SECTION

6

Acute inpatient services

General acute care hospitals
Inpatient psychiatric facilities

Chart 6-1 Nearly one-quarter of inpatient stays at general acute care hospitals were for FFS Medicare beneficiaries, and almost all of those were paid under IPPS, 2022

	Number of hospitals	All-payer inpatient stays	FFS Medicare inpatient stays	FFS Medicare share of all inpatient stays
All general acute	**4,500**	**29.4 million**	**7.0 million**	**24%**
Share of total				
IPPS	69%	96%	95%	23
Location				
Metropolitan (urban)	52	89	86	23
Rural micropolitan	12	6	8	31
Other rural	5	1	1	31
Ownership				
For profit	17	16	15	22
Nonprofit	42	68	69	24
Government	10	13	11	11
DSH and teaching				
Both	26	64	60	22
DSH only	33	26	28	25
Teaching only	2	3	3	28
Neither	8	3	4	34
Critical access	30	2	3	40
Maryland	1	2	2	26

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 that was valid as of our analysis and had a midpoint in the specified fiscal year. "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. The year is fiscal.

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

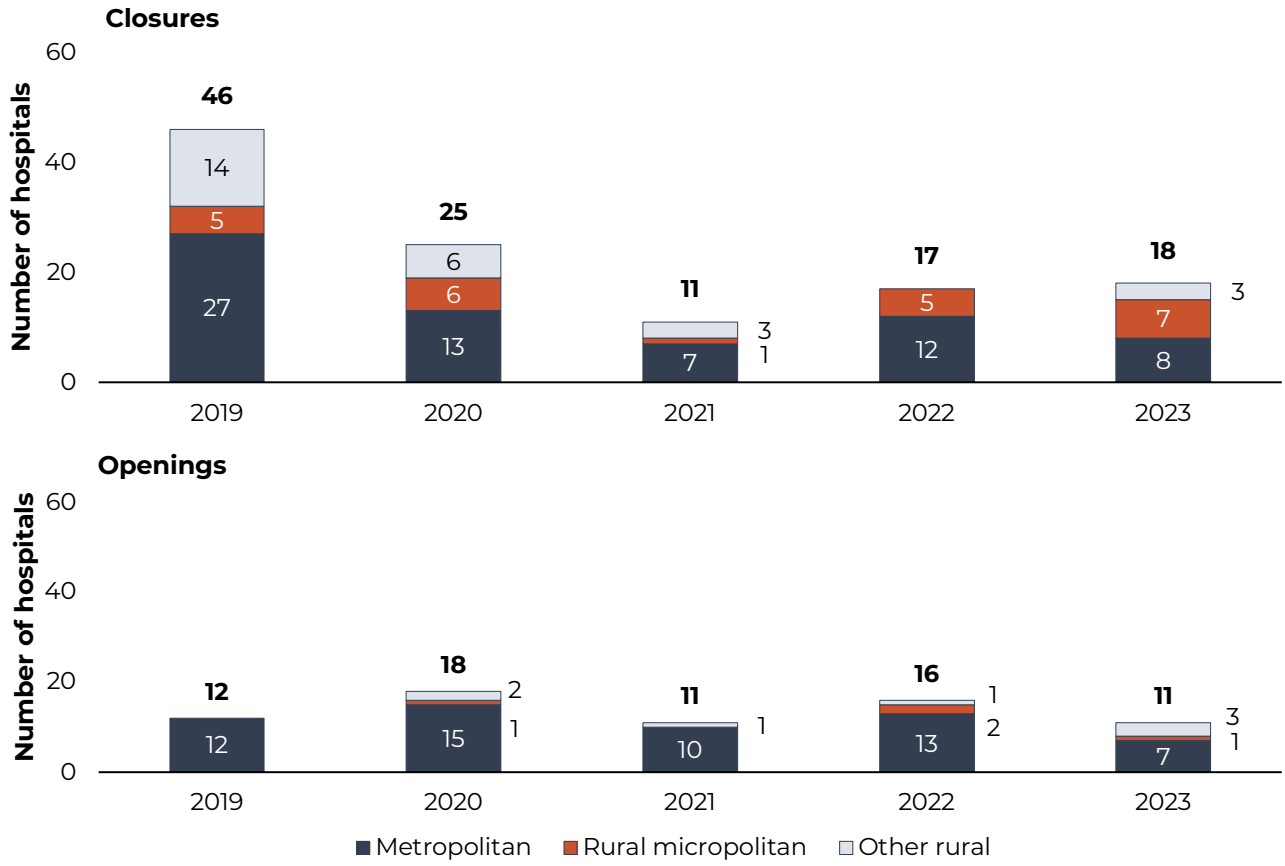
> In 2022, there were approximately 4,500 general acute care hospitals, at which there were 29.4 million inpatient stays. Nearly a quarter of these stays (7.0 million) were for FFS Medicare beneficiaries.

> For about two-thirds of general acute care hospitals, FFS Medicare pays for inpatient stays under Medicare's IPPS. Nearly all (96 percent) inpatient stays and FFS Medicare stays were at IPPS hospitals; further, the vast majority of all FFS Medicare stays were at the half of IPPS hospitals located in urban areas. FFS Medicare inpatient stays were a larger share of all stays at rural hospitals and a lower share at government-run hospitals.

> About 30 percent of general acute care hospitals are designated critical access hospitals (CAHs), which are hospitals with fewer than 25 beds, which 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 40 percent of all CAH inpatient stays.

> Data on Medicare Advantage (MA) inpatient stays in 2022 were not available at the time of publication. In 2021, there were over 5 million MA inpatient stays at general acute care hospitals (data not shown).

Chart 6-2 Number of general acute care hospital closures exceeded openings in 2023



Note: "Closure" refers to a general acute care hospital that ceased inpatient services and did not convert to a rural emergency hospital, while "opening" refers to a new location for general acute care inpatient services. The counts do 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. 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." The years are fiscal. The number of hospital closures and openings in a given year can change over time as hospitals reopen or dates of closure are updated.

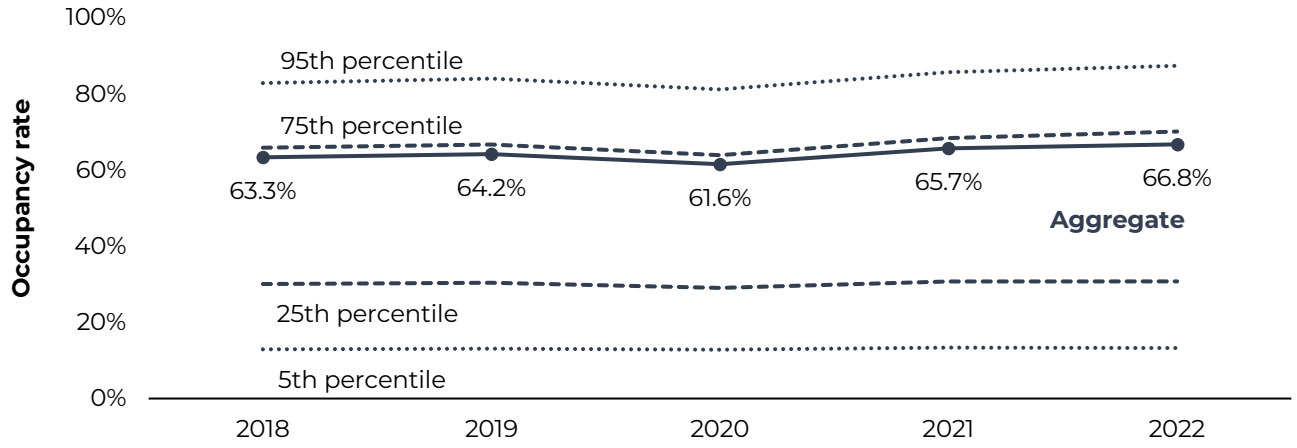
Source: MedPAC analysis of the CMS Provider of Services file, census data on metropolitan and micropolitan areas, and internet searches.

