SECTION

6

Acute inpatient services

General acute care hospitals
Inpatient psychiatric facilities

Chart 6-1 Almost all FFS Medicare beneficiary inpatient stays were paid under IPPS, FY 2023

	Number of hospitals	All-payer inpatient stays	FFS Medicare inpatient stays
All	**4,305**	**29.5 million**	**6.8 million**
Share of total			
IPPS	68%	96%	94%
Ownership			
For profit	16	15	13
Nonprofit	42	68	70
Government	10	13	11
Geography*			
Metropolitan	53	90	86
Rural micropolitan	11	5	7
Other rural	4	1	1
DSH and teaching			
Both	28	67	61
DSH only	31	24	26
Teaching only	2	2	3
Neither	7	3	4
Critical access	30	2	3
Other	2	2	3

Note: FFS (fee-for-service), IPPS (inpatient prospective payment systems), FY (fiscal year), DSH (disproportionate share). Data include all Subsection (d) and critical access hospitals that, as of our analysis, had a complete cost report with 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. Components may not sum to totals due to rounding.

* 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.

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

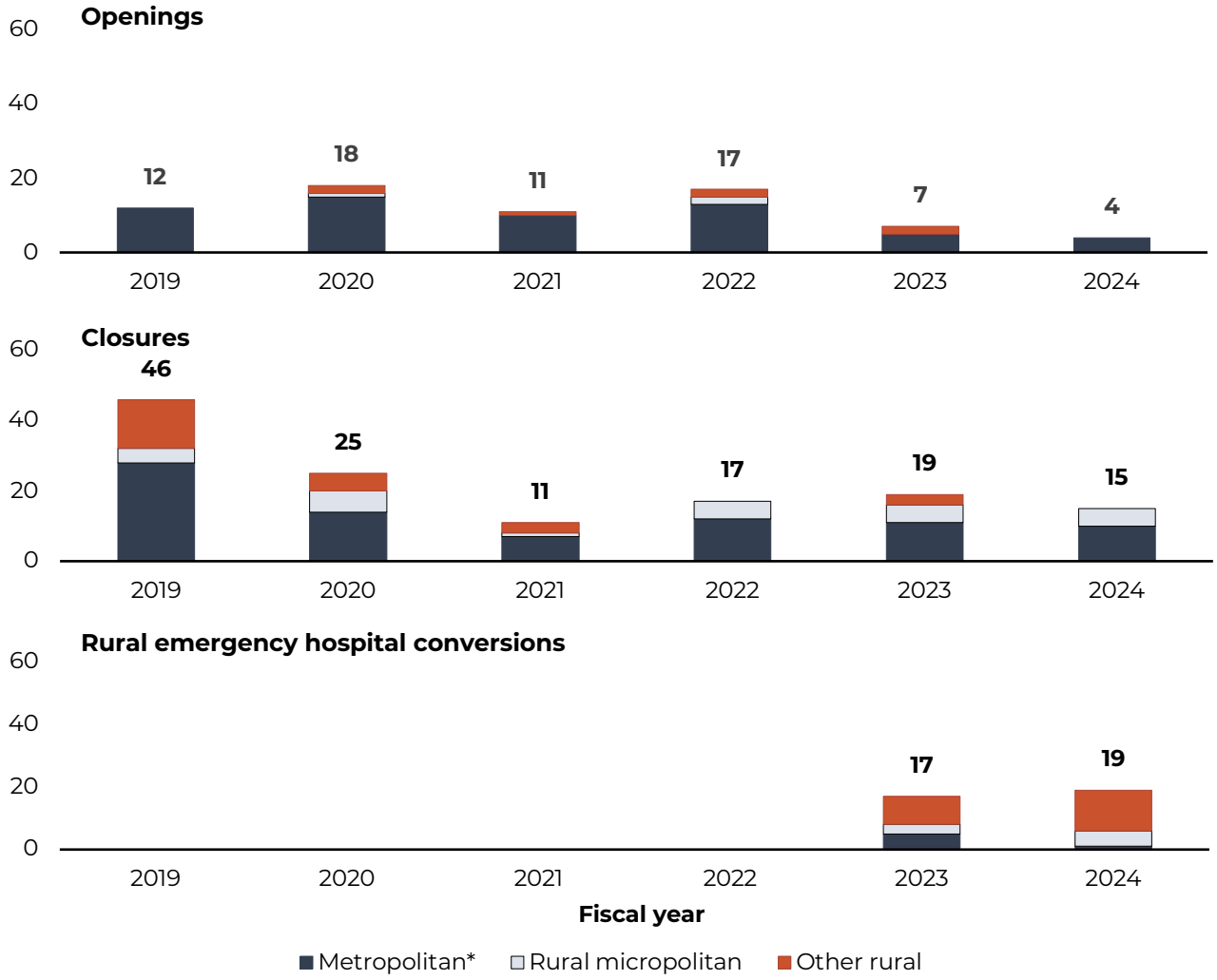
> In FY 2023, there were approximately 4,300 hospitals with complete cost reports as of our analysis, at which there were 29.5 million inpatient stays. Nearly a quarter of these stays (6.8 million) were by FFS Medicare beneficiaries.

> For about two-thirds of hospitals, FFS Medicare paid for inpatient stays under Medicare's IPPS. These hospitals accounted for nearly all inpatient stays and FFS Medicare inpatient stays.

> About 30 percent of hospitals were designated by Medicare as critical access hospitals (CAHs), which FFS Medicare pays on a cost basis. Because CAHs have 25 or fewer inpatient beds, only a very small share of inpatient stays were at CAHs. However, nearly 40 percent of inpatient stays at CAHs were by FFS Medicare beneficiaries.

> About 2 percent of hospitals were paid by FFS Medicare using other methodologies, such as hospitals participating in the Maryland Total Cost of Care Model or other demonstrations.

Chart 6-2 More hospitals closed than opened in FY 2024, and others converted to rural emergency hospitals



Note: FY (fiscal year). Data include all Subsection (d) and critical access hospitals. "Openings" refers to a new location for inpatient services, while "closures" refers to a hospital that ceased inpatient services and did not convert to a rural emergency hospital. The counts of openings and closures do not include the relocation of inpatient services from one hospital to another under common ownership within 10 miles, nor do they include hospitals that both opened and closed within a five-year period. The number of closures and openings in a given year can differ from prior publications as hospitals reopen and newer data become available.
* 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.

