SECTION

6

Acute inpatient services

General acute care hospitals
Inpatient psychiatric facilities

Chart 6-1 Most general acute care hospitals and inpatient stays paid by FFS Medicare under IPPS, 2021

	Hospitals		Inpatient stays			
			All payer		FFS Medicare	
Hospital group	Number (in thousands)	Share of total	Number (in millions)	Share of total	Number (in millions)	Share of total
All general acute	4.5	100	29.3	100	7.3	100
IPPS	3.1	67	27.6	94	6.9	94
Location						
Metropolitan (urban)	2.3	51	25.6	87	6.2	85
Rural micropolitan	0.5	11	1.7	6	0.6	8
Other rural	0.2	5	0.3	1	0.1	1
Ownership						
For profit	0.7	16	4.5	16	1.1	15
Nonprofit	1.9	41	19.4	66	5.1	67
Government	0.5	10	3.7	12	0.8	11
DSH and teaching						
Both	1.1	25	18.0	62	4.2	58
DSH only	1.5	32	7.8	27	2.1	29
Teaching only	0.1	2	0.8	3	0.2	3
Neither	0.4	8	0.9	3	0.3	4
Critical access	1.3	29	0.5	2	0.2	3
Maryland	<0.1	1	0.5	2	0.2	2

Note: FFS (fee-for-service), IPPS (inpatient prospective payment systems), DSH (disproportionate share hospital). Data are for general acute care hospitals in the U.S. that had a cost report with a midpoint in fiscal year 2021 and was complete as of our analysis. "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.

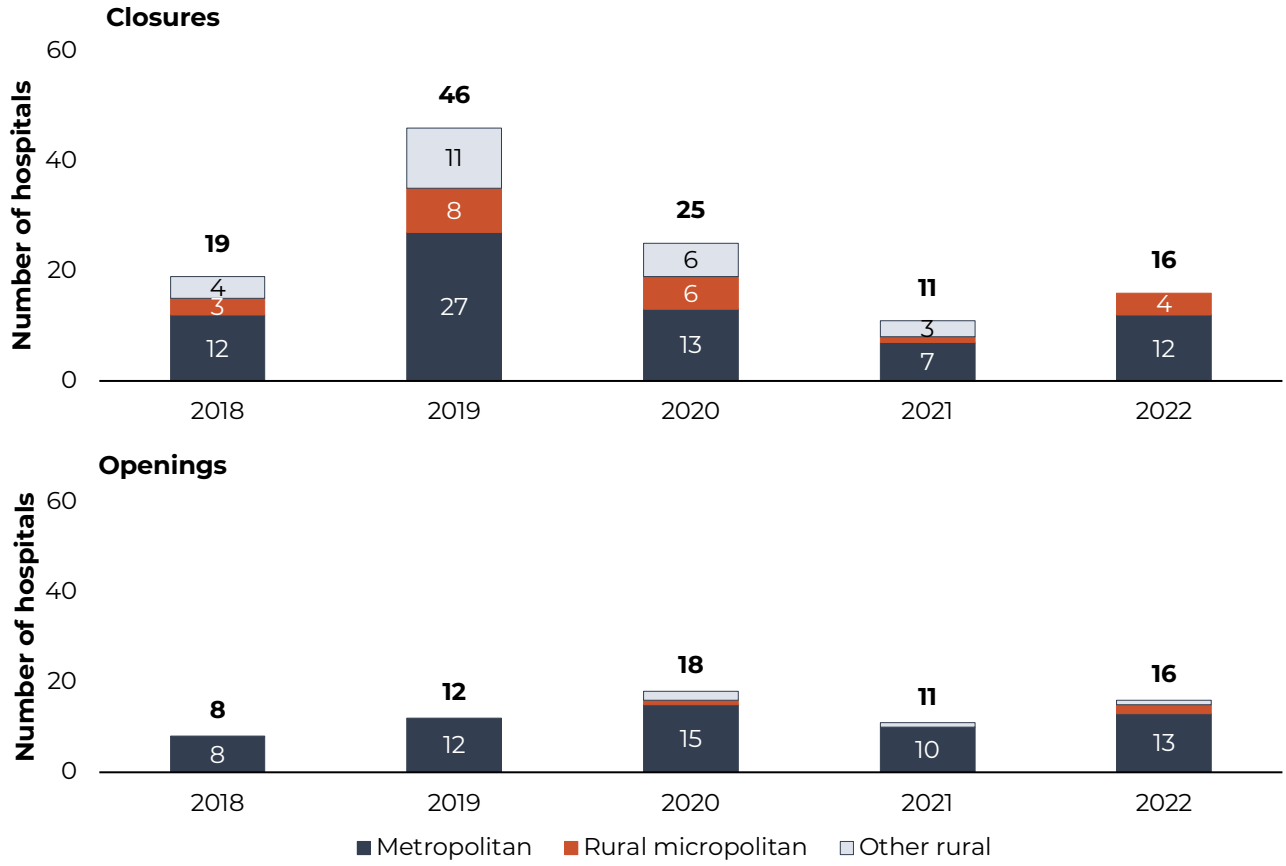
Source: MedPAC analysis of hospital cost report data from CMS and Census data on metropolitan and micropolitan areas.

> In 2021, there were approximately 4,500 general acute care hospitals, at which there were 29.3 million inpatient stays. A quarter of these stays (7.3 million) were for FFS Medicare beneficiaries.

> For about two-thirds of general acute care hospitals, FFS Medicare pays for inpatient stays under Medicare's IPPS. Nearly all (94 percent) inpatient stays and FFS Medicare stays were at IPPS hospitals; further, the vast majority of all FFS Medicare stays were at urban IPPS hospitals.

> Nearly 30 percent of general acute care hospitals are designated critical access hospitals (CAHs), which are hospitals with fewer than 25 beds that FFS Medicare pays on a cost basis. However, only 2 percent of all inpatient stays and 3 percent of FFS Medicare inpatient stays were at CAHs. FFS Medicare patients accounted for over 40 percent of all CAH inpatient stays.

Chart 6-2 Supply of general acute care hospitals was steady in fiscal years 2021 and 2022



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 period. Data are for general acute care hospitals in the U.S. paid under the inpatient prospective payment systems, 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 figures pertain to fiscal years.

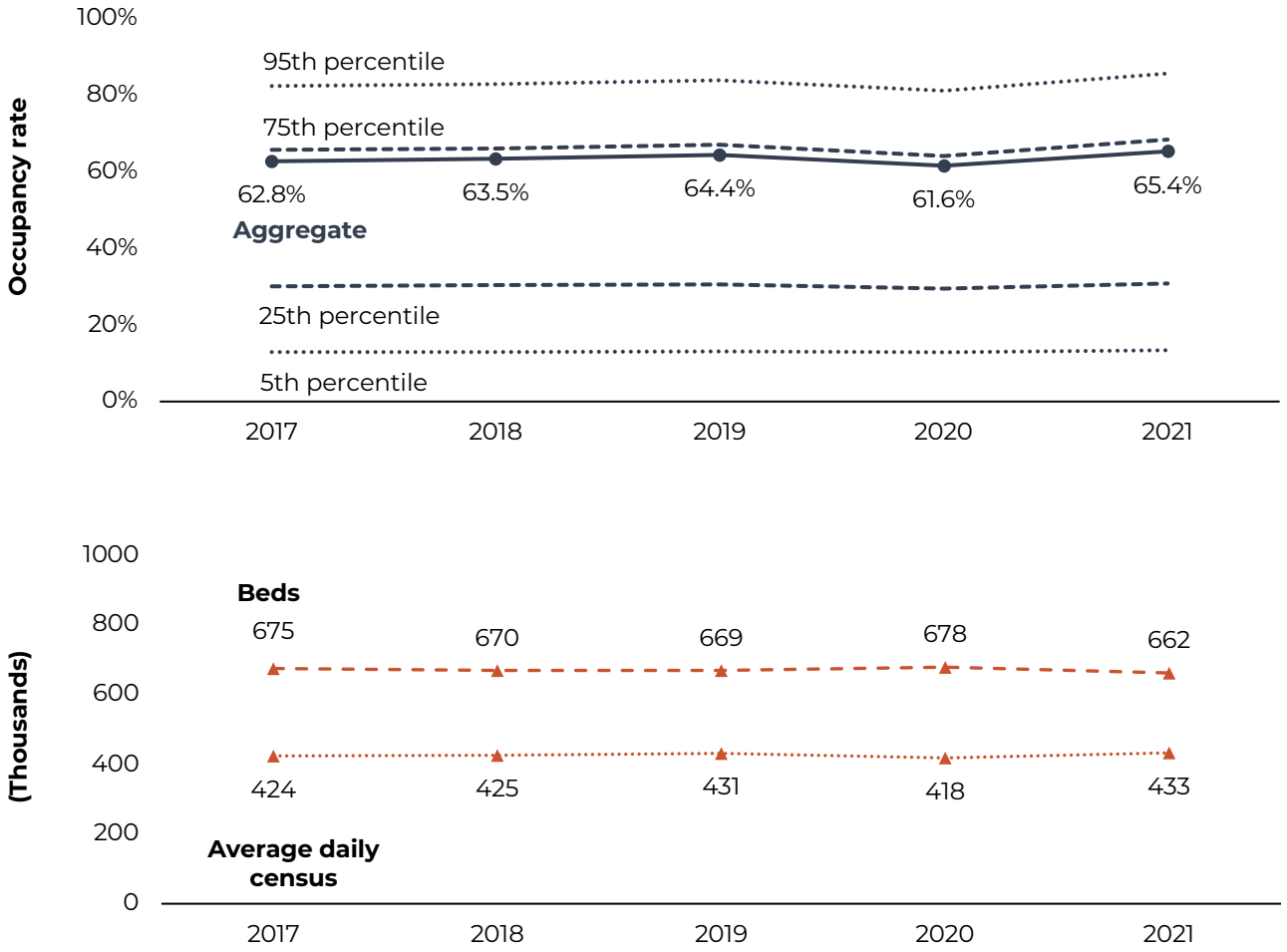
Source: MedPAC analysis of the CMS Provider of Services file, Census data on metropolitan and micropolitan areas, internet searches, and personal communication with the Department of Health and Human Services Office of Rural Health Policy.