> In fiscal year (FY) 2023, 18 general acute care hospitals closed and 11 opened, leading to a slight net decrease in the number of hospitals providing inpatient services to Medicare beneficiaries.

> In addition to these changes, about 20 hospitals converted to the new rural emergency hospital (REH) designation (data not shown). Some of the hospitals that closed are considering reopening as REHs.

> The decrease in the supply of hospitals in FY 2023 was a contrast to FY 2021 and FY 2022, in which the supply was steady. However, it is similar to the slight decrease in 2020 and markedly smaller than the large decrease in 2019.

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; total bed days available may be higher than staffed bed days. Data are for general acute care hospitals in the U.S. that had a cost report that was valid as of our analysis and had a midpoint in the specified fiscal year. The years are fiscal.

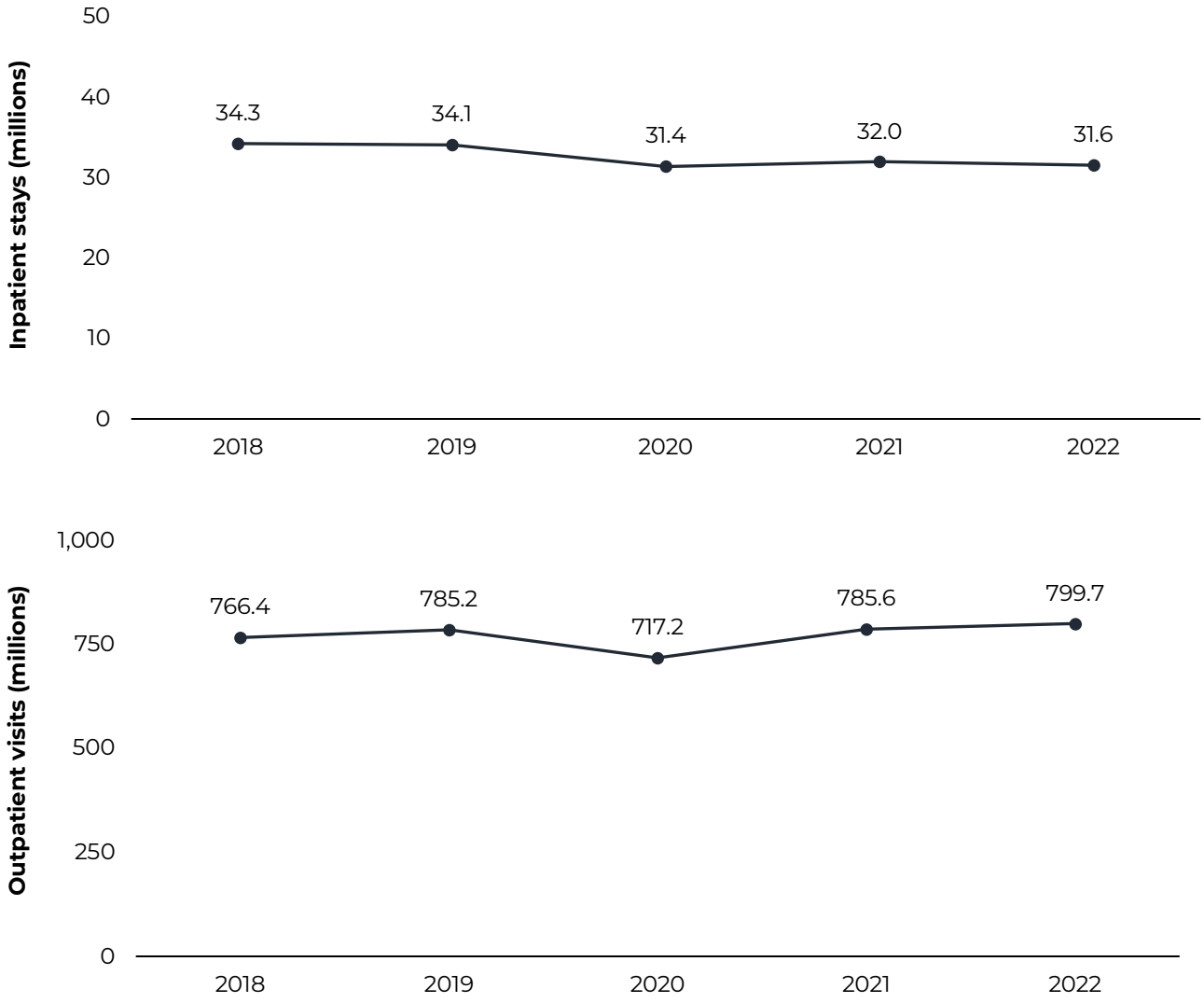
Source: MedPAC analysis of hospital cost report data from CMS.

> General acute care hospitals continued to have excess capacity in aggregate, with about 67 percent of all beds occupied during fiscal year 2022, 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. For example, in 2022, 5 percent of hospitals had occupancy rates of over 85 percent while 5 percent had occupancy rates below 15 percent. These hospitals with significant excess capacity were more likely to be small rural hospitals, while those with higher occupancy rates were more likely to be large hospitals with over 250 beds or more than 100 medical residents.

> Although hospital employment has increased to above prepandemic levels, some hospitals continued to report staffing shortages (data not shown).

Chart 6-4 All-payer inpatient stays remained below prepandemic levels in 2022, while hospital outpatient visits grew to above prepandemic levels



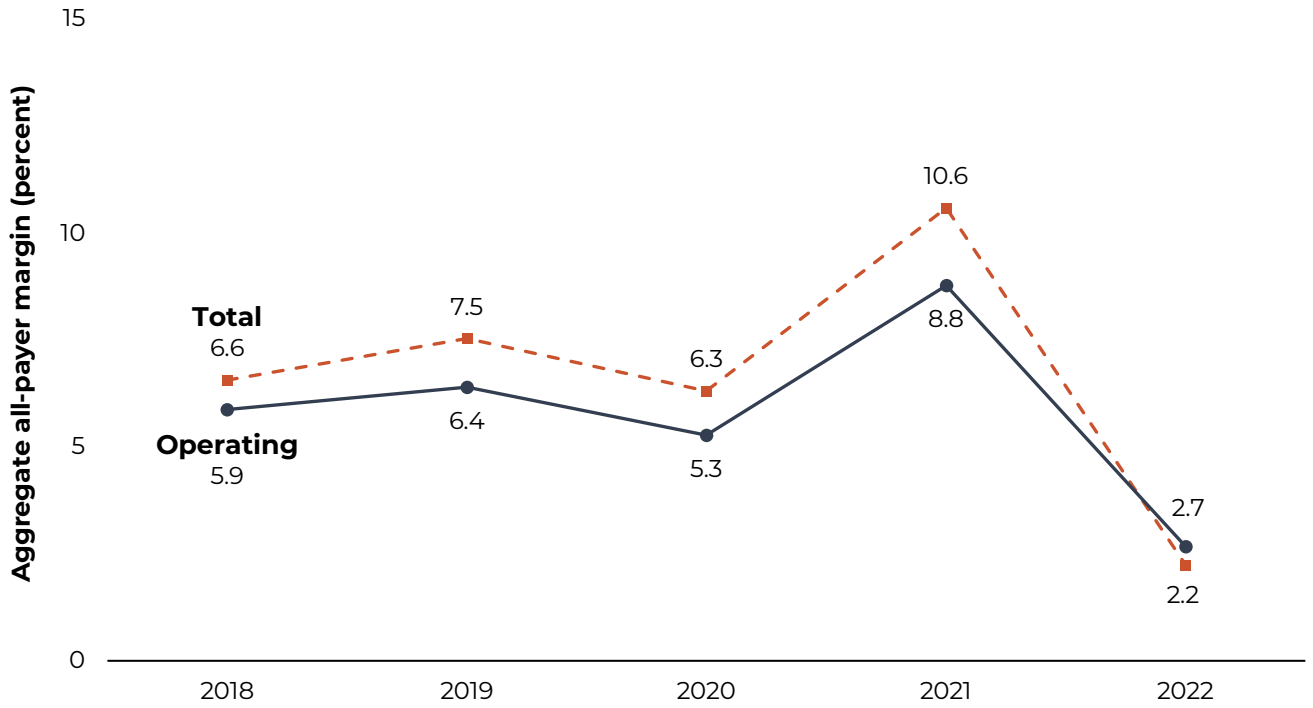
Note: "Outpatient visits" includes all clinic visits, referred visits, observation services, outpatient surgeries, and emergency department visits, regardless of the number of diagnostic and/or therapeutic treatments the patient received during the visit. Data are for community hospitals (nonfederal 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 data reflect varying numbers of months of COVID-19 impacts. The years are fiscal.