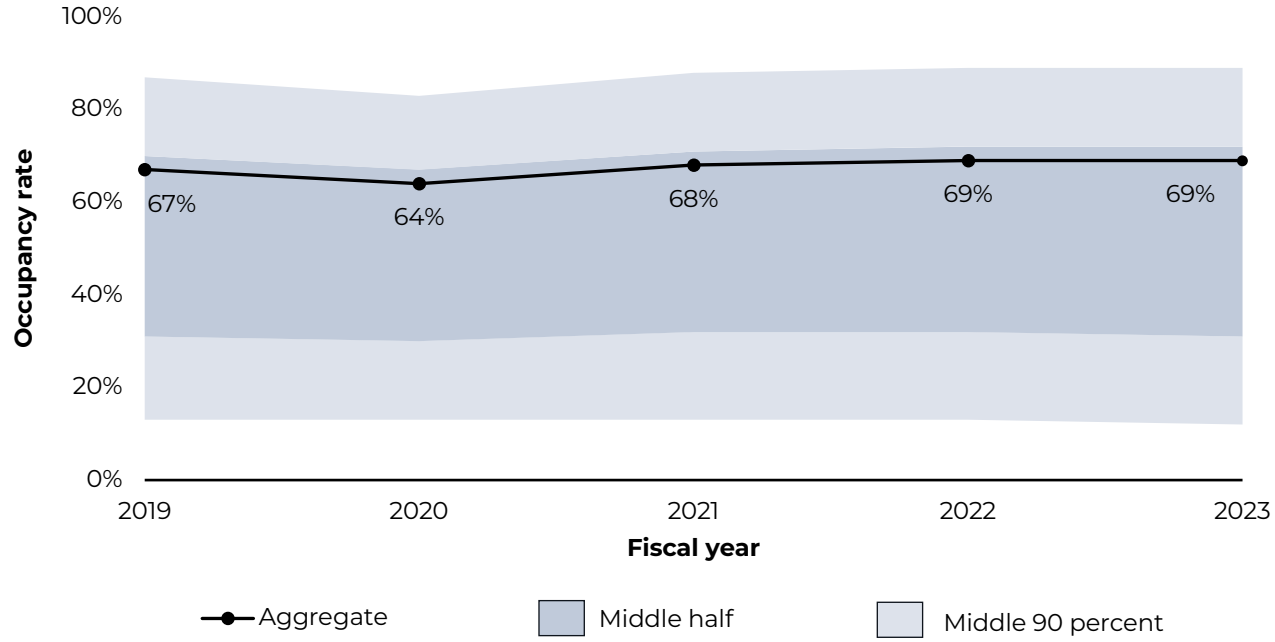
Source: MedPAC analysis of the CMS Provider of Services file, census geographic data, and internet searches.

> In FY 2024, 4 hospitals opened while 15 closed; another 19 converted to rural emergency hospitals (REHs). (The REH program is an outpatient-only hospital designation that first became available in 2023.)

> Consistent with prior years, the majority of openings and closures in FY 2024 were in urban (metropolitan) areas. The majority of REH conversions were in rural nonmicropolitan areas ("other rural" in the chart).

> In FY 2024, all closures but one were located less than 50 miles from another hospital (data not shown).

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



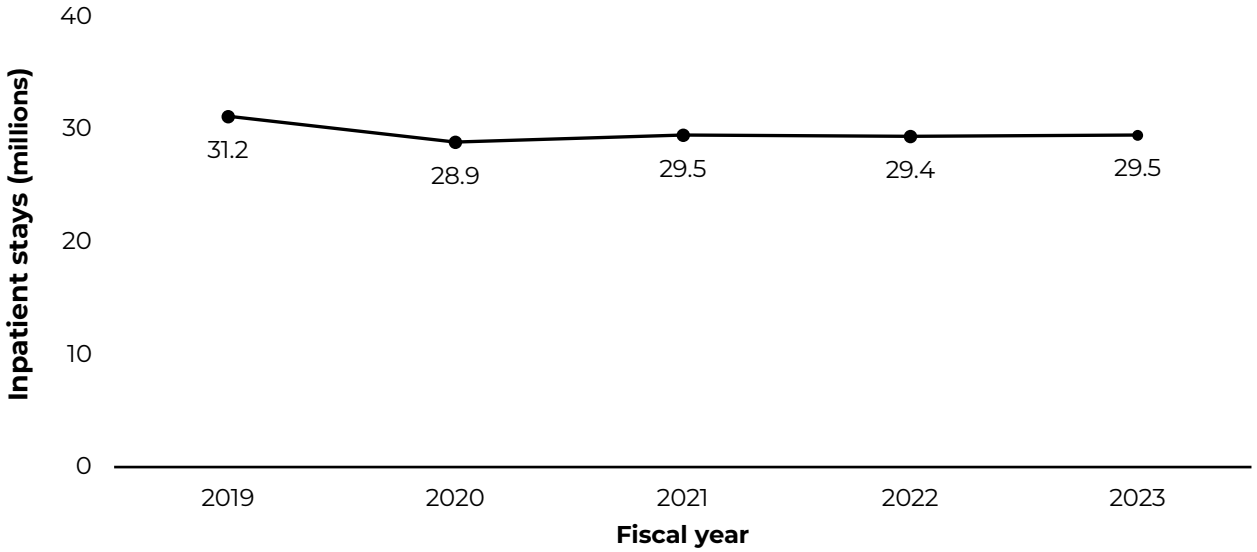
Note: Data include all Subsection (d) and critical access hospitals that, as of our analysis, had a complete cost report with a midpoint in the specified fiscal year and had non-outlier data. "Occupancy rate" refers to the share of inpatient bed days that were occupied by a patient (regardless of whether the patient was receiving inpatient, observation, or swing-bed services). The number of inpatient bed days available may be higher than staffed bed days. Results differ from those published last year because of newer data and methodological updates.

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

> In fiscal year (FY) 2023, hospitals continued to have available inpatient capacity in aggregate. Hospitals' occupancy rate was 69 percent in FY 2023, the same level as in FY 2022.

> However, as in past years, there was significant variation within these aggregates, with some hospitals having substantially higher available capacity while others faced capacity constraints. In FY 2023, 5 percent of hospitals had an occupancy rate under 12 percent, while another 5 percent had an occupancy rate over 89 percent.

Chart 6-4 All-payer inpatient stays remained steady in FY 2023 and below prepandemic level



Note: FY (fiscal year). Data include all Subsection (d) and critical access hospitals that, as of our analysis, had a complete cost report with a midpoint in the specified fiscal year. Results differ from those published last year because of changing the data source and limiting the data to Subsection (d) and critical access hospitals that had at least one fee-for-service Medicare stay.

