medicare beneficiaries who had at least one IPF stay in 2019, 56.6 percent qualified for Medicare because of a disability. These beneficiaries tend to be younger and poorer than the typical fee-for-service beneficiary.
- Approximately 28 percent of Medicare beneficiaries who used an IPF in 2019 had more than one IPF stay during the year. These beneficiaries were much more likely than all IPF users to be disabled, often because of a psychiatric diagnosis.