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.

> By 2022, all-payer inpatient stays remained below levels immediately prior to the pandemic, while hospital outpatient visits grew to above prepandemic levels.

Chart 6-5 IPPS hospitals' aggregate all-payer margin fell from a record high in 2021 to a relative low in 2022



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, for 2020 through 2022, federal relief funds that were reported by hospitals. "Total" margin includes investments; "operating" margin excludes revenue from investments and contributions. Data are for IPPS hospitals that had a cost report that was valid as of our analysis and had a midpoint in the specified fiscal year. Given that not all hospitals are reporting the same 12-month period, the data reflect varying numbers of months of COVID-19 impacts. The years are fiscal.

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. For 2020 through 2022, these measures include reported federal relief funds to support hospitals during the COVID-19 public health emergency.

> IPPS hospitals' aggregate all-payer total and operating margins remained strong in 2020 with the support of about $35 billion in reported federal relief funds and reached record highs in 2021 when including the nearly $18 billion in reported relief funds. The 2021 operating margin excluding relief funds was 7.3 percent, also a record high (data not shown).

> However, in 2022, IPPS hospitals' all-payer total and operating margins fell to relative lows; the 2.7 percent aggregate all-payer operating margin was the lowest level since 2008 (data not shown). Federal relief funds contributed a much smaller amount to revenue in 2022 ($9 billion), while operating costs grew about 8 percent (data not shown). Furthermore, IPPS hospitals' all-payer total margin decreased to below their operating margin due to investment losses.

Chart 6-6 Magnitude of 2022 decrease in IPPS hospitals' all-payer operating margin varied by type, with less decline among for-profit hospitals

	Aggregate all-payer operating margin							
			2020		2021		2022	
	2018	2019	With relief funds	Without relief funds	With relief funds	Without relief funds	With relief funds	Without relief funds
IPPS	5.9%	6.4%	5.3%	1.9%	8.8%	7.3%	2.7%	1.9%
Location								
Metropolitan (urban)	6.1	6.5	5.3	1.9	8.8	7.4	2.8	2.1
Rural micropolitan	3.8	5.0	5.8	1.5	8.9	6.4	1.1	–0.8
Other rural	–0.2	0.4	2.8	–1.9	7.4	2.5	–0.2	–3.5
Ownership								
For profit	11.3	12.1	12.6	10.4	15.5	14.3	12.7	12.3
Nonprofit	5.5	6.1	4.7	1.1	8.3	6.9	1.2	0.4
DSH and teaching								
Both	5.5	6.1	4.7	1.2	8.6	7.2	2.5	1.8
DSH only	6.0	6.7	6.4	3.0	8.9	7.2	2.5	1.6
Teaching only	8.2	8.1	5.6	3.6	7.4	6.4	3.2	2.9
Neither	8.6	8.9	8.5	6.0	13.5	11.8	6.4	5.7
CAH	1.7	2.4	4.9	0.4	10.7	5.9	4.2	2.3

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' margins are 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 through 2022, 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 that was valid as of our analysis and had a midpoint in the specified fiscal year. Because not all hospitals report the same 12-month period, the data reflect varying numbers of months of COVID-19 impacts. The years are fiscal. Results for some years are different from previous reports due to newer data and updated group definitions.

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 2022 operating margin ranged from –6 percent to 10 percent among the middle half of IPPS hospitals (data not shown).

> While there was variation within each group of IPPS hospitals, in aggregate, the operating margin continued to be higher among for-profit hospitals and, to a lesser extent, urban hospitals. For-profit hospitals' operating margin remained above levels in the immediate prepandemic period, while the margin fell among nonprofits and most other hospital groups.

> Critical access hospitals' aggregate all-payer operating margin also declined in 2022. However, it remained above the levels in the immediate prepandemic period (when including federal relief funds).

Chart 6-7 IPPS hospitals' FFS Medicare margin across service lines fell to a record low in 2022, but for-profit hospitals' margin remained positive

	Aggregate FFS Medicare margin							
			2020		2021		2022	
Hospital group	2018	2019	With relief funds	Without relief funds	With relief funds	Without relief funds	With relief funds	Without relief funds
IPPS	–9.3%	–8.5%	–8.1%	–12.3%	–6.1%	–8.1%	–11.6%	–12.7%
Location								
Metropolitan (urban)	–9.5	–8.8	–8.6	–12.6	–6.5	–8.4	–11.9	–12.8
Rural micropolitan	–7.0	–6.5	–4.1	–9.0	–2.3	–5.7	–9.5	–12.2
Other rural	–6.9	–5.2	–0.3%	–5.9	5.3	–1.1	–2.5	–7.1
Ownership								
For profit	–0.6	0.8	4.3	1.7	5.9	4.4	0.9	0.4
Nonprofit	–10.6	–10.0	–10.3	–14.7	–8.1	–10.1	–13.5	–14.7
DSH and teaching								
Both	–8.1	–7.6	–7.6	–11.8	–5.9	–7.8	–7.8	–11.1
DSH only	–10.2	–8.9	–7.6	–11.9	–5.6	–.7.9	–12.3	–13.7
Teaching only	–13.4	–13.7	–14.8	–17.4	–9.8	–11.4	–15.8	–16.3
Neither	–15.7	–15.2	–15.4	–18.7	–9.6	–12.1	–13.3	–14.2
CAH	–1.7	–1.7	3.8	–0.9	6.5	0.1	1.8	–0.5

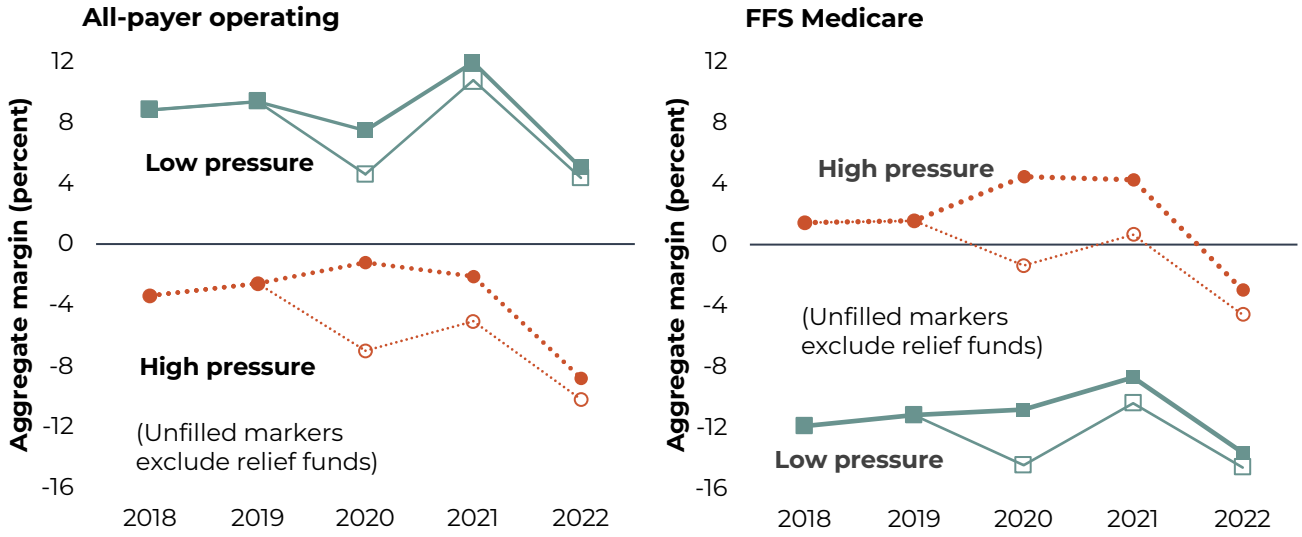
Note: IPPS (inpatient prospective payment systems), FFS (fee-for-service), DSH (disproportionate share hospital), CAH (critical access hospital). "Relief funds" refers to Provider Relief Fund payments and Paycheck Protection Program forgiven loans recorded on hospitals' cost reports, with the Medicare share calculated using FFS 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 that was valid as of our analysis and had a midpoint in the specified fiscal year. The years are fiscal. Results for some years are different from prior-year reports' results due to newer data and updated group definitions.