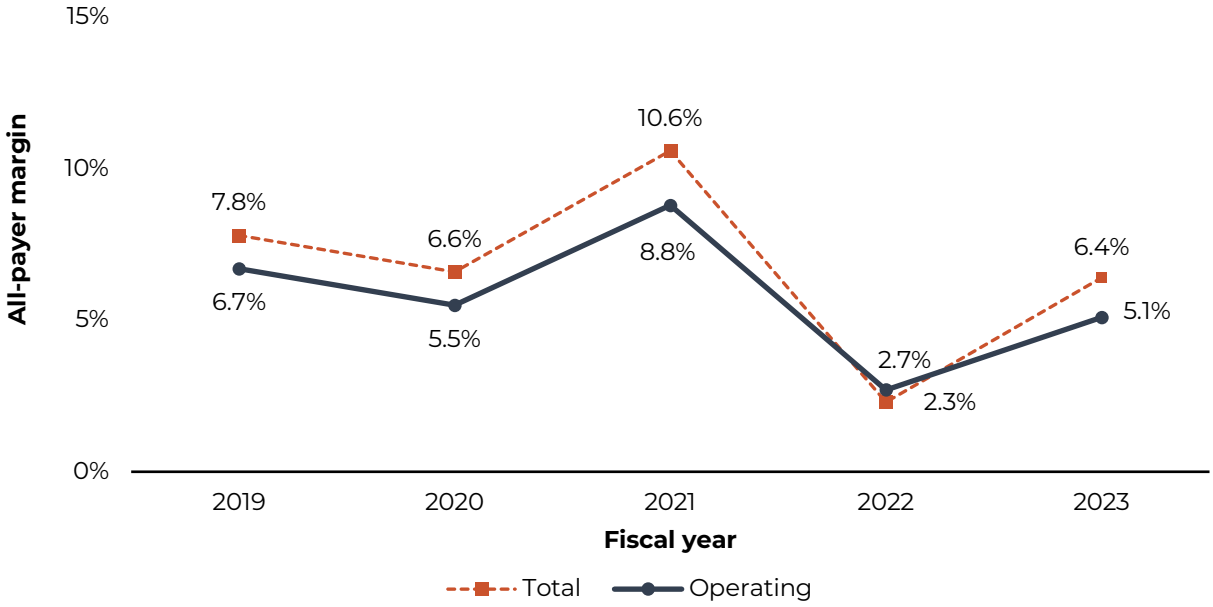
Source: MedPAC analysis of hospital cost-report data from CMS.

> In FY 2019, hospitals provided about 31 million inpatient stays, similar to the level since 2015 (latter data not shown).

> In FY 2020, the number of inpatient stays declined, reflecting delayed and forgone care during the start of the coronavirus public health emergency.

> Inpatient volume partially rebounded to 29.5 million stays in FY 2021 and remained at a similar level in FY 2022 and FY 2023.

Chart 6-5 Hospitals' all-payer margins increased in FY 2023 from relative lows in FY 2022



Note: FY (fiscal year). Data are for hospitals paid under the inpatient prospective payment systems that, as of our analysis, had a complete cost report with a midpoint in the specified fiscal year and had non-outlier data. Hospitals' all-payer total margin is an aggregate, calculated as the percentage of revenue from all payers and sources that is left as profit after accounting for costs. Hospitals' all-payer operating margin excludes investment and donation income. Results differ from those published last year because of newer data and methodological updates.

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

> Hospitals' all-payer total margin is an aggregate, calculated as the percentage of revenue from all payers and sources that is left as profit after accounting for costs. Hospitals' all-payer operating margin excludes investment and donation income.

> Among hospitals that Medicare pays under the inpatient prospective payment systems (IPPS), the all-payer total margin and all-payer operating margin both increased in FY 2023 from relative lows in FY 2022, despite a decline in coronavirus relief funds.

> Hospitals' all-payer total margin experienced a larger change than hospitals' operating margin because of changes in investment income: Hospitals reported about $7 billion in investment losses in FY 2022 but about $13 billion in investment income in FY 2023 (data not shown).

Chart 6-6 Hospitals' all-payer operating margin varied by type of hospital, including continued higher margin among for-profit hospitals

Hospital category	All-payer operating margin, by fiscal year				
	2019	2020	2021	2022	2023
Including relief funds					
IPPS					
Aggregate	6.7%	5.5%	8.8%	2.7%	5.1%
25th percentile	–1.5	–1.2	0.9	–5.5	–4.0
Median	4.3	4.6	7.2	1.6	2.8
75th percentile	11.0	11.3	14.9	9.8	10.4
Ownership					
For profit	12.5	13.0	15.4	12.9	12.9
Nonprofit	6.2	4.8	8.3	1.0	4.4
Geography*					
Metropolitan	6.9	5.5	8.8	2.8	5.3
Rural micropolitan	5.1	5.7	9.0	1.2	3.2
Other rural	0.9	3.9	7.7	0.9	–0.5
MSNI**					
Lowest quartile	N/S	N/S	11.6	5.9	7.6
2nd quartile	N/S	N/S	9.7	3.4	7.1
3rd quartile	N/S	N/S	8.7	4.3	5.7
Highest quartile	N/S	N/S	4.9	3.1	3.7
CAH					
Aggregate	3.1	5.2	11.1	4.2	4.2
25th percentile	–3.2	–1.3	4.3	–3.2	–3.8
Median	1.4	4.2	11.6	3.2	2.4
75th percentile	6.3	10.8	18.0	9.5	8.4
Excluding relief funds					
IPPS					
Aggregate	6.7	2.1	7.4	2.0	4.9
25th percentile	–1.5	–6.6	–1.8	–7.1	–4.5
Median	4.3	0.8	4.6	0.5	2.5
75th percentile	11.0	8.4	13.0	8.8	10.1
Ownership					
For profit	12.5	10.7	14.3	12.5	12.7
Nonprofit	6.2	1.2	7.0	0.2	4.1
Geography*					
Metropolitan	6.9	2.1	7.5	2.2	5.0
Rural micropolitan	5.1	1.2	6.5	–0.7	2.9
Other rural	0.9	–1.7	2.7	–2.5	–1.0
MSNI**					
Lowest quartile	N/S	N/S	10.5	5.4	7.4
2nd quartile	N/S	N/S	8.5	2.8	7.0
3rd quartile	N/S	N/S	7.3	3.4	5.3
Highest quartile	N/S	N/S	2.7	2.2	3.3
CAH					
Aggregate	3.1	0.5	6.2	2.4	3.7

(Chart continued next page)

Chart 6-6 Hospitals' all-payer operating margin varied by type of hospital, including continued higher margin among for-profit hospitals (continued)

Note: IPPS (inpatient prospective payment systems), MSNI (Medicare Safety-Net Index), N/S (not shown), CAH (critical access hospital). Data are for hospitals that, as of our analysis, had a complete cost report with a midpoint in the specified fiscal year and had non-outlier data. The all-payer operating margin excludes investment and donation income. "Relief funds" refers to federal or other coronavirus relief funds. Results differ from those published last year because of newer data and methodological updates, such as identification of statistical outliers and inclusion of other coronavirus relief funds.

* 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 MSNI is a Commission-developed index that identifies financially vulnerable hospitals that serve large shares of low-income Medicare beneficiaries.

Source: MedPAC analysis of hospital cost reports, census geographic data, and MSNI data.

> Among hospitals paid under the IPPS, the all-payer operating margin continued to vary significantly: In fiscal year (FY) 2023, a quarter of hospitals had an all-payer operating margin at or below –4 percent, while another quarter had a margin above 10 percent.

> While there was variation within each group of IPPS hospitals, the FY 2023 all-payer operating margin continued to be much higher among for-profit hospitals than nonprofit hospitals, among hospitals located in urban areas than hospitals located in rural nonmicropolitan areas, and among hospitals that serve lower shares of low-income Medicare beneficiaries (as measured by the Commission-developed Medicare Safety-Net Index).