> In both fiscal years 2021 and 2022, the number of general acute care hospitals that closed was the same as the number that opened: 11 in 2021 and 16 in 2022. The number of closures was substantially below the levels in 2019 (46) and 2020 (25) and comparable with the number in 2018. In contrast, the number of openings has been steadier, ranging from 8 to 18 over the 2018 through 2022 period.

> Among the 16 hospital closures in 2022, 12 were in metropolitan counties and 4 were in rural micropolitan counties.

> Nearly all of the hospital openings from 2018 to 2022 were in metropolitan counties.

Chart 6-3 General acute care hospitals continued to have excess inpatient capacity in aggregate, but some hospitals neared capacity



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, which may be higher than staffed bed days. "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 general acute care hospitals in the U.S. that had a cost report with a midpoint in the specified fiscal year and was complete as of our analysis. Occupancy rates may vary slightly from calculations of components due to rounding.

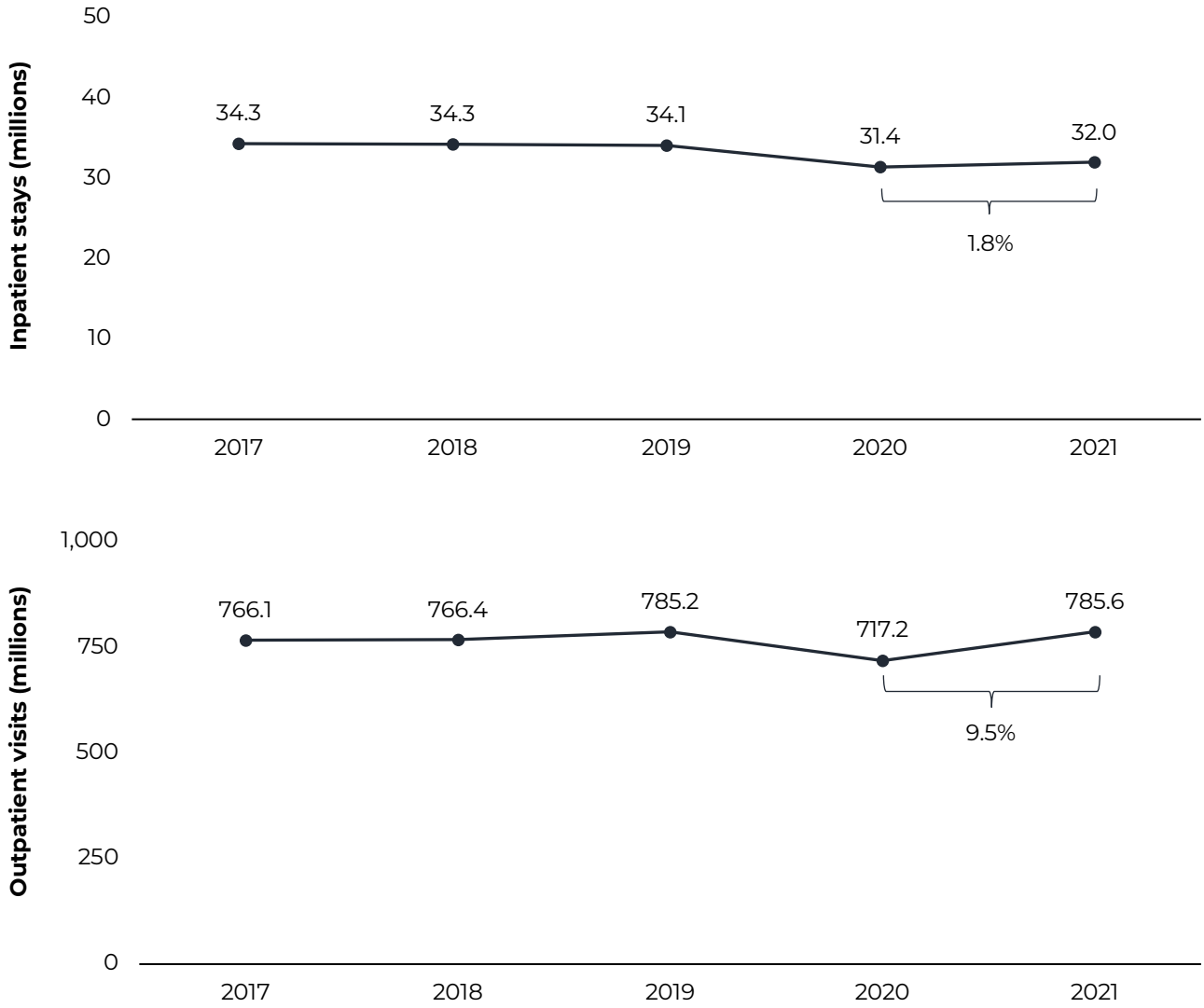
Source: MedPAC analysis of hospital cost report data from CMS.

> General acute care hospitals continued to have excess capacity in aggregate, with about 65 percent of all beds occupied during fiscal year 2021, slightly higher than in previous years. However, inpatient capacity continued to vary substantially across hospitals, with some reaching near capacity while others had substantial excess capacity.

> The increased aggregate occupancy rate in 2021 resulted from a decrease in beds and increase in average daily census.

> These charts are averages over the year; some hospitals faced capacity and staffing constraints at times (data not shown).

Chart 6-4 All-payer inpatient stays partially rebounded in 2021 and hospital outpatient visits fully rebounded to prepandemic levels



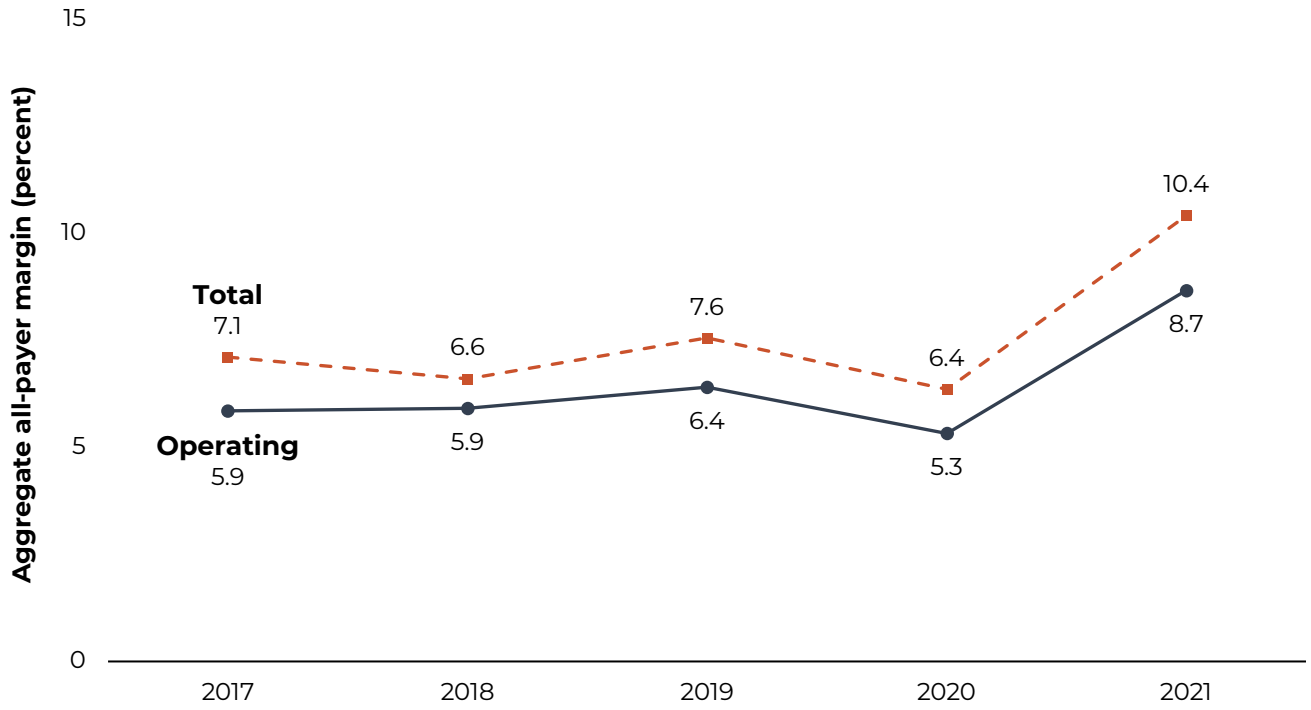
Note: "Outpatient visits" includes all clinic visits, referred visits, observation services, outpatient surgeries, and emergency department visits, regardless of the number of diagnostic and/or therapeutic treatments the patient received during the visit. Data are for community hospitals (nonfederal short-term general and specialty hospitals), estimated from those who responded to the American Hospital Association survey and reflect each hospital's own fiscal year. Given that not all hospitals are reporting the same 12-month period, the 2020 and 2021 data reflect varying numbers of months of COVID-19 impacts.

Source: MedPAC analysis of Hospital Statistics data from the American Hospital Association.

> In 2020, all-payer inpatient stays and hospital outpatient visits declined, reflecting delayed and forgone care during the COVID-19 public health emergency.

> In contrast, in 2021, all-payer inpatient stays and hospital outpatient visits had divergent trends, with inpatient stays partially rebounding and outpatient visits fully rebounding to prepandemic levels.