Source: MedPAC analysis of hospital cost reports and census geographic files.

> Hospitals' Medicare margin across service lines reflects the relationship between hospitals' FFS Medicare 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 2022, IPPS hospitals' aggregate FFS Medicare margin fell to a record low. Among most groups of IPPS hospitals, the FFS Medicare margin fell below levels in the immediate prepandemic period; however, for-profit hospitals' margin remained positive and near prepandemic levels.

Chart 6-8 IPPS hospitals under high financial pressure continued to have higher FFS Medicare margins



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. Data are for IPPS hospitals that had a cost report that was valid as of our analysis and had a midpoint in the specified fiscal year. The years are fiscal. Results for some years are different from prior-year reports' results due to newer data and updated group definitions.

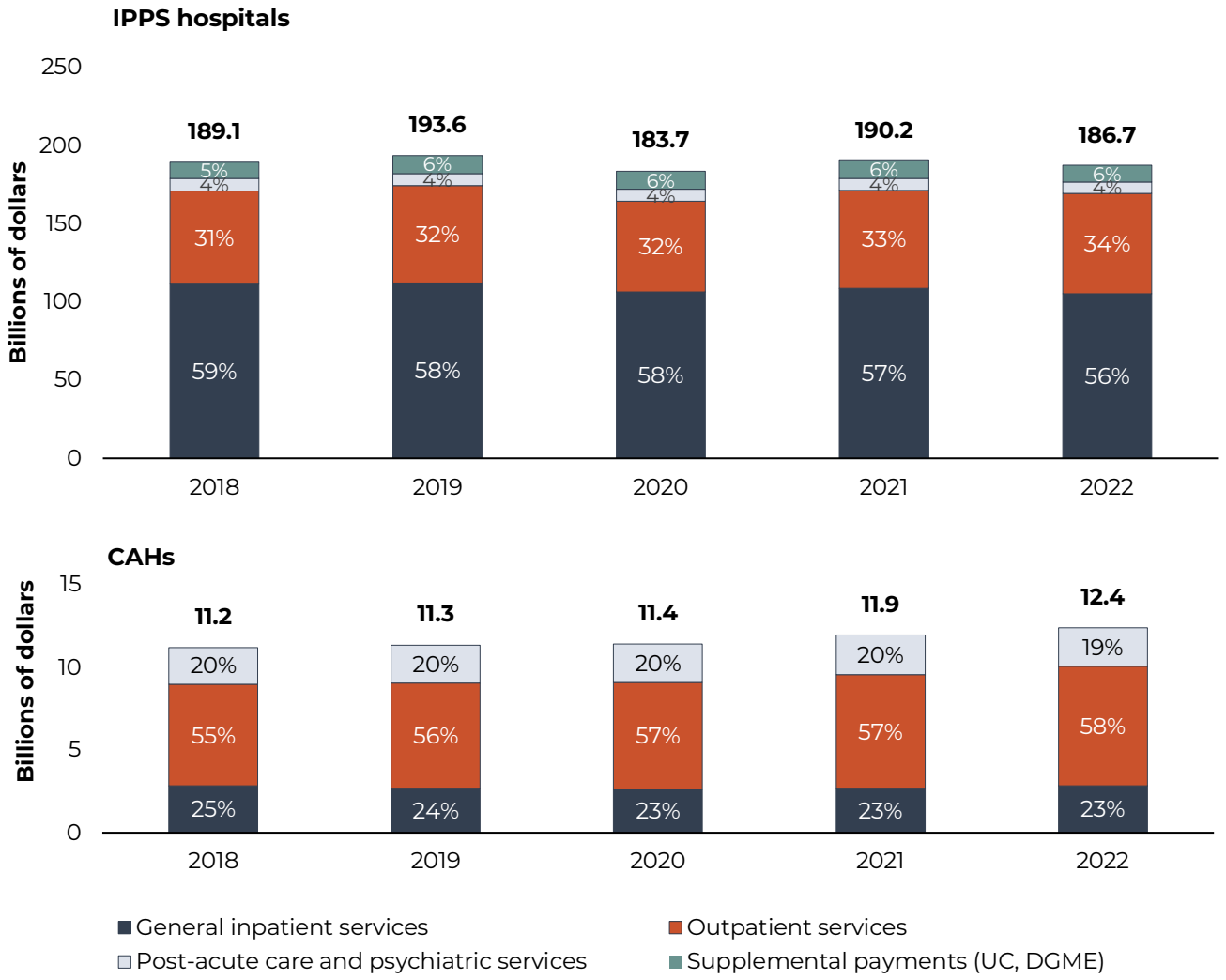
Source: MedPAC analysis of hospital cost report data from CMS.

> IPPS hospitals experience different levels of financial pressure from non-Medicare payers. Hospitals under higher financial pressure from non-Medicare payers continue to have lower all-payer operating margins but higher FFS Medicare margins than hospitals under low financial pressure.

> This finding suggests that hospitals with high non-Medicare margins—that is, those under low fiscal pressure—have, on average, negotiated prices that are high enough to not only offset their losses on non-Medicare patients but also generate above-average all-payer margins.

> Nonprofit hospitals under high levels of financial pressure tended to have lower standardized inpatient and outpatient costs than nonprofit hospitals under low pressure to constrain their costs (data not shown). The relationship between financial pressure and costs is less consistent for for-profit hospitals.

Chart 6-9 FFS Medicare payments for inpatient services continued to be the largest component of payments to IPPS hospitals but not to CAHs, 2018–2022



Note: FFS (fee-for-service), IPPS (inpatient prospective payment systems), CAH (critical access hospital), UC (uncompensated care), DGME (direct graduate medical education). Hospitals also receive payments from FFS Medicare that are not included in these totals, such as payments for hospital-based clinics. The 2020 through 2022 payment amounts do not include Medicare's share of Provider Relief Fund payments or Paycheck Protection Program forgiven loans that were provided as part of the public health emergency. Data are for IPPS hospitals or CAHs that had a cost report that was valid as of our analysis and had a midpoint in the specified fiscal year. The years are fiscal. Dollar amounts are nominal figures, not adjusted for inflation.

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 59 percent in 2018 to 56 percent in 2022.

> For CAHs, outpatient services continued to be the largest component of FFS Medicare payments, and the share has been slowly increasing, from 55 percent in 2018 to 58 percent in 2022. In addition, 19 percent of FFS Medicare payments to CAHs in 2022 were for post-acute care and psychiatric services, almost all of which were for swing-bed skilled nursing facility services.

Chart 6-10 Over 15 percent of IPPS payments in 2022 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	82.6%	3.3%	7.2%	5.4%	1.4%	–0.7%
Location						
Metropolitan (urban)	82.7	3.3	7.6	5.6	0.7	–0.7
Micropolitan	82.0	2.4	2.9	3.0	9.2	–0.7
Other rural	77.4	2.0	0.6	2.5	16.3	–0.7
Ownership						
For profit	88.4	3.6	4.3	2.7	1.2	–0.8
Nonprofit	82.9	3.1	7.1	5.4	1.3	–0.7
Government	74.9	4.0	10.8	8.2	1.9	–0.9
DSH and teaching						
Both	89.4	3.6	10.1	6.2	0.5	–0.7
DSH only	89.6	3.1	0.0	3.6	3.4	–0.8
Teaching only	86.5	0.1*	7.6	4.7	1.0	–0.7
Neither	91.9	0.1*	0.0	3.3	4.1	–0.7
Rural and/or isolated						
Sole community	78.3	2.2	2.7	4.2	12.0	–0.6
Medicare dependent	78.2	1.6	2.0	2.2	15.8	–0.7
Low volume	76.5	1.9	0.6	2.6	17.5	–0.5

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. For sole community and Medicare-dependent hospitals that are paid on their hospital-specific rate, the "rural and/or isolated" column includes the amount by which their rate exceeds the otherwise applicable IPPS payments. "Quality" includes payments and penalties from the Value-Based Purchasing Program and penalties from the 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 that was valid as of our analysis and had a midpoint in the specified fiscal year. The years are fiscal.
*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.