> Critical access hospitals' all-payer operating margin held steady from FY 2022 to FY 2023 but increased when calculated exclusive of coronavirus relief funds.

Chart 6-7 Hospitals' FFS Medicare margin excluding relief funds remained relatively stable in FY 2023, but significant variation persisted

Hospital category	FFS Medicare margin, by fiscal year				
	2019	2020	2021	2022	2023
Including relief funds					
IPPS					
Aggregate	–8.0%	–8.2%	–6.3%	–11.9%	–12.6%
25th percentile	–17.1	–17.2	–15.2	–21.5	–22.0
Median	–5.7	–4.4	–2.7	–8.7	–9.7
75th percentile	4.8	7.7	9.2	3.8	2.8
Ownership					
For profit	1.4	4.3	5.6	1.1	0.4
Nonprofit	–9.4	–10.2	–8.1	–13.6	–13.8
Geography*					
Metropolitan	–8.4	–8.8	–6.9	–12.3	–12.8
Rural micropolitan	–4.6	–2.7	–1.5	–8.7	–9.8
Other rural	0.4	5.1	8.1	0.1	–3.2
Fiscal pressure**					
Low pressure	–10.6	–10.8	–8.9	–13.9	–14.6
High pressure	4.0	7.5	5.8	–2.6	–4.3
MSNI***					
Lowest quartile	N/S	N/S	–10.0	–16.1	–16.8
2nd quartile	N/S	N/S	–9.5	–14.3	–14.7
3rd quartile	N/S	N/S	–4.2	–8.7	–10.1
Highest quartile	N/S	N/S	3.2	–3.6	–4.8
CAH					
Aggregate	–1.0	4.6	6.4	2.3	0.1
Excluding relief funds					
IPPS					
Aggregate	–8.0	–12.3	–8.3	–13.1	–13.0
25th percentile	–17.1	–22.2	–17.2	–22.7	–22.5
Median	–5.7	–8.6	–5.2	–10.2	–10.1
75th percentile	4.8	3.3	6.4	2.0	2.3
Ownership					
For profit	1.4	1.7	4.1	0.5	0.1
Nonprofit	–9.4	–14.6	–10.1	–14.7	–14.3
Geography*					
Metropolitan	–8.4	–12.8	–8.7	–13.3	–13.2
Rural micropolitan	–4.6	–7.8	–4.7	–11.3	–10.4
Other rural	0.4	–1.1	2.8	–4.1	–3.9
Fiscal pressure**					
Low pressure	–10.6	–14.4	–10.6	–14.9	–15.0
High pressure	4.0	1.4	2.5	–4.2	–5.1
MSNI***					
Lowest quartile	N/S	N/S	–11.7	–16.9	–17.2
2nd quartile	N/S	N/S	–11.3	–15.2	–15.0
3rd quartile	N/S	N/S	–6.1	–9.9	–10.7
Highest quartile	N/S	N/S	0.4	–5.2	–5.4
CAH					
Aggregate	–1.0	–0.2	0.7	0.3	–0.5

(Chart continued next page)

Chart 6-7 Hospitals' FFS Medicare margin excluding relief funds remained relatively stable in FY 2023, but significant variation persisted (continued)

Note: FFS (fee-for-service), IPPS (inpatient prospective payment systems), FY (fiscal year), MSNI (Medicare Safety-Net Index), N/S (not shown), CAH (critical access hospital). Data are for hospitals that, as of our analysis, had a cost report with a midpoint in the specified fiscal year and had non-outlier data. For hospitals paid under the IPPS, the "FFS Medicare margin" is limited to revenue and costs for services included under the IPPS or outpatient prospective payment system, including separately payable drugs, including any reported discounts to drug costs under the 340B Drug Pricing Program. For CAHs, the "FFS Medicare margin" is limited to revenue and costs for inpatient, outpatient, and swing-bed skilled nursing services, with inpatient costs calculated by assigning inpatient routine costs per day equally across inpatient and swing-bed days. "Relief funds" refers to FFS Medicare's share of federal and other coronavirus relief funds. Results differ from those published last year because of newer data and methodological updates, such as narrowing the services included in the FFS Medicare margin, and identification of statistical outliers.

* 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.

** "Low [fiscal] pressure" hospitals are defined as those with a median non-FFS Medicare margin greater than 5 percent over five years and a net worth that would have grown by more than 1 percent per year over that period if the hospital's FFS Medicare profits had been zero. "High [fiscal] pressure" hospitals are defined as those with a median non-FFS Medicare margin of 1 percent or less over five years and a net worth that would have grown by less than 1 percent per year.

*** "MSNI" refers to a Commission-developed index that identifies financially vulnerable hospitals that serve large shares of low-income Medicare beneficiaries.

Source: MedPAC analysis of hospital cost reports, census geographic data, and MSNI data.

> Hospitals' FFS Medicare margin is an aggregate, calculated as the percentage of revenue from FFS Medicare inpatient and outpatient services that is left as profit after accounting for the allowable costs of providing these services to FFS Medicare patients.