Chart 6-5 IPPS hospitals' all-payer margins reached record highs in 2021 with the support of federal relief funds



Note: IPPS (inpatient prospective payment systems). Hospitals' margin is calculated as aggregate payments minus aggregate allowable costs, divided by aggregate payments. "All-payer" margin includes payments from all payers and, in 2020 and 2021, reported federal relief funds. "Total margin" includes investments; "operating" margin excludes revenue from investments and contributions. Data are for IPPS hospitals that had a cost report with a midpoint in the specified fiscal year and was complete as of our analysis. Given that not all hospitals are reporting the same 12-month period, the 2020 and 2021 data reflect varying numbers of months of COVID-19 impacts.

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). The all-payer total margin includes investment income, while the operating margin excludes revenue from investments and contributions. In 2020 and 2021, these measures include reported federal relief funds to support hospitals during the COVID-19 public health emergency.

> IPPS hospitals' all-payer total and operating margins remained strong in 2020 with the support of over $34 billion in reported federal relief funds, and reached record highs in 2021 when including the over $17 billion in reported relief funds. The 2021 operating margin excluding relief funds was 7.2 percent, also a record high (data not shown).

> Overall, the federal relief funds that IPPS hospitals received in 2021 more than offset the additional coronavirus pandemic–related expenses that were not covered by the higher patient revenues associated with COVID-19. Rather, the increase in the operating margin of over 3 percentage points resulted from hospitals' operating revenues growing more than their costs: Operating revenue increased over 11 percent, while costs increased by only about 7 percent (data not shown).

Chart 6-6 IPPS hospitals' all-payer operating margins continued to vary across hospital groups in 2021, including all-time high among for-profit hospitals

	All-payer total margin						
				2020		2021	
Hospital group	2017	2018	2019	With relief funds	Without relief funds	With relief funds	Without relief funds
IPPS	5.9%	5.9%	6.4%	5.3%	1.9%	8.7%	7.2%
Location							
Metropolitan (urban)	6.0	6.1	6.6	5.3	2.0	8.6	7.3
Rural micropolitan	4.9	3.9	5.2	6.2	1.9	9.2	6.8
Other rural	2.1	0.2	0.7	3.4	–1.5	7.6	3.0
Ownership							
For profit	10.5	11.4	12.2	12.6	10.4	15.1	13.9
Nonprofit	5.9	5.5	6.1	4.7	1.2	8.2	6.8
DSH and teaching							
Both	5.7	5.8	6.2	4.8	1.4	8.4	6.9
DSH only	5.5	5.6	6.3	6.2	2.8	8.9	7.3
Teaching only	8.8	8.7	7.7	6.0	4.1	7.7	6.7
Neither	9.0	9.1	10.1	8.4	6.0	13.5	11.8
CAH	2.3	1.7	2.4	5.0	0.4	10.8	6.0

Note: IPPS (inpatient prospective payment systems), DSH (disproportionate share hospital), CAH (critical access hospital). "Relief funds" refers to Provider Relief Fund payments and Paycheck Protection Program forgiven loans recorded on hospitals' cost reports. Hospitals' margin is calculated as aggregate payments minus aggregate allowable costs, divided by aggregate payments. "All-payer operating margin" includes payments from all payers, excluding revenue from investments and contributions and, for 2020 and 2021, is reported with and without reported federal relief funds. Metropolitan (urban) counties contain an urban cluster of 50,000 or more people; rural micropolitan counties contain a cluster of 10,000 to 50,000 people; all other counties are classified as "other rural." Data are for IPPS hospitals that had a cost report with a midpoint in the specified fiscal year and was complete as of our analysis. Given that not all hospitals are reporting the same 12-month period, the 2020 and 2021 data reflect varying numbers of months of COVID-19 impacts.

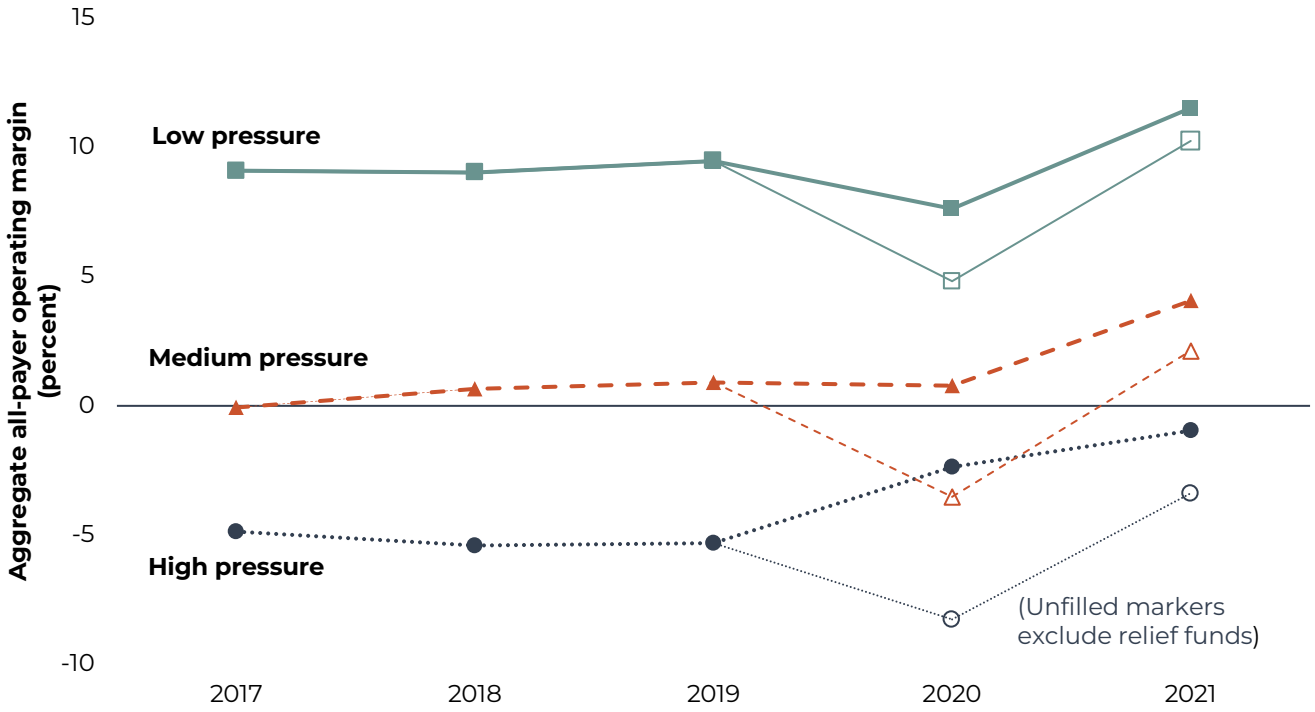
Source: MedPAC analysis of hospital cost report data from CMS and Census data on metropolitan and micropolitan areas.

> Within IPPS hospitals' aggregate all-payer operating margin, there continued to be significant variation: The 2021 operating margin ranged from 0.8 percent to 14.9 percent among the middle half of IPPS hospitals (data not shown).

> While there was variation within each group of hospitals, in aggregate, the operating margin continued to be higher among for-profit hospitals and those that were neither teaching hospitals nor receiving disproportionate share payments. In contrast, the operating margin continued to be lower among hospitals in rural nonmicropolitan areas. However, rural hospitals received targeted federal relief funds, so the difference in the all-payer operating margin between rural and urban hospitals was smaller than it was prior to the pandemic.

> Critical access hospitals' all-payer operating margin also reached a record high in 2021.

Chart 6-7 IPPS hospitals' all-payer operating margin continued to be higher in 2021 for those under low financial pressure, but the spread narrowed due to targeted federal relief funds



Note: IPPS (inpatient prospective payment systems). "Relief funds" refers to Provider Relief Fund payments and Paycheck Protection Program forgiven loans recorded on hospitals' cost reports. Hospitals' margin is calculated as aggregate payments minus aggregate allowable costs, divided by aggregate payments. "All-payer operating margin" includes payments from all payers, excluding revenue from investments and contributions and, for 2020 and 2021, is reported with and without reported federal relief funds. "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. "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. "Medium-pressure" hospitals are those that fit into neither the high- nor the low-pressure categories. Data are for IPPS hospitals that had a cost report with a midpoint in the specified fiscal year and was complete as of our analysis. Given that not all hospitals are reporting the same 12-month period, the 2020 and 2021 data reflect varying numbers of months of COVID-19 impacts.

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

> By definition, IPPS hospitals' all-payer operating margin continued to vary depending on their level of financial pressure. In 2021, IPPS hospitals under low financial pressure—defined as those with a median non-Medicare profit margin of greater than 5 percent and growth in net worth—had an all-payer operating margin of 11.5 percent, significantly higher than the margin among hospitals under more financial pressure. (In contrast, the aggregate Medicare margin is lower among IPPS hospitals under low financial pressure, see Chart 6-9.)

> While this variation held in 2020 and 2021, IPPS hospitals under high financial pressure disproportionately benefited from federal relief funds, decreasing the spread in the operating margin between hospitals under low and high financial pressure.