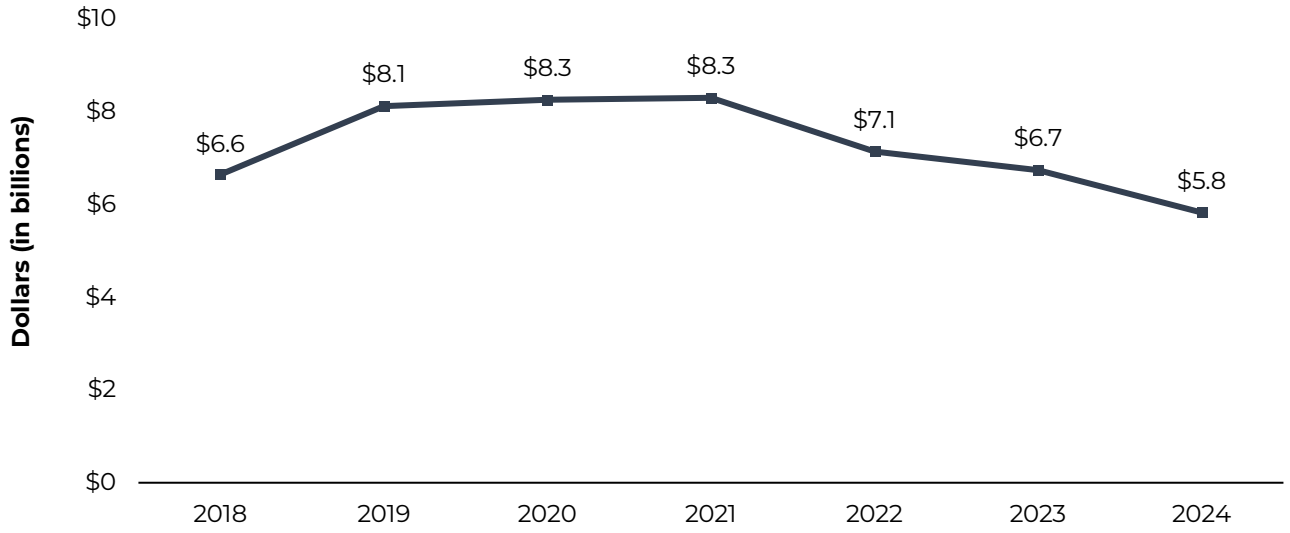
Source: MedPAC analysis of hospital cost report data from CMS and census data on metropolitan and micropolitan areas.

> In 2022, base payments accounted for 82.6 percent of IPPS payments to hospitals for inpatient services provided to FFS Medicare beneficiaries. The remaining amount—over 15 percent—comprised IPPS adjustments to the base rates and additional payments such as low-income and teaching adjustments, outlier payments, and rural and/or isolated payments.

> The IPPS adjustments and additional payments are targeted to specific groups of hospitals. For example, the additional rural/isolated payments to low-volume hospitals accounted for 17.5 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 are otherwise paid outside of the IPPS, such as organ acquisition (data not shown).

Chart 6-11 Medicare's uncompensated care payments to IPPS hospitals fell between 2021 and 2024



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. The years are fiscal.

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

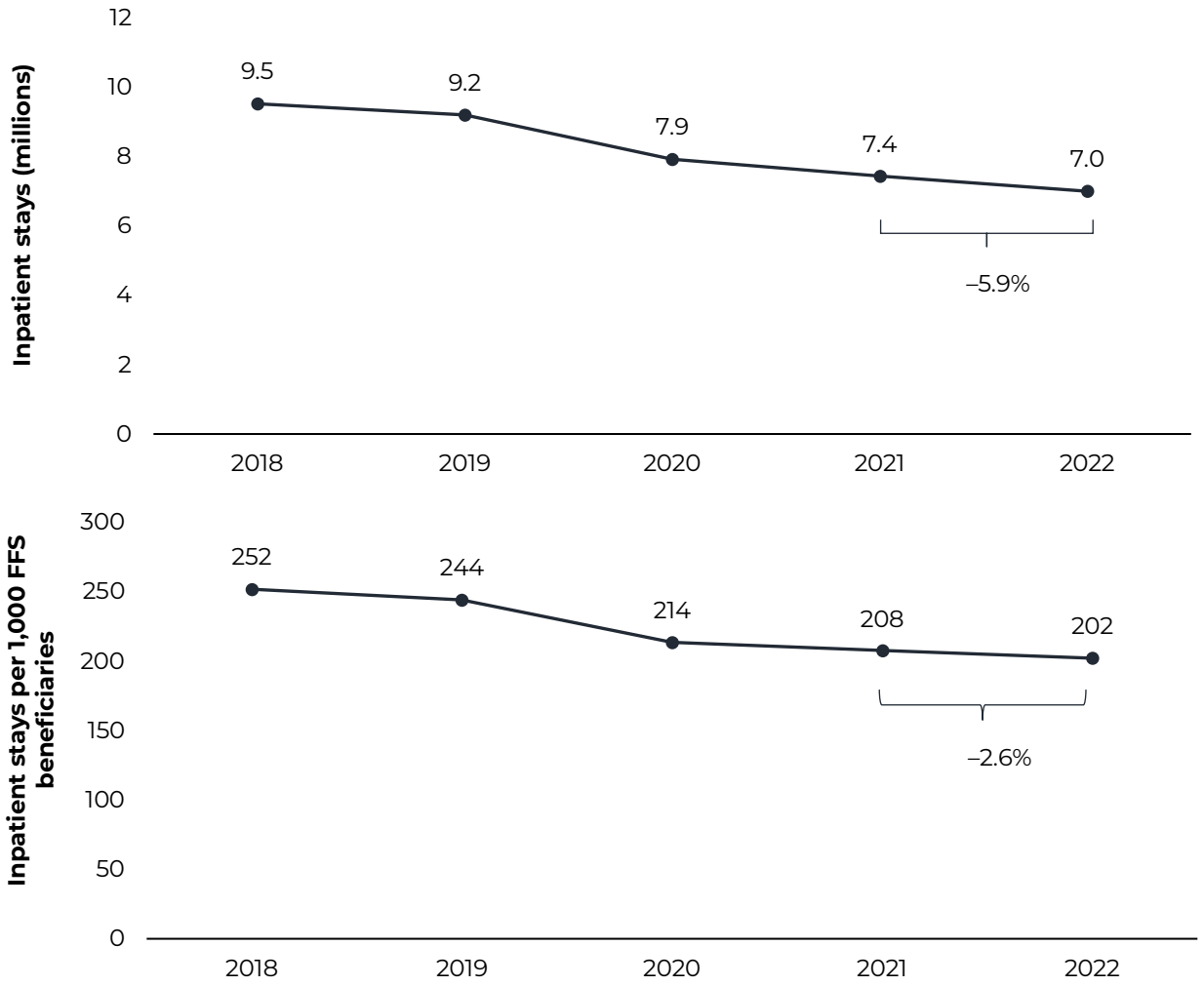
> In addition to IPPS payments for fee-for-service Medicare beneficiaries' inpatient stays, the Medicare program makes uncompensated care payments to IPPS hospitals to help cover their costs of treating uninsured patients. When the rate of uninsured individuals increases and hospitals have greater losses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

> However, uncompensated care payments fell in each year from 2022 through 2024, down to $5.8 billion, or similar to the level in 2017 (2017 data not shown). 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 6-12 FFS Medicare inpatient stays and stays per capita declined in 2022



Note: FFS (fee-for-service). Data are for FFS Medicare beneficiaries' stays at general acute care hospitals in the U.S. 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. The years are fiscal.