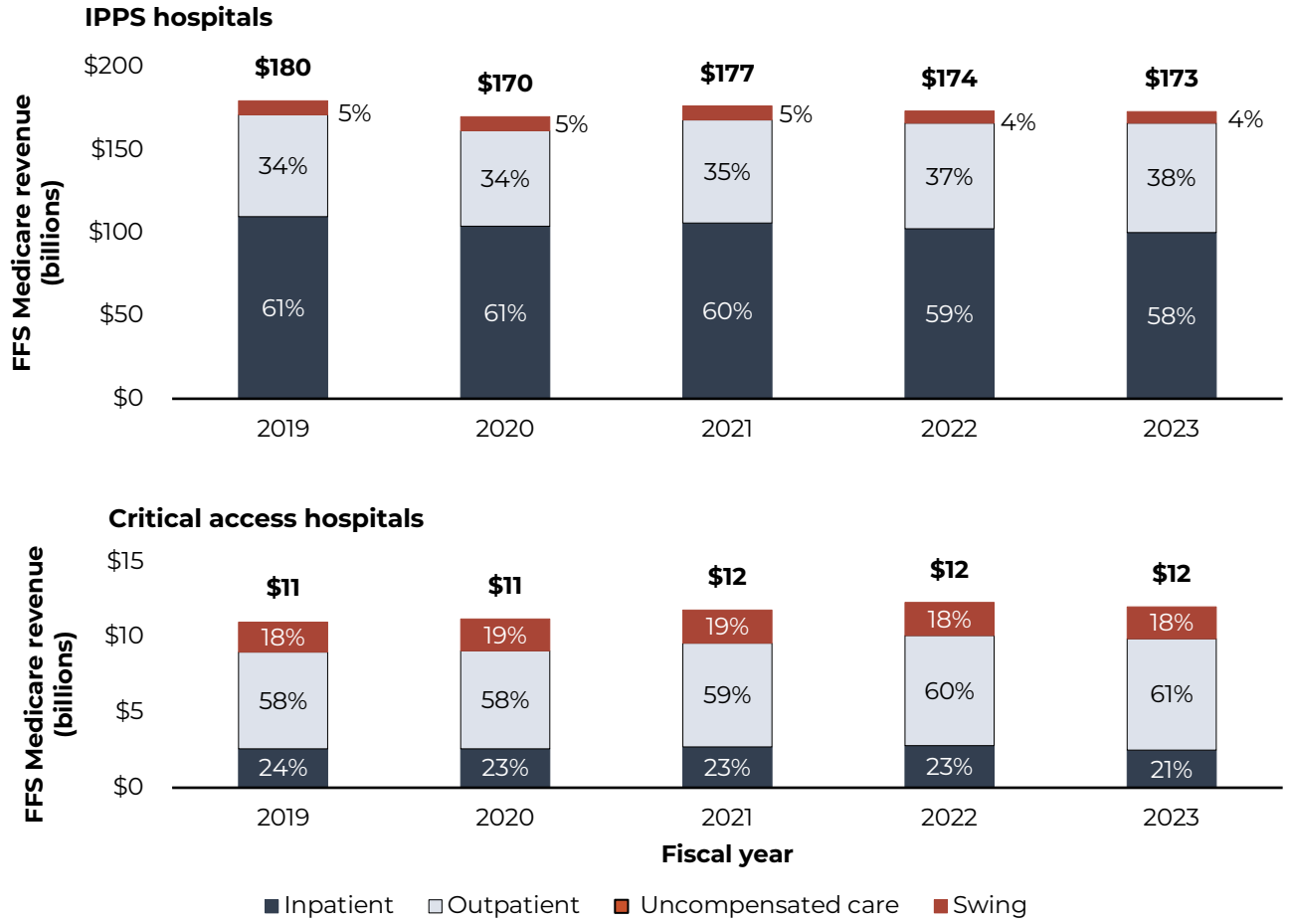
> Among hospitals paid under the IPPS, the FFS Medicare margin including coronavirus relief funds fell to –12.6 percent in FY 2023. However, exclusive of these funds, it remained steady at about –13 percent. The 0.7 percentage point decline in hospitals' FFS Medicare margin from FY 2022 to FY 2023 when including coronavirus relief funds was exclusively due to a decline in relief funds.

> As in prior years, there was significant variation within IPPS hospitals' aggregate margin in FY 2023: A quarter of hospitals had a FFS Medicare margin below –22 percent, while a quarter had a margin above 2 percent.

> While there was variation within each group of IPPS hospitals, hospitals' aggregate FFS Medicare margin remained higher at for-profit hospitals (relative to nonprofit hospitals); rural hospitals (relative to urban hospitals); hospitals under higher fiscal pressure (relative to those under low pressure); and hospitals that served larger shares of Medicare beneficiaries with low incomes (as measured by the Commmission's MSNI).

> Among critical access hospitals, the FFS Medicare margin declined to nearly 0 percent in FY 2023 when including relief funds and to a slightly negative margin when excluding relief funds.

Chart 6-8 Hospitals' revenue from FFS Medicare services continued to slowly shift toward outpatient services



Note: FFS (fee-for-service), IPPS (inpatient prospective payment systems). Data are for hospitals that, as of our analysis, had a complete cost report with a midpoint in the specified fiscal year. For prospective payment system (PPS) hospitals, data are limited to revenue from inpatient and outpatient prospective payment services and uncompensated-care payments. For critical access hospitals, data are limited to revenue from inpatient, outpatient, and swing-bed skilled nursing services. Hospitals also receive payments from FFS Medicare that are not included in these totals, such as payments for post-acute care and other subproviders and pass-through amounts. The FFS Medicare share of coronavirus relief funds is not shown. Dollar amounts are nominal figures, not adjusted for inflation. Components may not sum to 100 percent due to rounding.

Source: MedPAC analysis of hospital cost-report data.

> From fiscal year (FY) 2019 to FY 2023, hospitals' revenue from FFS Medicare services continued to slowly shift toward outpatient services and away from inpatient services.

> For PPS hospitals, revenue from inpatient and outpatient PPS services provided to FFS Medicare beneficiaries was $173 million in FY 2023, of which outpatient services accounted for 38 percent.

> For critical access hospitals, revenue from inpatient, outpatient, and swing-bed services provided to FFS Medicare beneficiaries was $12 billion in FY 2023, of which outpatient services accounted for 61 percent. Swing-bed services—skilled nursing services provided in an inpatient bed—accounted for another 18 percent.

Chart 6-9 Nearly 17 percent of IPPS payments in FY 2023 were from adjustments and additional payments

Hospital group	Share of IPPS payments for FFS Medicare inpatient services						
	Base PPS	Low income (DSH)*	Teaching (IME)	New technology	Outliers	Rural and/or isolated **	Quality ***
IPPS	83.3%	3.2%	7.6%	0.5%	4.4%	1.3%	–0.4%
Ownership							
For profit	89.0	3.5	4.7	0.2	2.0	1.0	–0.5
Nonprofit	83.7	3.1	7.5	0.5	4.3	1.3	–0.3
Government	75.3	3.9	11.3	0.7	7.3	1.7	–0.3
Geography****							
Metropolitan	83.3	3.3	7.9	0.5	4.6	0.7	–0.4
Micropolitan	82.4	2.4	3.2	0.4	2.0	9.9	–0.3
Other rural	78.6	2.2	0.9	0.4	1.6	16.6	–0.3
DSH and teaching*							
Both	80.2	3.5	10.4	0.5	5.1	0.6	–0.3
DSH only	90.6	3.1	0.0	0.4	2.6	3.6	–0.4
Teaching only	86.4	0.1	8.7	0.6	3.7	0.8	–0.3
Neither	94.2	0.1	0.0	0.4	2.3	2.8	–0.3
Rural and/or isolated							
Sole community	78.4	2.3	3.2	0.4	3.3	12.7	–0.3
Medicare dependent	80.0	1.6	2.0	0.3	1.1	15.3	–0.3
Low volume	78.1	2.0	0.6	0.4	1.4	17.5	–0.2

Note: IPPS (inpatient prospective payment systems), FY (fiscal year), FFS (fee-for-service), DSH (disproportionate share hospital), IME (indirect medical education). Data are for hospitals that, as of our analysis, had a complete cost report with a midpoint in FY 2023. Data exclude uncompensated-care payments. Row components may not sum to 100 percent due to rounding and not separately showing smaller components of IPPS payments.

* The "low income (DSH)" column includes inpatient operating and capital DSH payments, while the DSH categories are defined by receiving inpatient operating DSH payments.

** The "rural and/or isolated" column includes the payments above the otherwise applicable IPPS payments received by hospitals designated as sole community hospitals, Medicare dependent hospitals, and/or low-volume hospitals.