Chart 6-8 IPPS hospitals' Medicare margin rose above prepandemic levels in 2021 and continued to vary across hospital groups

	Medicare margin						
				2020		2021	
Hospital group	2017	2018	2019	With relief funds	Without relief funds	With relief funds	Without relief funds
IPPS	–9.9%	–9.3%	–8.5%	–8.2%	–12.3%	–6.2%	–8.2%
Location							
Metropolitan (urban)	–10.1	–9.5	–8.8	–8.7	–12.8	–6.6	–8.5
Rural micropolitan	–8.3	–7.1	–6.1	–3.7	–8.5	–2.6	–5.8
Other rural	–5.6	–5.2	–2.5	1.6	–4.0	4.9	–0.8
Ownership							
For profit	–2.2	–0.3	1.3	4.3	1.6	5.3	3.7
Nonprofit	–11.1	–10.6	–10.0	–10.3	–14.8	–8.2	–10.2
DSH and teaching							
Both	–8.7	–8.4	–7.8	–7.7	–11.8	–5.8	–7.8
DSH only	–11.2	–10.3	–9.1	–7.9	–12.2	–5.7	–8.0
Teaching only	–14.3	–12.0	–11.7	–14.4	–16.9	–11.0	–12.5
Neither	–17.2	–15.3	–14.3	–13.9	–17.0	–10.8	–13.3
CAH	–1.7	–1.7	–1.7	3.8	–1.0	6.3	0.1

Note: IPPS (inpatient prospective payment systems), DSH (disproportionate share hospital), CAH (critical access hospital). "Relief funds" refers to Provider Relief Fund payments and Paycheck Protection Program forgiven loans recorded on hospitals' cost reports, with the Medicare share calculated using fee-for-service Medicare's share of 2019 all-payer operating revenue. Hospitals' "Medicare margin" is calculated as aggregate Medicare payments minus aggregate allowable Medicare costs, divided by aggregate payments. Payments and costs include multiple hospital service lines (including inpatient, outpatient, swing bed, skilled nursing, rehabilitation, psychiatric, and home health services) as well as direct graduate medical education and uncompensated care payments. Metropolitan (urban) counties contain an urban cluster of 50,000 or more people; rural micropolitan counties contain a cluster of 10,000 to 50,000 people; all other counties are classified as "other rural." Data are for IPPS hospitals or CAHs that had a cost report with a midpoint in the specified fiscal year and was complete as of our analysis. Given that not all hospitals are reporting the same 12-month period, the 2020 and 2021 data reflect varying numbers of months of COVID-19 impacts.

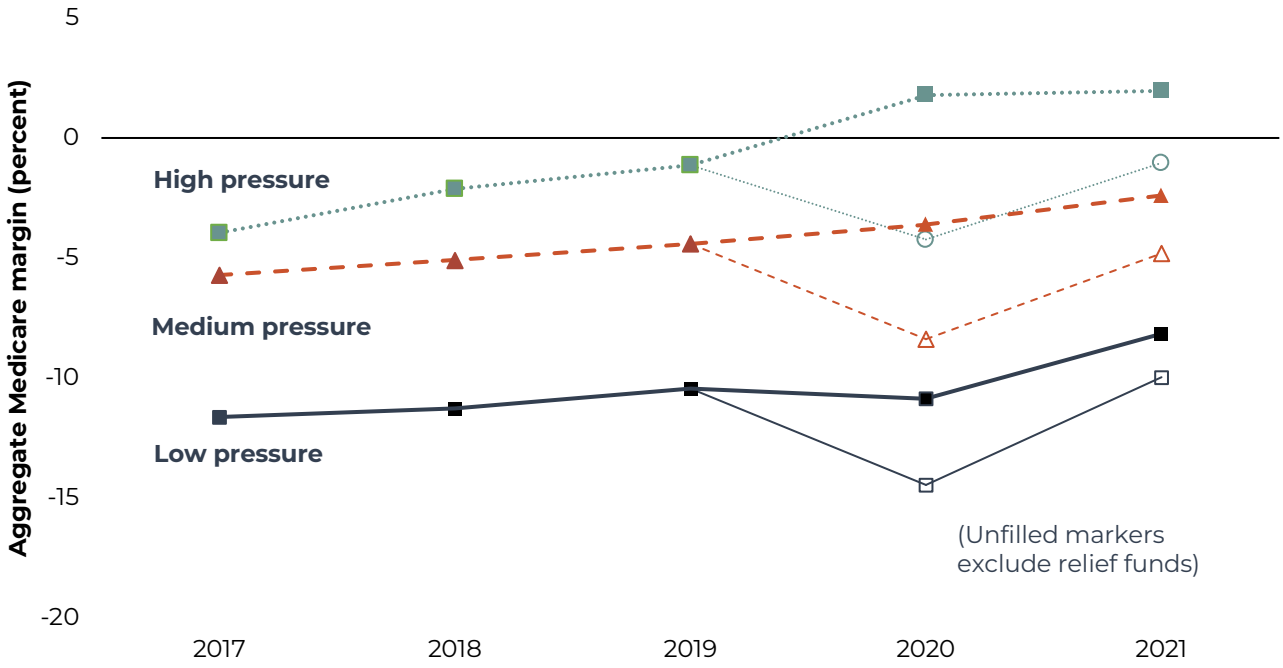
Source: MedPAC analysis of hospital cost report data from CMS and Census data on metropolitan and micropolitan areas.

> Hospitals' Medicare margin reflects the relationship between hospitals' Medicare fee-for-service (FFS) 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).

> In 2021, IPPS hospitals' aggregate Medicare margin remained negative but increased above prepandemic levels, even before including any federal relief funds.

> While there was variation within each group of IPPS hospitals, in aggregate, the Medicare margin continued to be higher—and positive—at for-profit hospitals (even before including any federal relief funds) and higher at hospitals in small rural communities.

Chart 6-9 IPPS hospitals' Medicare margin continued to be higher in 2021 for those under high financial pressure



Note: IPPS (inpatient prospective payment systems). "Relief funds" refers to Provider Relief Fund payments and Paycheck Protection Program forgiven loans recorded on hospitals' cost reports. Hospitals' "Medicare margin" is calculated as aggregate Medicare payments minus aggregate allowable Medicare costs, divided by aggregate payments. Payments and costs include multiple hospital service lines (including inpatient, outpatient, swing bed, skilled nursing, rehabilitation, psychiatric, and home health services) as well as direct graduate medical education and uncompensated care payments. "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. Data are for IPPS hospitals that had a cost report with a midpoint in the specified fiscal year and was complete as of our analysis. Given that not all hospitals are reporting the same 12-month period, the 2020 and 2021 data reflect varying numbers of months of COVID-19 impacts.

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

> IPPS hospitals' Medicare margin continued to vary depending on their level of financial pressure. IPPS hospitals under the highest financial 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 Medicare margin than hospitals under less financial pressure. (In contrast, IPPS hospitals under higher financial pressure have a lower all-payer operating margin; see Chart 6-7.)

> IPPS hospitals under high financial pressure disproportionately benefited from federal relief funds, causing their 2020 and 2021 Medicare margins including relief funds to become positive.

Chart 6-10 Financial pressure led to lower hospital costs per inpatient stay, 2021

	Level of financial pressure, 2016–2020		
	High pressure (non-Medicare margin ≤ 1%)	Medium pressure	Low pressure (non-Medicare margin > 5%)
Number of hospitals	609	335	1,701
Financial characteristics, 2021 (medians)			
Non-Medicare margin (private, Medicaid, uninsured)	2%	7%	17%
Standardized cost per Medicare inpatient stay (as a share of the national median)	0.96	0.98	1.01
Nonprofit hospitals	*0.99*	*1.00*	*1.04*
For-profit hospitals	*0.89*	*0.89*	*0.90*
Annual growth in cost per Medicare inpatient stay, 2018–2021	8%	7%	7%
Medicare margin (before federal relief funds)	0%	–4%	–7%
Patient characteristics, 2021 (medians)			
Total hospital discharges	3,249	6,284	7,615
Medicare share of inpatient days	57%	59%	58%
Medicaid share of inpatient days	23%	26%	23%
Medicare case-mix index	1.64	1.73	1.81

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 hospitals paid under the inpatient prospective payment systems with over 500 discharges that had complete cost reports as of the time of our analysis. "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. The share of Medicare and Medicaid inpatient days includes fee-for-service days and managed care days. Most inpatient days are now either Medicaid or Medicare.

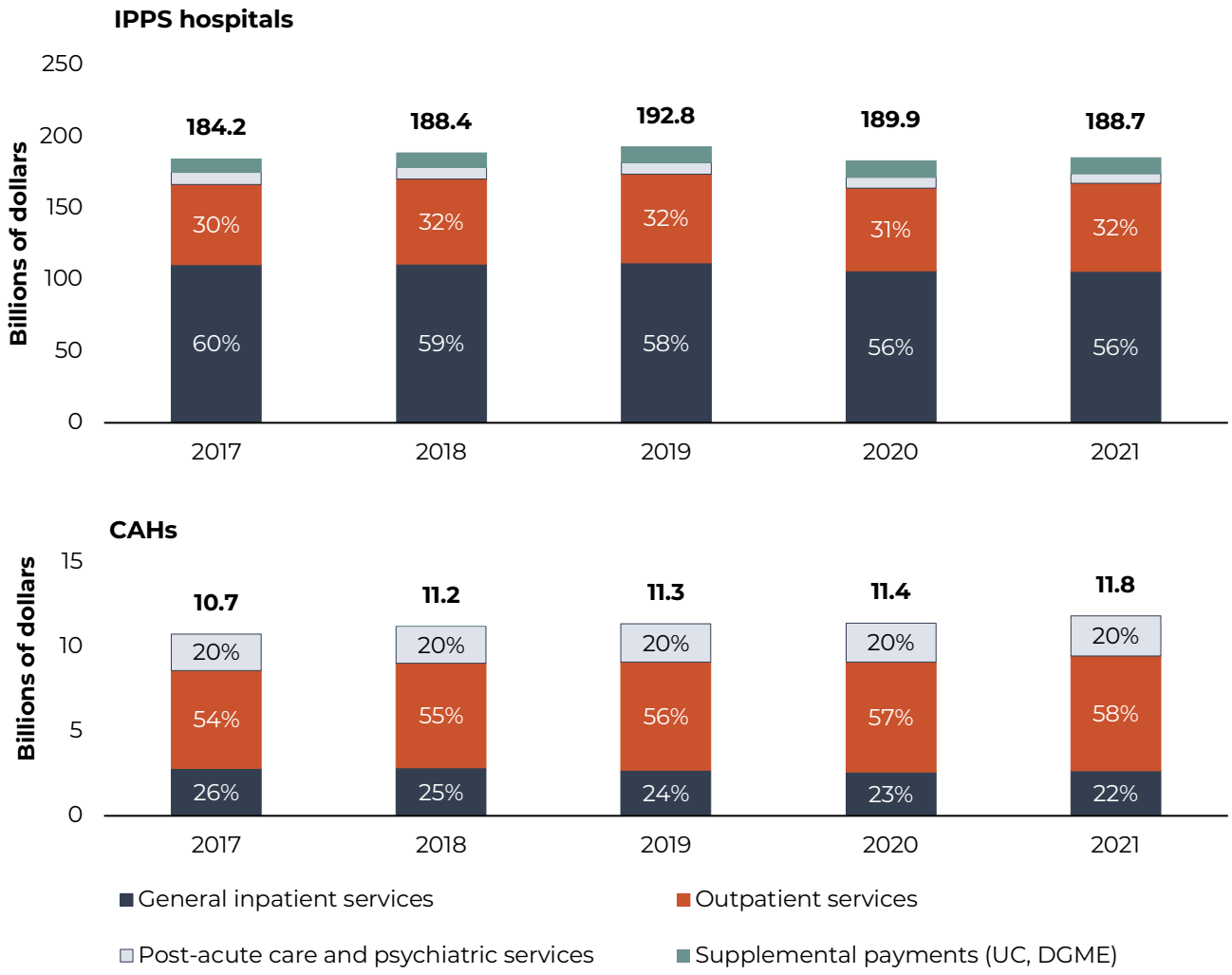
Source: MedPAC analysis of hospital cost report data and claims files from CMS.