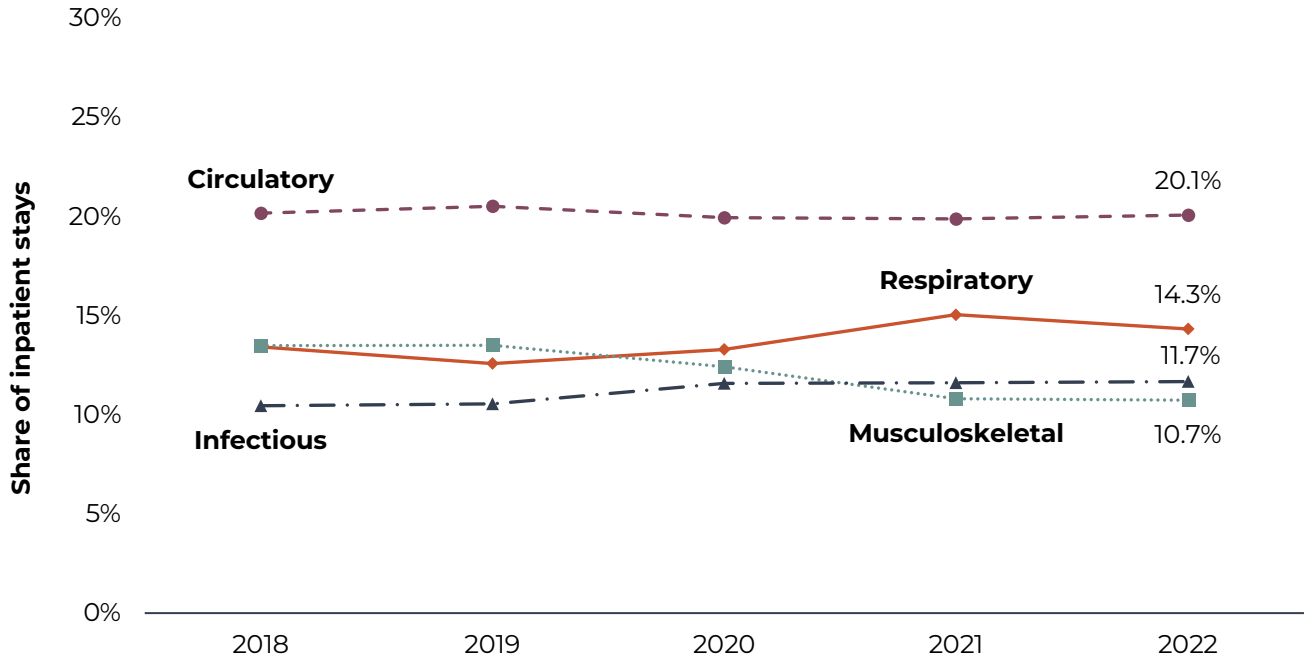
Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS and reports of the Boards of Trustees of the Medicare trust funds.

> From 2021 to 2022, the number of inpatient stays by FFS Medicare beneficiaries at general acute care hospitals declined by 5.9 percent to 7.0 million stays. Controlling for the number of FFS beneficiaries, the number of inpatient stays declined by 2.6 percent, to 202 stays per 1,000 FFS beneficiaries. (The number of all-payer inpatient stays also decreased (see Chart 6-4).)

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

> While FFS Medicare inpatient stays have continued to decline, the average length of stay has continued to increase (see Chart 6-15).

Chart 6-13 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 general acute care hospitals in the U.S. The years are fiscal.

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

> In each year from 2018 through 2022, 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, respiratory, musculoskeletal, or infectious diseases.

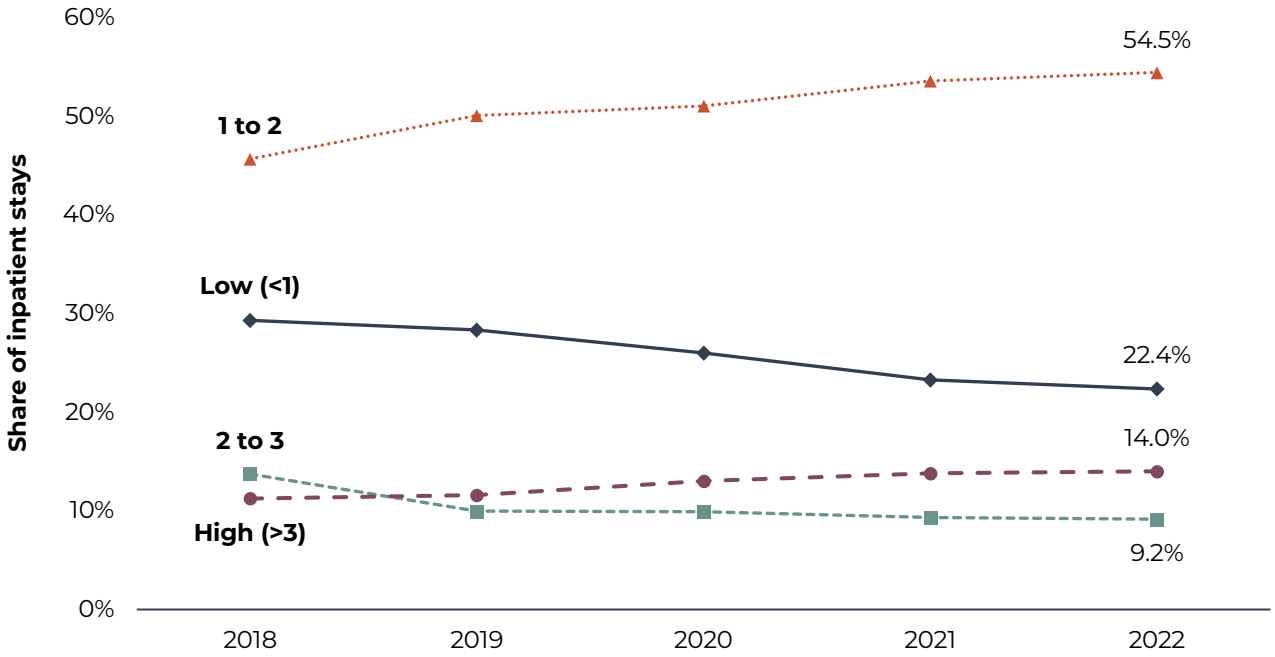
> The most common major diagnostic category is circulatory system diseases, such as heart failure and cardiac arrhythmia, accounting for about 20 percent of FFS Medicare inpatient stays in each year from 2018 through 2022.

> The share of FFS Medicare inpatient stays for respiratory infections surged during the pandemic but declined in 2022, though it remained above the immediate prepandemic level.

> The share of FFS Medicare inpatient stays for musculoskeletal conditions, which can increasingly be safely treated in outpatient settings, has declined substantially since 2018.

> The share of FFS Medicare stays for infectious diseases has slowly increased in each year from 2018 through 2022.

Chart 6-14 The least resource-intensive cases have made up a declining share of FFS Medicare inpatient stays



Note: FFS (fee-for-service). The lines refer to the Medicare severity–diagnosis related group weight, which reflects CMS's estimate of the relative average resource intensity (i.e., costs) of that type of stay. Data are for FFS Medicare beneficiaries' stays at hospitals general acute care hospitals in the U.S. The years are fiscal. Components do not sum to 100 percent due to rounding.