*** The "quality" column includes payments and penalties from the Value-Based Purchasing programs and penalties from the Hospital Readmissions Reduction Program and Hospital-Acquired Conditions Reduction Program.

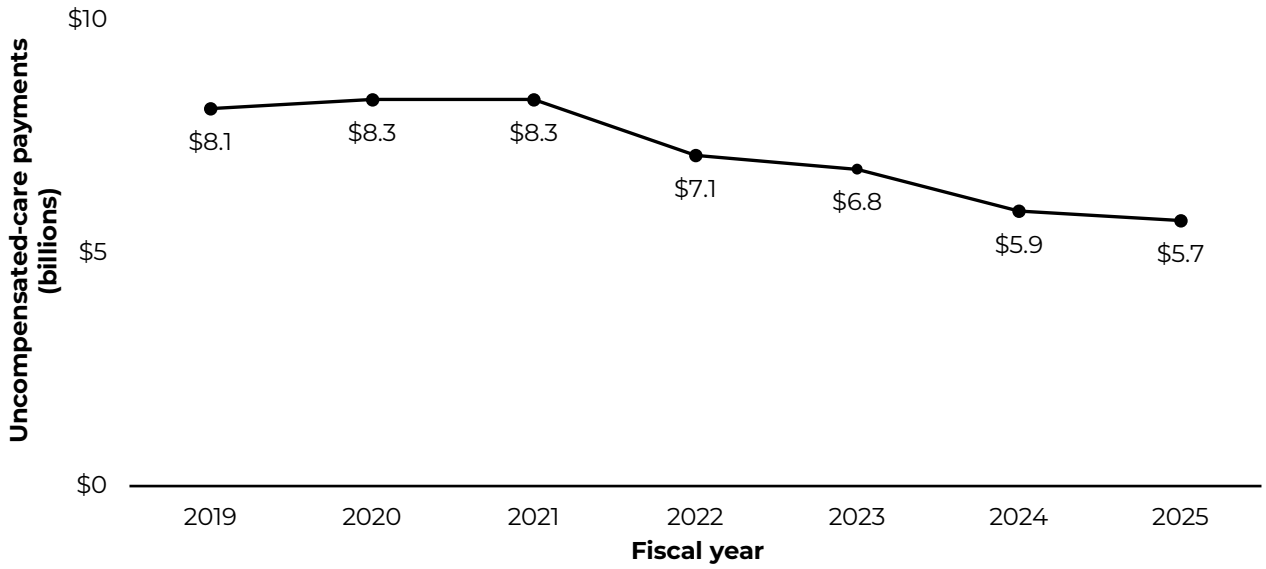
**** Metropolitan (urban) counties contain an urban cluster of 50,000 or more people, and rural micropolitan counties contain a cluster of 10,000 to 50,000 people.

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

> In FY 2023, base payments accounted for 83.3 percent of IPPS payments to hospitals for inpatient services provided to FFS Medicare beneficiaries.

> The remaining amount—nearly 17 percent—comprised adjustments to base rates targeted to certain hospitals or additional payments or penalties for certain services or quality levels. For example, among hospitals designated low-volume hospitals—which can receive an up to 25 percent increase to the otherwise applicable IPPS payments—over 17 percent of their IPPS payments were from additional payments under this and/or other rural designations. And among government hospitals, over 7 percent of IPPS payments were outlier payments—which are made for inpatient stays that are substantially more costly than the standard IPPS payment.

Chart 6-10 FFS Medicare's uncompensated-care payments fell between FY 2021 and FY 2025



Note: FFS (fee-for-service), FY (fiscal year). Uncompensated-care payments are presented postsequestration; the 2 percent sequestration of Medicare payments was suspended in May 2020 and reinstated in spring 2022. Beginning in FY 2023, figures include uncompensated-care supplemental payments to hospitals for Indian Health Service and tribal hospitals and Puerto Rican hospitals; in FY 2025, these payments totaled about $80 million (data not shown). Dollar amounts are nominal figures, not adjusted for inflation.

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

> As required by law, in FY 2014, Medicare reduced IPPS operating disproportionate share (DSH) hospital payments to 25 percent of prior law and introduced uncompensated-care payments.

> 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 DSH hospital payments under prior law and the uninsured rate as a percentage of the rate in 2013 (plus an additional reduction from FY 2014 to FY 2017). Therefore, when the rate of uninsured individuals increases and hospitals have greater losses on uncompensated care, the Medicare program makes higher uncompensated-care payments.

> For each fiscal year between 2019 and 2021, uncompensated-care payments were slightly over $8 billion dollars on a nominal basis.

> However, uncompensated-care payments fell each year from FY 2022 through FY 2025, down to $5.7 billion in 2025.

Chart 6-11 FFS Medicare inpatient stays per capita increased in FY 2023 but remained well below the FY 2019 level

Inpatient measure	Fiscal year					Average annual change	
	2019	2020	2021	2022	2023	2019–2022	2022–2023
Inpatient stays (in millions)	9.2	7.9	7.4	7.0	6.9	–6.9%	–1.3%
Inpatient stays per 1,000 beneficiaries	244.5	213.6	207.7	202.3	205.3	–4.3	1.5
Average length of stay (in days)	4.9	5.1	5.5	5.6	5.3	1.9	–4.1
Payments (in billions)*	$117.9	$110.5	$114.6	$110.8	$108.9	–2.0	–1.7
Payment per stay (in thousands)*	12.8	13.9	15.4	15.8	$15.7	5.3	–0.4

Note: FFS (fee-for-service), FY (fiscal year). Data include all Subsection (d) and critical access hospitals. FFS beneficiary enrollment is limited to those who resided in the U.S. and had Part A. Dollars are nominal, not adjusted for inflation. * Payments include FFS Medicare program payments and beneficiaries' cost-sharing liabilities. For hospitals paid under the inpatient prospective payment system, payments exclude uncompensated-care payments.

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

> The volume of FFS Medicare inpatient stays fell in FY 2020, reflecting delayed and forgone care during the coronavirus public health emergency.

> While FFS Medicare inpatient stays per capita increased slightly in FY 2023 ("Inpatient stays per 1,000 beneficiaries" in the chart), it has not rebounded to the FY 2019 level. This finding is consistent with the trends in all-payer inpatient stays (see Chart 6-4).

> Payment per FFS Medicare stay increased in each fiscal year from 2020 through 2022 and then was relatively stable in FY 2023. However, because of the decline in volume, on an aggregate basis, payments for FFS Medicare inpatient stays were below the level in FY 2019.