> In 2021, hospitals under high financial pressure had standardized costs per Medicare inpatient stay that were 96 percent of the national median. For-profit hospitals tended to constrain their costs more than nonprofit hospitals. The median for-profit hospital had costs that were 90 percent of the median even when they were not under financial pressure.

> Hospitals under high financial pressure are more likely to have lower patient volume (a median of 3,249 discharges in 2021 compared with 7,615 for hospitals under low pressure) and lower case mix (1.64 in 2021 compared with 1.81 for hospitals under low pressure). There was little difference between hospitals under high and low financial pressure in Medicare and Medicaid shares.

> Cost per stay grew rapidly in 2020 due to the pandemic's effect on costs, volume, and case mix. One limitation of this analysis is that it measures only hospital inpatient costs.

Chart 6-11 FFS Medicare payments for inpatient services continued to be the largest component of payments to IPPS hospitals but not to CAHs, 2017–2021



Note: FFS (fee-for-service), IPPS (inpatient prospective payment systems), CAH (critical access hospital), UC (uncompensated care), DGME (direct graduate medical education). The 2020 and 2021 payment amounts do not include Medicare's share of Provider Relief Fund payments or Paycheck Protection Program forgiven loans provided as part of the public health emergency. Data are for IPPS hospitals or CAHs that had a cost report with a midpoint in the specified fiscal year and was complete as of our analysis.

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

> For IPPS hospitals, general inpatient services continued to be the largest component of FFS Medicare payments; however, the share for inpatient payments has been slowly declining from 60 percent in 2017 to 56 percent in 2021.

> For CAHs, outpatient services continued to be the largest component of FFS Medicare payments, and the share has been slowly increasing, from 54 percent in 2017 to 58 percent in 2021.

Chart 6-12 About 15 percent of IPPS payments in 2021 were from adjustments and additional payments

Hospital group	Share of IPPS payments for FFS Medicare inpatient services					
	Base PPS	Low income (DSH)	Teaching (IME)	Outliers	Rural and/or isolated	Quality
All IPPS	83.7%	3.2%	6.8%	4.7%	1.4%	–0.8%
Location						
Metropolitan (urban)	83.8	3.3	7.2	4.9	0.7	–0.8
Micropolitan	83.1	2.3	2.3	2.5	9.2	–0.5
Other rural	78.7	2.2	0.6	1.7	15.8	–0.6
Ownership						
For profit	88.9	3.5	3.9	2.8	1.1	–1.1
Nonprofit	84.0	3.0	6.7	4.6	1.3	–0.7
Government	76.4	3.9	10.5	7.1	2.2	–1.0
DSH and teaching						
Both	80.7	3.6	9.9	5.3	0.6	–0.9
DSH only	89.8	3.1	0.0	3.4	3.2	–0.7
Teaching only	87.1	0.1*	6.7	4.6	1.2	–0.4
Neither	91.7	0.1*	0.0	3.2	4.1	–0.5
Rural and/or isolated						
Sole community	78.7	2.2	2.6	3.8	12.1	–0.5
Medicare dependent	78.7	1.4	1.6	2.0	15.6	–0.6
Low volume	77.7	1.9	0.4	2.2	16.6	–0.3

Note: IPPS (inpatient prospective payment systems), FFS (fee-for-service), DSH (disproportionate share hospital), IME (indirect medical education). Payments are shares of IPPS payments for FFS Medicare inpatient services and exclude uncompensated care payments. "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 IPPS payments, 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." 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. Data are for IPPS hospitals that had a cost report with a midpoint in the specified fiscal year and was complete as of the time of our analysis.
*The DSH group is defined by receiving inpatient operating DSH payments, while the 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.

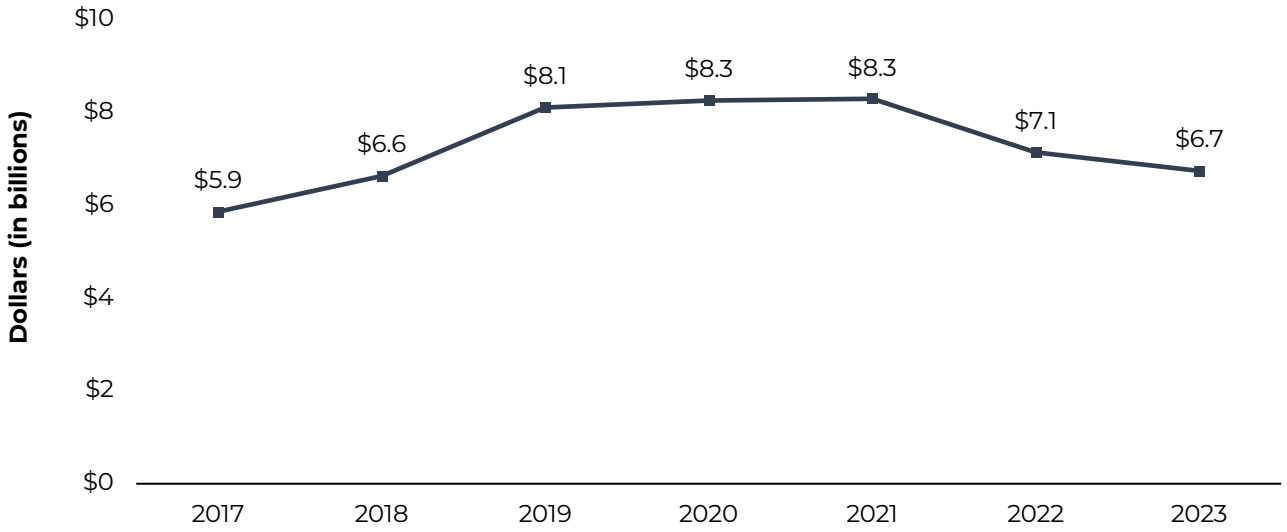
Source: MedPAC analysis of hospital cost report data from CMS and Census data on metropolitan and micropolitan areas.

> In 2021, base payments accounted for about 84 percent of IPPS payments to hospitals for inpatient services provided to FFS Medicare beneficiaries. The remaining approximately 15 percent were from IPPS adjustments to the base rates and additional payments, such as low-income and teaching adjustments, outlier payments, rural and/or isolated payments, and quality payments.

> The IPPS adjustments and additional payments are targeted to specific groups of hospitals. For example, the additional payments to Medicare-dependent and low-volume hospitals accounted for over 15 percent of those hospitals' IPPS payments.

> IPPS hospitals also receive payments from Medicare that are not for the provision of inpatient services to FFS Medicare beneficiaries, such as uncompensated care and direct graduate medical education payments, or otherwise paid outside of the IPPS, such as organ acquisition (data not shown).

Chart 6-13 Medicare's uncompensated care payments to IPPS hospitals rose in 2019 through 2021 then fell in 2022 and 2023



Note: IPPS (inpatient prospective payment systems). "Uncompensated care payments" are postsequestration; the 2 percent sequestration of Medicare payments was suspended in May 2020 and reinstated in spring 2022.

Source: MedPAC analysis of IPPS final rules published by CMS.