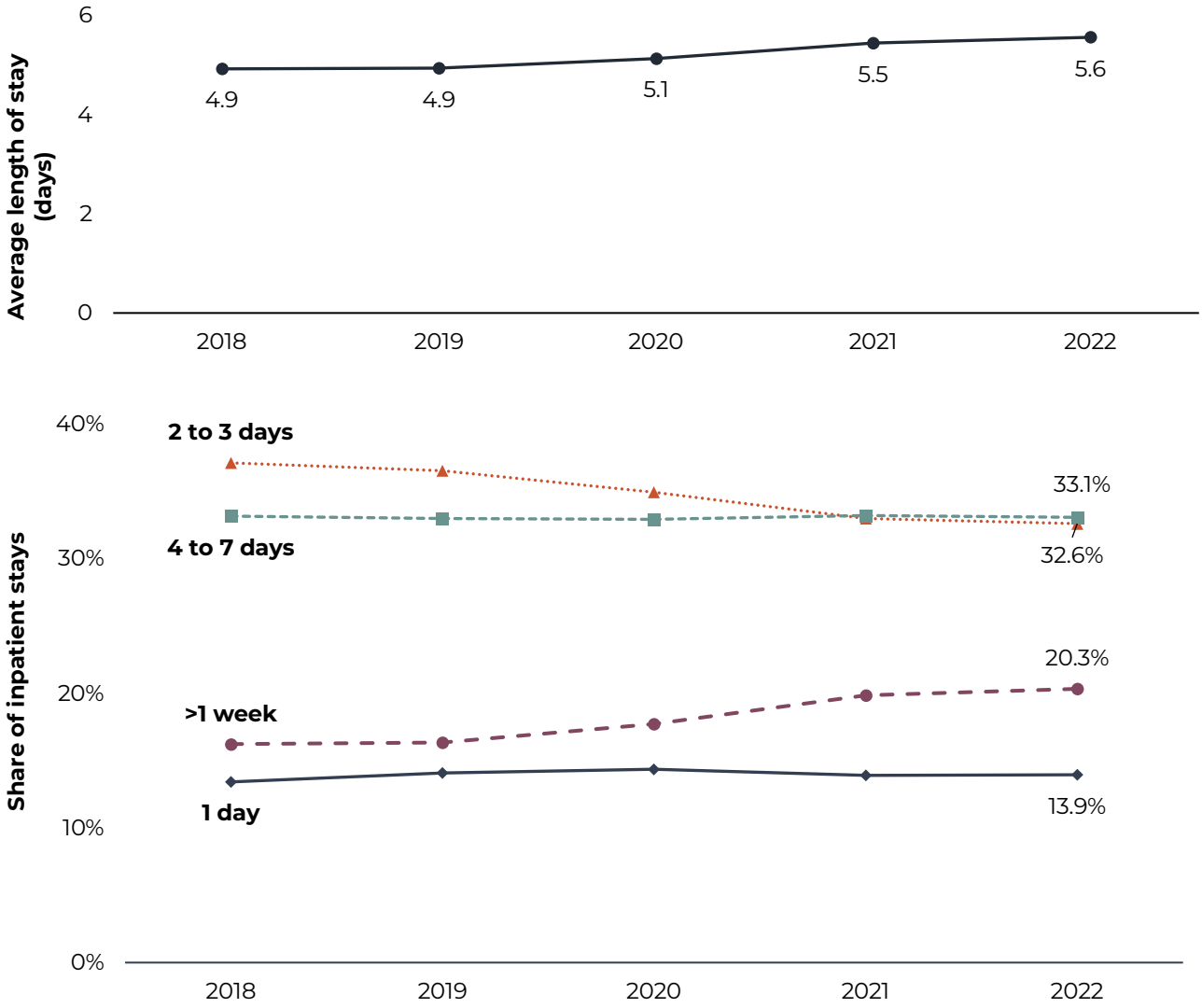
Source: MedPAC analysis of Medicare Provider Analysis and Review data and IPPS final rules published by CMS.

> 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 because these less resource-intensive conditions can increasingly be treated in hospital outpatient settings. However, this decline accelerated during the public health emergency, falling to under 23 percent of stays in 2022. (In 2022, the most common FFS Medicare inpatient stays with a weight of less than 1 were those for kidney and urinary tract infections, esophagitis and gastroenteritis, gastrointestinal hemorrhage, and renal failure, all without major complications or comorbidities (MCCs).)

> In contrast, the share of inpatient stays with a weight of greater than 3 accelerated its increase, reaching 14 percent in 2022. (In 2022, the most common FFS inpatient stays with a weight of greater than 3 were stays for infectious diseases with operating room procedures and MCCs, percutaneous and other intracardiac procedures, and endovascular cardiac valve replacement and supplement procedures.)

Chart 6-15 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 general acute care hospitals in the U.S. The years are fiscal. 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 5.6 days in 2022.

> The increase in average length of stay during the COVID-19 public health emergency was driven by the increase in the share of FFS Medicare beneficiaries' inpatient stays that were longer than 1 week, which increased from about 16 percent in 2019 to 20 percent in 2022.

> 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 6-16 The number of Medicare-certified inpatient psychiatric facilities declined in 2022, but the number of freestanding and for-profit facilities increased

Type of IPF	2018	2019	2020	2021	2022	Average annual change 2018–2020	Average annual change 2020–2022
All	1,610	1,580	1,540	1,530	1,480	–1.6%	–2.3%
Share of all							
Urban	78%	79%	79%	80%	80%	0.5	0.6
Rural	20	20	20	19	19	–2.0	–2.2
Teaching	36	37	38	38	38	1.8	0.4
Nonteaching	64	63	62	62	62	–1.1	–0.3
Hospital-based units	67	65	64	63	62	–1.8	–2.1
Nonprofit	41	40	39	39	38	–2.1	–1.5
For profit	14	14	14	13	13	–2.2	–3.2
Government	12	12	12	11	11	–0.3	–2.7
Freestanding	33	35	36	37	38	3.6	3.6
Nonprofit	5	5	5	5	5	–1.0	–0.5
For profit	19	20	21	22	23	5.2	5.5
Government	10	10	10	11	11	2.6	1.7

Note: IPF (inpatient psychiatric facility). Data are from facilities that had a cost report that was valid as of our analysis 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. The years are fiscal. 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 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.

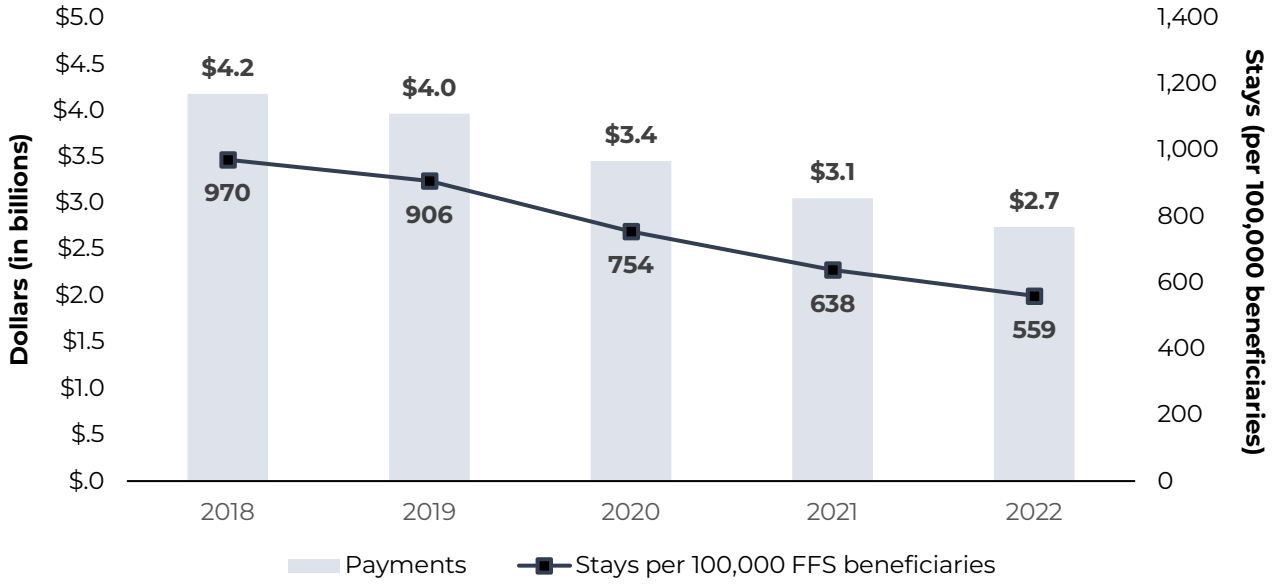
> From 2018 to 2020, the number of IPFs nationwide decreased by 1.6 percent each year, from 1,610 to 1,540. From 2020 to 2022, the decline in the number of IPFs was over 2 percent.