Chart 6-12 Four major diagnostic categories accounted for over half of all FFS Medicare inpatient stays

Major diagnostic category	Share of FFS Medicare stays, by fiscal year				
	2019	2020	2021	2022	2023
Circulatory system	20.5%	20.0%	19.9%	20.1%	20.5%
Respiratory system	12.6	13.3	15.1	14.3	12.9
Infectious and parasitic	10.6	11.6	11.6	11.7	12.2
Musculoskeletal	13.5	12.4	10.8	10.7	10.9
Digestive system	9.7	9.5	9.5	9.5	9.5
Nervous system	7.9	8.0	8.2	8.4	8.5
Kidney and urinary	7.7	7.5	7.5	7.9	8.2
Endocrine, nutritional, and metabolic	3.9	4.0	4.0	4.1	4.0
Skin, subcutaneous, and breast	2.3	2.1	2.0	2.0	2.1
Blood and immunologic	1.4	1.5	1.5	1.4	1.5

Note: FFS (fee-for-service). Data include all Subsection (d) and critical access hospitals. Components do not sum to 100 percent because table shows only the top 10 by 2023 share.

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

> FFS Medicare categorizes each inpatient stay into a major diagnostic category (MDC), primarily based on the patient's principal diagnosis.

> In each fiscal year from 2019 through 2023, over half of all FFS Medicare inpatient stays were in one of four MDCs: diseases of the circulatory system, respiratory system, musculoskeletal system, and infectious and parasitic diseases.

> For most MDCs, the share of FFS Medicare inpatient stays has been relatively steady. For example, diseases of the circulatory system accounted for about 20 percent of inpatient stays in each fiscal year from 2019 through 2023.

> However, the share of FFS Medicare inpatient stays has been more variable for some MDCs. For example, the share of stays that were for diseases of the respiratory system rose during the coronavirus pandemic.

Chart 6-13 FFS Medicare inpatient stays slightly shifted away from the most resource-intensive stays in FY 2023

Resource weight	Share of FFS Medicare stays, by fiscal year				
	2019	2020	2021	2022	2023
Low (<1)	28.3%	26.0%	23.3%	22.4%	23.2%
1 up to 2	50.1	51.1	53.6	54.5	53.8
2 up to 3	10.0	9.9	5.5	9.2	10.0
High (≥3)	11.6	13.0	13.8	14.0	13.0

Note: FFS (fee-for-service), FY (fiscal year). Data include all Subsection (d) and critical access hospitals. Components may not sum to 100 percent due to rounding.

Source: MedPAC analysis of Medicare Provider Analysis and Review data and inpatient prospective payment systems final rules published by CMS.

> Most FFS Medicare payments for inpatient stays 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.

> In FY 2023, the most common MS–DRGs were:

>> resource weight less than 1: kidney and urinary tract infections without major complications or comorbidities

>> resource weight 1 up to 2: septicemia or sepsis without major complications or comorbidities

>> resource weight of 2 up to 3: hip and femur procedures except major joint with complications or comorbidities

>> resource weight greater or equal to 3: infectious and parasitic diseases with operating room procedures and major complications or comorbidities

> From FY 2019 through 2022, the share of FFS Medicare inpatient stays with a resource weight of less than 1 declined, while the share with a weight greater than 3 increased.

> In contrast, in FY 2023, FFS Medicare inpatient stays slightly shifted away from the most resource-intensive stays, though the share remained higher than in 2019.

Chart 6-14 FFS Medicare inpatient stays slightly shifted away from stays longer than one week in FY 2023

	Share of FFS Medicare stays, by fiscal year				
Length of stay	2019	2020	2021	2022	2023
1 day	14.1%	14.4%	13.9%	13.9%	14.5%
2 to 3 days	36.6	35.0	33.0	32.6	33.5
4 to 7 days	33.0	32.9	33.2	33.1	33.1
8 to 30 days	15.8	17.0	19.0	19.4	18.0
>30 days	0.6	0.7	0.9	1.0	0.8

Note: FFS (fee-for-service), FY (fiscal year). Data include all Subsection (d) and critical access hospitals. Components may not sum to 100 percent due to rounding.

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

> FFS Medicare inpatient stays can be very short (a minimum of one day) or very long (in rare cases, over one year).

> Since the start of the pandemic in 2020 through FY 2022, the share of short inpatient stays (one, two, or three days) decreased, while long FFS Medicare inpatient stays (of between one week and one month or greater than one month) increased.

> In contrast, in FY 2023, FFS Medicare stays shifted away from those longer than one week, though the share remained higher than in FY 2019. As a result, the average length of stay decreased in FY 2023 (see Chart 6-11).

Chart 6-15 Total number of Medicare-certified inpatient psychiatric facilities continued to decline in FY 2023, but the share of freestanding and for-profit facilities increased

	Fiscal year					Average annual change	
Type of IPF	2019	2020	2021	2022	2023	2019–2022	2022–2023
All	1,610	1,570	1,530	1,510	1,470	–2.2%	–2.3%
Share of all							
Urban	79%	79%	81%	81%	81%	0.4	0.5
Rural	20	20	19	19	19	–1.8	–2.2
Teaching	37	37	38	38	39	0.8	2.4
Nonteaching	63	63	62	62	61	–0.5	–1.5
Hospital-based units	65	64	63	61	61	–2.0	–1.3
Nonprofit	40	39	39	38	38	–1.3	–0.5
For profit	14	14	13	13	12	–3.9	–1.9
Government	12	11	11	11	10	–2.4	–3.3
Freestanding	35	36	37	39	39	3.7	2.0
Nonprofit	5	5	5	5	5	0.9	1.0
For profit	20	21	22	23	24	4.5	4.1
Government	9	10	10	10	10	3.1	–2.2

Note: FY (fiscal year), 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. 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.

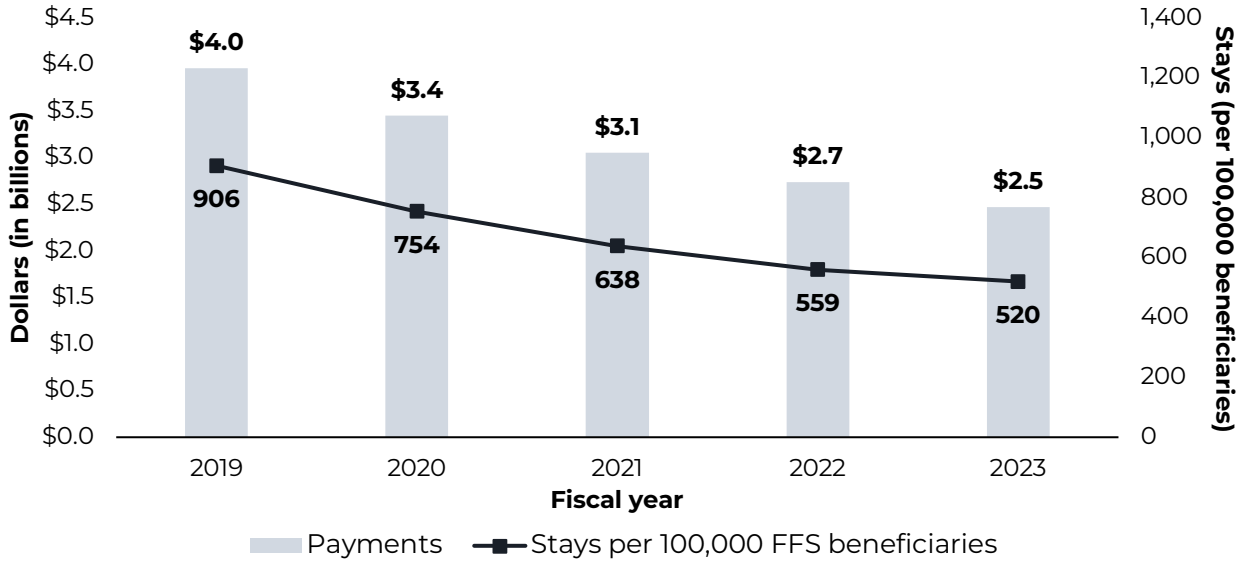
> In FY 2023, compared with the prior year, the number of IPFs nationwide decreased to 1,470 from 1,510 (2.3 percent decrease). This decline was similar to the decline observed from 2019 to 2022 (2.2 percent).