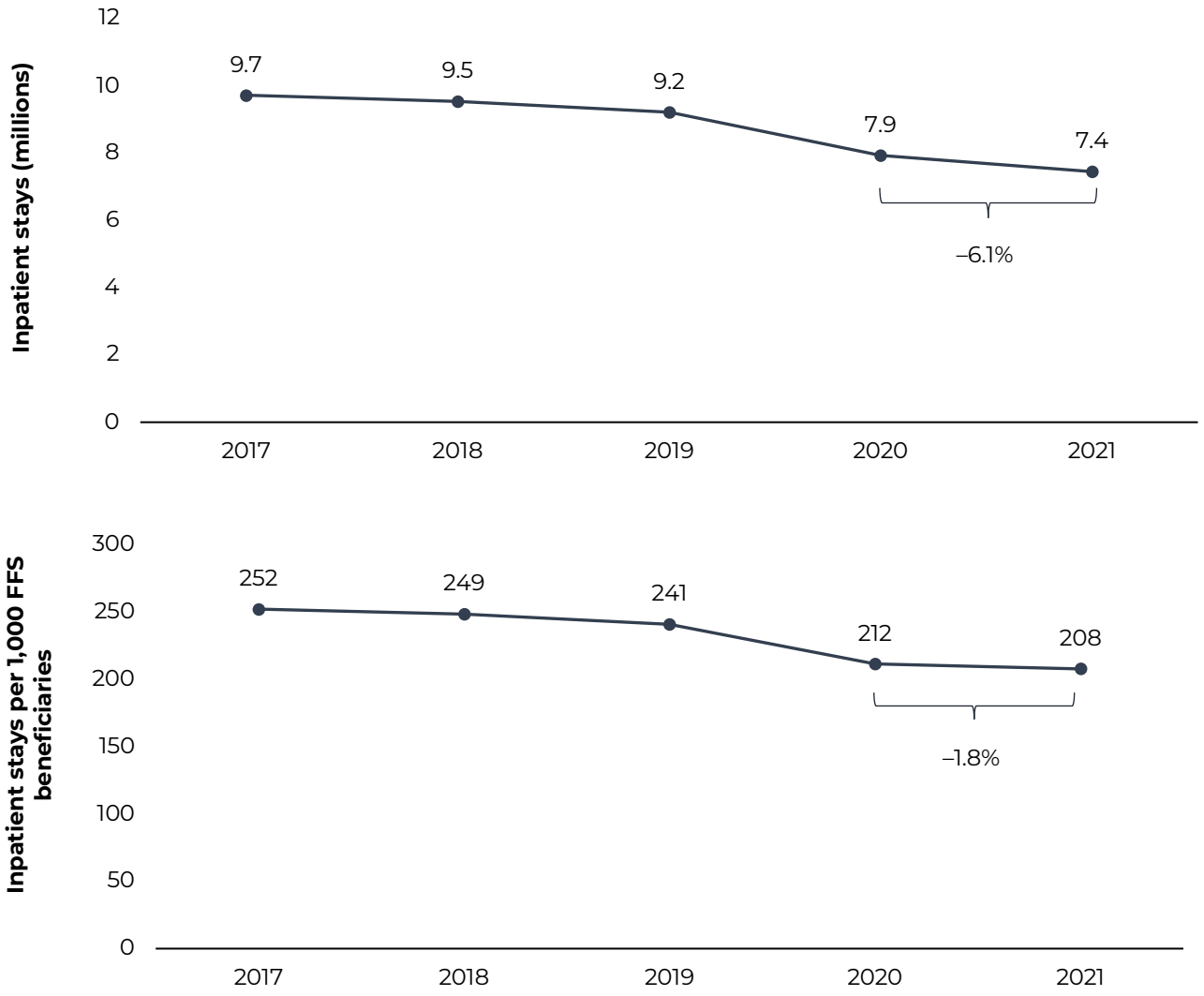
> In addition to IPPS payments for fee-for-service Medicare beneficiaries' inpatient stays, the Medicare program makes uncompensated care payments to IPPS hospitals to help cover their costs of treating uninsured patients. When the rate of uninsured individuals increases and hospitals have greater losses on uncompensated care, the Medicare program makes higher uncompensated care payments to hospitals.

> Under current law, aggregate uncompensated care payments for a fiscal year are set prospectively as the product of two estimates for the upcoming payment year: 75 percent of the operating disproportionate share (DSH) payments under prior law and the uninsured rate as a percentage of the rate in 2013. This amount is subject to sequestration (when the sequester is in effect).

> In 2019 through 2021, uncompensated care payments rose to slightly over $8 billion dollars. In 2021, estimated DSH payments decreased about 9 percent while uninsured rates increased by slightly less. However, as sequestration was suspended for all of 2021 but only part of 2020, the net effect was a minimal change in Medicare's uncompensated care payments to IPPS hospitals.

> However, uncompensated care payments fell nearly 14 percent in 2022 to $7.1 billion dollars, followed by an over 5 percent decline in 2023 to $6.7 billion. These declines stemmed from decreases in estimated DSH payments and in the national uninsured rate, as well as the reinstatement of the 2 percent sequestration on Medicare payments.

Chart 6-14 FFS Medicare inpatient stays and stays per capita declined in 2021



Note: FFS (fee-for-service). Data are for FFS Medicare beneficiaries' stays at hospitals paid under the inpatient prospective payment systems, critical access hospitals, and acute care hospitals in Maryland and U.S. territories. The number of inpatient stays per 1,000 FFS Part A beneficiaries can change from what was previously published when CMS updates its estimates of FFS enrollment.

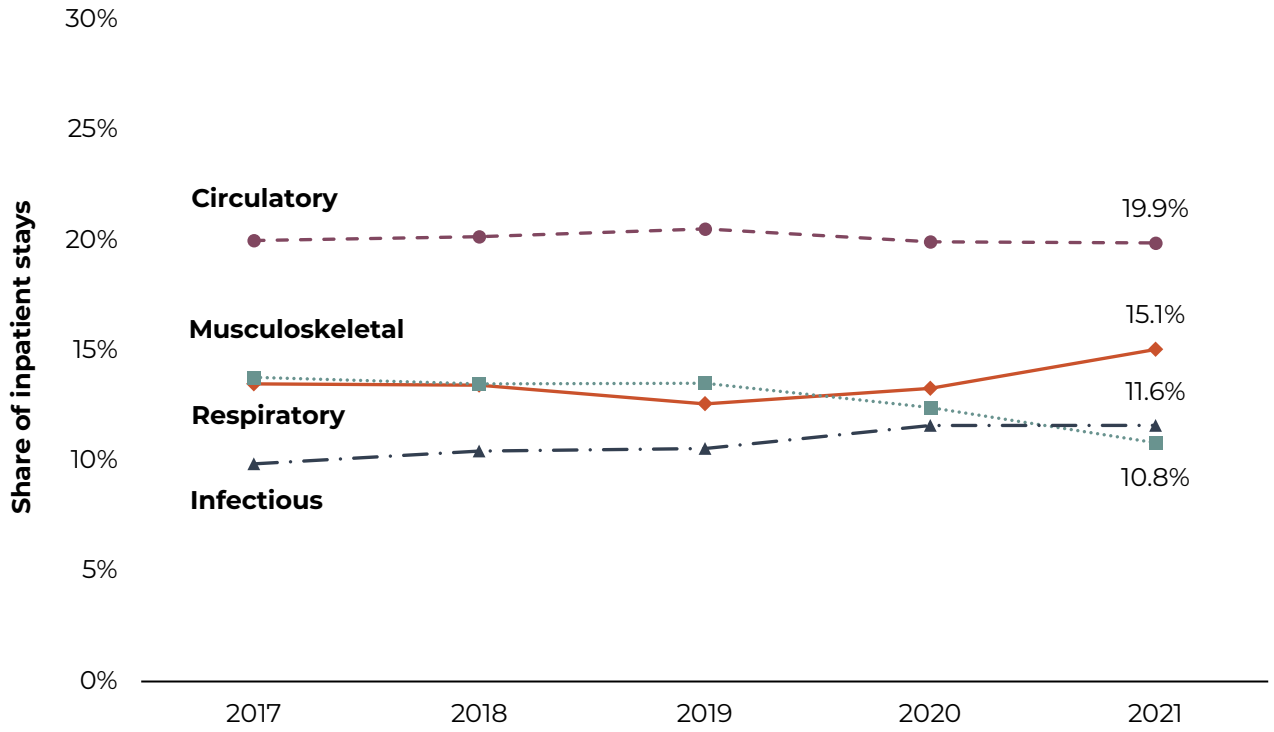
Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS and reports of the Boards of Trustees of the Medicare trust funds.

> From 2020 to 2021, the number of inpatient stays by FFS Medicare beneficiaries at general acute care hospitals declined by 6.1 percent to 7.4 million stays. Controlling for the number of FFS beneficiaries, the number of inpatient stays declined by 1.8 percent, to 208 stays per 1,000 FFS beneficiaries. In contrast, the number of all-payer inpatient stays per capita increased 1.8 percent (see Chart 6-4).

> The decline in FFS Medicare inpatient stays was larger than the decline in stays per capita, as the number of FFS Medicare beneficiaries continued to decline (FFS enrollment data not shown).

> Inpatient stays per beneficiary were relatively steady throughout 2021, at a level similar to the end of fiscal year 2020 (data not shown).