> Most IPFs are located in urban areas (80 percent in 2022). The share of IPFs in urban and rural areas remained mostly steady between 2018 and 2022, with a slight shift toward urban areas.

> In 2022, a majority of IPFs (62 percent) were hospital-based units; however, from 2018 to 2022, the share of freestanding IPFs grew by 3.6 percent annually while the share of hospital-based IPFs declined.

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

Chart 6-17 FFS Medicare inpatient psychiatric facility stays and payments continued to decline in 2022



Note: FFS (fee-for-service). The 2020 to 2022 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. The years are fiscal. Dollar amounts are nominal figures, not adjusted for inflation.

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 prospective payment system (PPS).

> From 2018 to 2022, FFS Medicare inpatient stays in IPFs decreased by 13 percent per year, on average, declining from 970 stays per 100,000 Medicare FFS beneficiaries to 559. Total (Medicare FFS plus beneficiary) payments for IPF PPS services decreased from $4.2 billion to $2.7 billion—equivalent to a 10 percent annual decrease on a nominal basis. Some of the decline in IPF use is likely related to avoidance or deferral of stays during the coronavirus pandemic, though the decline began prior to 2020 and continued into 2022. Some observers have suggested that IPFs faced staffing challenges after 2020 that may have limited bed capacity.

> Medicare beneficiaries may also receive inpatient psychiatric services in general acute care hospitals (sometimes referred to as "scatter-bed" stays). These cases are inpatient stays with a principal diagnosis in the major diagnostic category of mental diseases and disorders (MDC 19). In 2022, about 30 percent of Medicare FFS inpatient psychiatric stays occurred in general acute care hospitals (the remaining 70 percent occurred in IPFs) (data not shown).

Chart 6-18 A growing share of Medicare FFS beneficiaries' stays at IPFs were for schizophrenia, 2019–2022

Psychiatric MS–DRG grouping	2019	2020	2021	2022	Annual change 2019–2022
Share of total					
Psychosis	73.4%	74.4%	74.8%	75.1%	0.8%
Mood disorders	38.6	37.5	36.9	36.8	–1.6
Schizophrenia and other non-mood psychotic disorders	34.8	36.9	37.9	38.3	3.3
Organic disturbances	7.0	6.9	6.8	7.0	–0.2
Alcohol/drug dependency	6.4	6.2	6.2	5.7	–3.7
Neurosis	4.5	4.2	3.9	4.0	–3.8
Nervous system disorder	5.9	5.4	5.3	5.2	–4.0
Other psychiatric	1.8	1.9	2.0	2.0	4.3
Other nonpsychiatric	1.0	1.0	1.0	0.9	–2.0

Note: FFS (fee-for-service), IPF (inpatient psychiatric facility), MS–DRG (Medicare severity–diagnosis related group). 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, delusional, 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). The years are fiscal. Totals may not sum to 100 percent due to rounding.

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

> Medicare FFS patients in IPFs are generally assigned to 1 of 17 psychiatric MS–DRGs. However, the MS–DRG system does not differentiate well among Medicare beneficiaries in IPFs; in 2022, over 75 percent of cases were assigned to the psychosis MS–DRG.

> The psychosis MS–DRG is a broad category that includes 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 2022, the share of patients with non-mood psychotic disorders increased annually by 3.3 percent. In contrast, the share of patients with mood disorders decreased each year between 2019 and 2022. Part of the increase may be explained by the start of the coronavirus pandemic when the number of overall IPF stays decreased substantially and patients with certain diagnoses (such as schizophrenia) were likely less able than others to avoid or defer IPF use. However, the increase in the share of patients with non-mood psychotic disorders continued to increase in 2022.

Chart 6-19 Medicare FFS beneficiaries using IPFs tended to be disabled, under age 65, low income, and non-White, 2022

Characteristic	Share of all IPF users	Share of IPF users with more than one IPF stay in 2022	Share of all FFS beneficiaries
All	100%	26%	—
Current eligibility status and demographics			
Aged	46	33	89
Disabled	54	67	11
ESRD	0.1	0.0	0.2
Female	50	46	53
Male	50	54	47
<45	25	35	3
45–64	28	33	8
65–79	33	26	67
80+	13	7	22
Non-Hispanic White	72	67	78
Black	15	19	8
Asian/Pacific Islander	2	2	3
Hispanic	7	7	6
American Indian/Alaska native	1	1	0.5
Other or unknown	4	4	4
Urban	80	82	80
Rural	20	18	20
Dual eligible or LIS during year			
No	35	24	84
Yes	65	76	16

Note: FFS (fee-for-service), IPF (inpatient psychiatric facility), FY (fiscal year), ESRD (end-stage renal disease), LIS (low-income subsidy). The year is fiscal. 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 2022, 54 percent qualified for Medicare because of a disability, compared with 11 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 2022 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 disorder), under age 65, low income, and non-White.

Chart 6-20 Medicare beneficiaries near or reaching the lifetime limit on care in freestanding IPFs were highly vulnerable, 2022

Characteristic	Any day in freestanding IPF	Within 15 days of reaching limit	Reached limit
Number of beneficiaries	800,380	9,920	37,250
Current eligibility status and demographics (share)			
Aged	40%	28%	27%
Disabled	60	72	73
ESRD	0.0	0.0	0.0
Female	50	39	40
Male	50	61	60
<45	17	18	17
45–64	43	54	56
65–79	32	26	23
80+	9	2	5
Non-Hispanic White	70	64	63
Black	18	25	26
Asian/Pacific Islander	1	2	1
Hispanic	8	7	6
American Indian/Alaska native	1	1	1
Other or unknown	2	1	1
Urban	83	87	86
Rural	17	12	14
Dual eligible or LIS during year (share)			
No	27	12	13
Yes	73	88	87

Note: IPF (inpatient psychiatric facility), ESRD (end-stage renal disease), LIS (low-income subsidy). Components may not sum to 100 percent due to rounding. "Any day in freestanding IPF" includes Medicare beneficiaries (fee-for-service and Medicare Advantage enrollees) who were alive through the end of 2022 and stayed for at least one day in a freestanding IPF from the time of Medicare enrollment through December 31, 2022. "Within 15 days of reaching limit" includes Medicare beneficiaries who were alive through the end of 2022 and were within 1 to 15 days of reaching the 190-day coverage limit in freestanding IPFs as of December 31, 2022. "Reached limit" includes Medicare beneficiaries who were alive through the end of 2022 and had reached or exceeded the 190-day limit as of December 31, 2022. The year is fiscal.

Source: MedPAC analysis of Medicare enrollment data from CMS.

> Under Medicare, coverage of treatment in freestanding psychiatric hospitals is subject to a lifetime limit of 190 days. This provision was established in 1965 (with the implementation of Medicare), when most inpatient psychiatric care was provided by state-run freestanding facilities. There is no lifetime limit for treatment in hospital-based IPFs or for behavioral health care provided in general acute care hospitals.

> As of December 31, 2022, 800,380 Medicare (fee-for-service and Medicare Advantage) beneficiaries had at least one day in a freestanding IPF since enrolling in Medicare. Of these beneficiaries, 47,170 (9,920 + 37,250) were within 15 days of reaching the 190-day limit or had reached the limit as of the end of 2022. These beneficiaries were highly vulnerable: The majority were disabled and had low incomes (as indicated by dual eligibility for Medicare and Medicaid or by having the LIS).

> About 1,100 Medicare beneficiaries (who were alive through the end of 2022) exhausted the 190-day limit between 2022 and 2023 (data not shown).