> Most IPFs are in urban areas (81 percent in FY 2023). Between FY 2019 and FY 2023, the share of IPFs in urban areas grew slightly and the share of IPFs in rural areas fell.

> In FY 2023, a majority of IPFs (61 percent) were hospital-based units; however, from FY 2019 to FY 2023, the share of hospital-based IPFs declined by 1.3 percent, while the share of freestanding IPFs grew by 2.0 percent.

> Almost a quarter of IPFs in FY 2023 were freestanding and for profit, up from about one-fifth of IPFs in 2019.

Chart 6-16 FFS Medicare inpatient psychiatric facility stays per capita and payments continued to decline in FY 2023



Note: FFS (fee-for-service), FY (fiscal year). The 2020 to 2023 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. 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 FY 2019 to FY 2023, FFS Medicare inpatient stays in IPFs decreased by 13 percent per year, on average, declining from 906 stays per 100,000 Medicare FFS beneficiaries to 520. Total (FFS Medicare plus beneficiary) payments for IPF PPS services decreased from $4.0 billion to $2.5 billion—equivalent to an 11 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 2023. 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 (MDC) of mental diseases and disorders (MDC 19). In FY 2023, 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 6-17 A growing share of Medicare FFS beneficiaries' stays at IPFs were for schizophrenia, FY 2020–2023

Psychiatric MS–DRG grouping	Fiscal year 2020	2021	2022	2023	Average annual change 2020–2023
Share of total					
Psychosis	74.4%	74.8%	75.1%	76.0%	0.7%
Mood disorders	37.5	36.9	36.8	37.0	–0.5
Schizophrenia and other non-mood psychotic disorders	36.9	37.9	38.3	38.9	1.8
Organic disturbances	6.9	6.8	7.0	6.0	–4.5
Alcohol/drug dependency	6.2	6.2	5.7	5.3	–4.8
Neurosis	4.2	3.9	4.0	4.1	–0.9
Nervous system disorder	5.4	5.3	5.2	5.5	0.8
Other psychiatric	1.9	2.0	2.0	2.0	0.9
Other nonpsychiatric	1.0	1.0	1.0	1.1	3.4

Note: FFS (fee-for-service), IPF (inpatient psychiatric facility), FY (fiscal year), 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); depressive neurosis and neurosis except 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). Totals may not sum to 100 percent due to rounding.

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

> FFS Medicare 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 FY 2023, 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 FY 2020 and FY 2023, the share of patients with non-mood psychotic disorders increased annually by 1.8 percent. Over the same time, the share of patients with mood disorders declined slightly.

> Between FY 2020 and FY 2023, patients with organic disturbances (which include diagnoses such as dementia) and alcohol/drug dependency MS–DRGs declined by nearly 5 percent annually. While these beneficiaries may be receiving care in other settings, the declines could also be related to difficulty in accessing inpatient psychiatric care due to the decreasing number of IPFs (see Chart 6-15).

Chart 6-18 FFS Medicare beneficiaries using IPFs tended to be disabled, under age 65, low income, and non-White, FY 2023

Characteristic	Share of all IPF users	Share of IPF users with more than one IPF stay	Share of all FFS beneficiaries
All	100%	26%	—
Current eligibility status and demographics			
Aged	48	34	90
Disabled	51	66	10
ESRD	0.1	<0.1	0.2
Female	49	45	53
Male	51	55	47
<45	24	34	3
45–64	27	32	8
65–79	35	27	67
80+	14	7	22
Non-Hispanic White	71	66	78
Black	15	19	8
Asian/Pacific Islander	2	2	3
Hispanic	7	8	6
American Indian/Alaska native	1	1	<1
Other or unknown	4	5	4
Urban	81	83	81
Rural	19	17	19
Dual eligibility or LIS during year			
No	36	23	84
Yes	64	77	16

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 FFS Medicare beneficiaries who had at least one IPF stay in FY 2023, 51 percent qualified for Medicare because of a disability, compared with 10 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 FY 2023 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 6-19 Medicare beneficiaries near or reaching the lifetime coverage limit on care in freestanding IPFs were highly vulnerable, 2023

Characteristic	History of freestanding IPF use but not near the coverage limit	Within 15 days of reaching the coverage limit	Reached the coverage limit
Number of beneficiaries with any IPF use since Medicare enrollment	813,970	10,100	39,170
Current eligibility status and demographics (percentage)			
Aged	41%	29%	29%
Disabled	59	71	71
ESRD	<1	<1	<1
Female	49	39	39
Male	51	61	61
<45	17	18	17
45–64	42	53	54
65–79	32	27	23
80+	8	2	6
Non-Hispanic White	69	63	62
Black	18	26	27
Asian/Pacific Islander	1	2	3
Hispanic	8	7	7
American Indian/Alaska native	1	1	1
Other or unknown	2	1	1
Urban	83	88	86
Rural	17	12	14
Dual eligibility or LIS during year (percentage)			
No	28	14	16
Yes	72	86	84

Note: IPF (inpatient psychiatric facility), ESRD (end-stage renal disease), LIS (low-income subsidy). The "coverage limit" refers to Medicare's lifetime coverage limit of 190 days in freestanding IPFs. "History of freestanding IPF use but not near the coverage limit" refers to Medicare beneficiaries (fee-for-service and Medicare Advantage enrollees) who were alive through the end of 2023 and stayed for at least one day in a freestanding IPF from the time of Medicare enrollment through December 31, 2023. "Within 15 days of reaching the coverage limit" refers to Medicare beneficiaries who were alive through the end of 2023 and were within 1 to 15 days of reaching the 190-day coverage limit in freestanding IPFs as of December 31, 2023. "Reached the coverage limit" refers to Medicare beneficiaries who were alive through the end of 2023 and had reached or exceeded the 190-day limit as of December 31, 2023. Components may not sum to 100 percent due to rounding.

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, 2023, there were 813,970 Medicare (fee-for-service and Medicare Advantage) beneficiaries who had at least one day in a freestanding IPF since enrolling in Medicare. Of these beneficiaries, 49,270 (10,100 + 39,170) were within 15 days of reaching the 190-day limit or had reached the limit as of the end of 2023. 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).