Chart 6-15 Four major diagnostic categories accounted for over half of all FFS Medicare inpatient stays, but distribution changed during the public health emergency



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

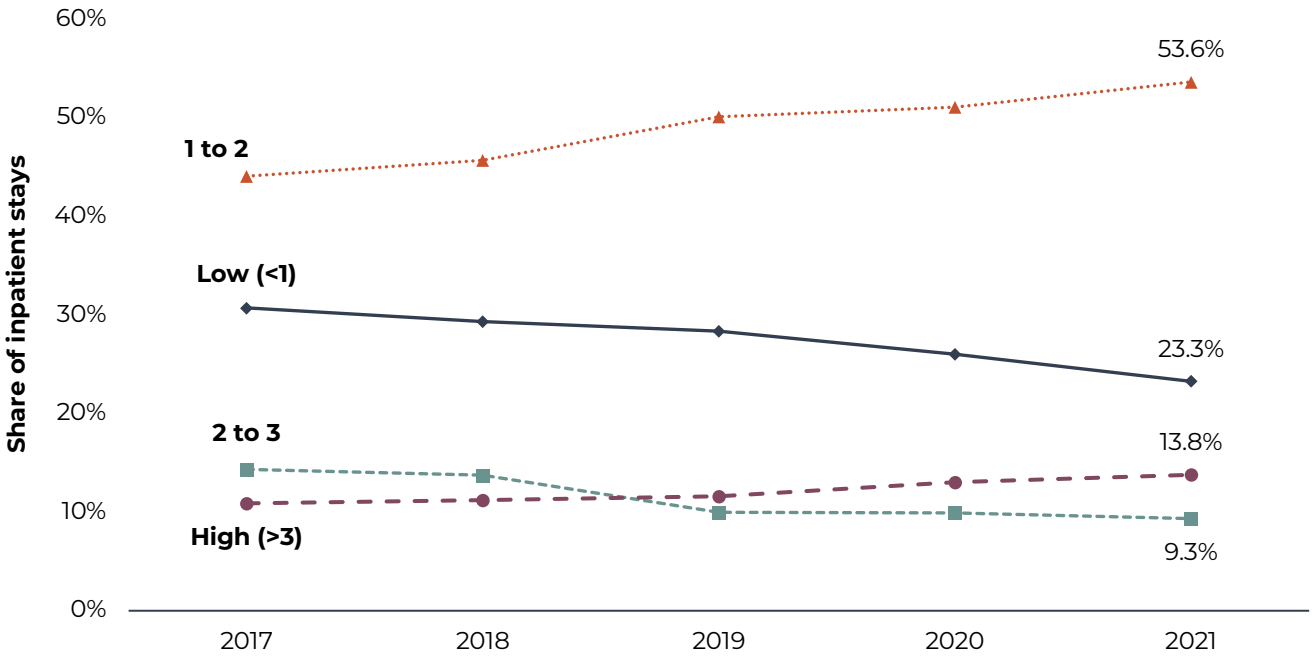
Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS.

> In each year from 2017 through 2021, over half of all FFS Medicare inpatient stays at general 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 is diseases of the circulatory system, such as heart failure and cardiac arrhythmia, accounting for about 20 percent of FFS Medicare inpatient stays in each year from 2016 through 2021.

> The share for the other three most common major diagnostic categories changed during the COVID-19 public health emergency (PHE). The share of FFS Medicare stays for respiratory diseases increased markedly to over 15 percent, reflecting the rise in COVID-19 stays, and the share for infectious diseases continued to increase. In contrast, the share of musculoskeletal conditions declined to under 11 percent due to delays in nonemergency stays, such as those for hip and knee replacements, during the PHE.

Chart 6-16 The lowest resource-intensive cases make up a declining share of FFS Medicare inpatient stays



Note: FFS (fee-for-service). Data are for FFS Medicare beneficiaries' stays at hospitals paid under the inpatient prospective payment systems (IPPS), critical access hospitals, and acute care hospitals in Maryland and U.S. territories. Components may not sum to 100 percent due to rounding.

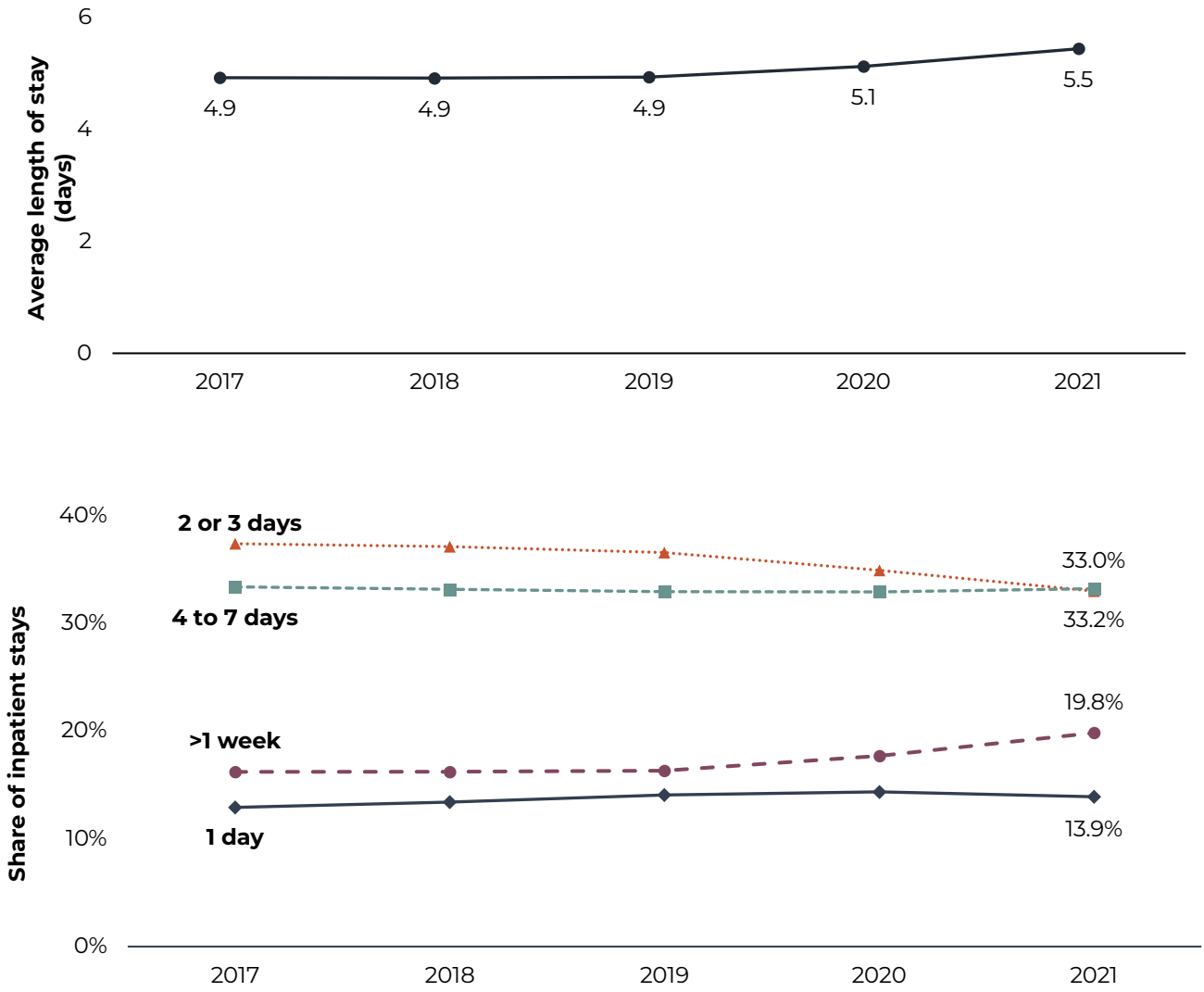
Source: MedPAC analysis of Medicare Provider Analysis and Review data and IPPS final rules published by CMS.

> IPPS payments are adjusted using a Medicare severity–diagnosis related group (MS–DRG) weight, which reflects CMS's estimate of the relative average resource intensity (i.e., costs) of that type of stay.

> The share of inpatient stays with a weight of less than 1 had been declining for multiple years, as these less resource-intensive conditions can increasingly be treated in hospital outpatient settings. However, this decline accelerated during the public health emergency, falling to about 23 percent of stays in 2021. (In 2021, the most common FFS Medicare inpatient stays with a weight of less than 1 were those for gastrointestinal hemorrhage, esophagitis without major complications or comorbidities (MCCs), and kidney and urinary tract infections without MCCs.)

> In contrast, the share of inpatient stays with a weight of greater than 3 accelerated its increase, reaching nearly 14 percent in 2021. (In 2021, the most common FFS inpatient stays with a weight of greater than 3 were stays for infectious diseases with operating room procedures and MCCs, septicemia or severe sepsis with mechanical ventilation for more than 96 hours, and percutaneous cardiovascular procedures with drug-eluting stents and MCCs.)

Chart 6-17 Average length of FFS Medicare inpatient stays increased during public health emergency, driven by increase in share of inpatient stays longer than one week



Note: FFS (fee-for-service). Data are for FFS Medicare beneficiaries' stays at hospitals paid under the inpatient prospective payment systems, critical access hospitals, and acute care hospitals in Maryland and U.S. territories. Components may not sum to 100 percent due to rounding.

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

> FFS Medicare beneficiaries' average length of stay at general acute care hospitals increased from 4.9 days prior to the public health emergency to 5.5 days in 2021.

> The increase in average length of stay during the COVID-19 public health emergency was driven by the increase in share of FFS Medicare beneficiaries' inpatient stays that were longer than 1 week, which increased from about 16 percent in 2017 through 2019 to about 18 percent in 2020 and 20 percent in 2021.

> In contrast, the share of FFS inpatient stays that were two or three days declined, which likely in part reflects the waiver during the public health emergency of the three-day stay requirement for skilled nursing facilities.

Chart 6-18 The number of Medicare-certified inpatient psychiatric facilities declined in 2021, though freestanding for-profit facilities grew over the same time, 2017–2021

						Average annual change	
Type of IPF	2017	2018	2019	2020	2021	2017–2020	2020–2021
All	1,610	1,580	1,540	1,530	1,480	–1.6%	–3.3%
Share of all							
Urban	78%	78%	79%	79%	80%	0.4	1.2
Rural	21	20	19	19	19	–1.8	–4.3
Hospital-based units	68	67	65	64	63	–1.6	–2.9
Nonprofit	41	41	40	39	39	–1.7	–1.5
For profit	15	14	14	14	13	–2.2	–3.5
Government	12	12	12	12	11	–0.4	–7.1
Freestanding	32	33	35	36	37	3.2	5.3
Nonprofit	5	5	5	5	5	0.7	–0.9
For profit	18	19	20	21	22	4.8	7.3
Government	10	10	10	10	11	1.2	4.0

Note: IPF (inpatient psychiatric facility). Data are from facilities that submitted valid Medicare cost reports and had at least one Medicare IPF prospective payment system stay in the given fiscal year. IPF counts are rounded to the 10s' place. "Average annual change" represents the change in the number of all IPFs in the first row and represents changes in shares of IPFs by type for all other rows. Components and annual changes may not match totals due to rounding.

Source: MedPAC analysis of Medicare Provider of Analysis and Review, Medicare hospital cost reports, and the Provider of Services data from CMS.

> Medicare beneficiaries experiencing an acute mental health or alcohol- or drug-related crisis can be treated in specialty IPFs that provide 24-hour care in a structured, intensive, and secure setting.

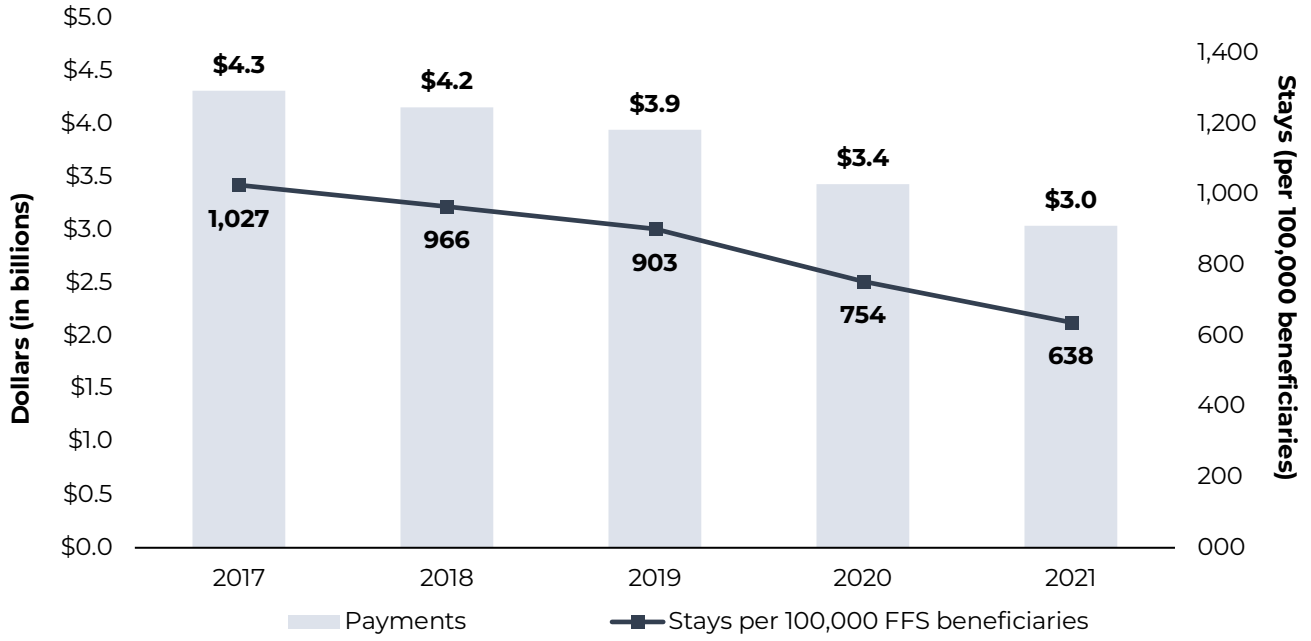
> From 2017 to 2020, the number of IPFs nationwide decreased by nearly 2 percent each year, from 1,610 to 1,530. From 2020 to 2021, the decline in the number of IPFs was over 3 percent.

> Most IPFs are located in urban areas (80 percent). The share of IPFs in urban and rural areas remained mostly steady, with a slight shift in the share of IPFs toward urban areas since 2017.

> Most IPFs (63 percent in 2021) are hospital-based units; however, from 2017 to 2021, the share of freestanding IPFs grew by approximately 4 percent annually while the share of hospital-based IPFs decreased.

> About 20 percent of IPFs are freestanding and for profit, and the share of freestanding for-profit IPFs has been increasing over time by more than 5 percent annually in the past five years.

Chart 6-19 Inpatient psychiatric facility PPS stays and payments continued to decline in FY 2021



Note: PPS (prospective payment system), FY (fiscal year), FFS (fee-for-service). The 2020 and 2021 payment amounts do not include Medicare's share of Provider Relief Fund payments or Paycheck Protection Program forgiven loans provided as part of the public health emergency.

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

> The Medicare FFS program pays for inpatient psychiatric facility (IPF) services under the IPF PPS.

> From 2017 to 2019, inpatient stays in IPFs decreased by 6 percent per year, on average, declining from 1,027 stays to 903 per 100,000 Medicare FFS beneficiaries. Total (Medicare FFS plus beneficiary) payments for IPF PPS services decreased from $4.3 billion to $3.9 billion—equivalent to a 5 percent annual decrease.

> From 2019 to 2020, the decline in the number of IPF stays per capita accelerated, falling 17 percent to 754 stays per capita, while total payments for IPF stays declined 13 percent. The accelerated decline in IPF use is likely related to avoidance or deferral of stays during the COVID-19 pandemic. However, the accelerated pace of decline continued in 2021, with the number of IPF stays per capita falling 15 percent, even as the decline in acute care hospital stays under the IPPS slowed to 1.8 percent (see Chart 6-14). Some observers have suggested that IPFs faced staffing challenges in 2021 that may have limited bed capacity.

Chart 6-20 Growing share of Medicare FFS beneficiaries' stays at IPFs were for schizophrenia, 2019–2021

Psychiatric MS–DRG grouping	2019	2020	2021	Annual change 2019–2020	Annual change 2020–2021
Psychosis	73.4%	74.4%	74.8%	1.3%	0.6%
Mood disorders	38.6	37.5	36.9	–2.8	–1.8
Schizophrenia and other non-mood psychotic disorders	34.8	36.9	37.9	5.9	2.9
Organic disturbances	7.0	6.9	6.8	–1.8	–1.5
Alcohol/drug dependency	6.4	6.2	6.2	–2.6	–0.6
Neurosis	4.5	4.2	3.9	–7.6	–6.2
Nervous system disorder	5.9	5.4	5.3	–8.7	–1.0
Other psychiatric	1.8	1.9	2.0	7.4	3.4
Other nonpsychiatric	1.0	1.0	1.0	4.8	–2.9
Total	100.0	100.0	100.0		

Note: FFS (fee-for-service), IPF (inpatient psychiatric facility), MS–DRG (Medicare severity–diagnosis related group). Totals may not sum to 100 percent due to rounding. Data represent FFS beneficiaries with an IPF stay ending in each respective fiscal year. Psychiatric MS–DRG groupings are categorized as the following: mood disorders (885 and International Classification of Diseases, 10th Revision (ICD-10) diagnosis codes F30–F39); schizophrenia, schizotypal, delusion, and other non-mood psychotic disorders (885 and ICD-10 diagnosis codes F20–F29); organic disturbances and mental retardation (884); alcohol/drug abuse or dependency with and without rehabilitation and with and without major complication or comorbidity (MCC) (894, 895, 896, 897); neurosis with and without depressive (881, 882); degenerative nervous system disorders with and without MCC (056, 057); other psychiatric MS–DRGs (880, 883, 896, 876, 887); other nonpsychiatric MS–DRGs (all others).

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

> Medicare FFS patients in IPFs are generally assigned 1 of 17 psychiatric MS–DRGs. However, the MS–DRG system does not differentiate well among Medicare beneficiaries in IPFs; in 2021, nearly 75 percent of cases were assigned to the psychosis MS–DRG.

> The psychosis MS–DRG is a broad category including patients with principal diagnoses of mood disorders (such as bipolar disorder and major depression) and non-mood psychotic disorders (such as schizophrenia). Between 2019 and 2020, corresponding with the start of the COVID-19 pandemic, the share of patients with non-mood psychotic disorders increased by nearly 6 percent. The increase continued in 2021, by nearly 3 percent compared with the prior year. In contrast, the share of patients with mood disorders decreased between 2019 and 2021. Given that the number of overall IPF stays decreased substantially during this time, it is likely that patients with certain diagnoses (such as schizophrenia) were less able to avoid or defer IPF use.

Chart 6-21 Medicare FFS beneficiaries using IPFs tended to be disabled, under age 65, low income, and non-White, FY 2021

Characteristic	Share of all IPF users	Share of IPF users with more than one IPF stay in 2021	Share of all FFS beneficiaries
All	100%	26%	—
Current eligibility status and demographics			
Aged	46	31	88
Disabled	54	69	12
ESRD	0.1	0.0	0.2
Female	49	45	53
Male	51	55	47
<45	25	35	3
45–64	30	34	9
65–79	32	24	67
80+	14	7	21
Non-Hispanic White	72	68	78
Black	16	19	9
Asian/Pacific Islander	2	2	3
Hispanic	6	7	6
American Indian/Alaska native	1	1	1
Other or unknown	3	4	3
Urban	80	83	80
Rural	20	17	20
Dual eligible or LIS during year			
No	35	24	83
Yes	65	76	17

Note: FFS (fee-for-service), IPF (inpatient psychiatric facility), FY (fiscal year), ESRD (end-stage renal disease), LIS (low-income subsidy). Components may not sum to totals due to rounding.

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

> Of Medicare FFS beneficiaries who had at least one IPF stay in 2021, 54 percent qualified for Medicare because of a disability, compared with 12 percent across all FFS beneficiaries. Beneficiaries who used IPF care also tended to be younger and poorer.

> Twenty-six percent of Medicare FFS beneficiaries who used an IPF in 2021 had more than one IPF stay during the year. These beneficiaries were even more likely than all IPF users to be disabled (often because of a psychiatric diagnosis), under age 65, low income, and non-White.

> The shares and patterns were similar for beneficiaries using IPFs in 2020.