SECTION

6

Acute inpatient services

General acute care hospitals

Inpatient prospective payment systems hospitals

Critical access hospitals

Inpatient psychiatric facilities

Chart 6-1 Almost all FFS Medicare beneficiary inpatient stays at general acute care hospitals were paid under the IPPS, FY 2024

	Number of hospitals	All-payer inpatient stays	FFS Medicare inpatient stays
All	***4,400***	***30.8 million***	***6.8 million***
Share of total			
IPPS	68%	96%	94%
Ownership			
For profit	15	14	13
Nonprofit	43	69	70
Government	10	13	11
Geography			
Metropolitan	53	90	87
Rural micropolitan	11	6	7
Other rural	4	1	1
DSH and teaching			
Both	28	68	62
DSH only	29	22	24
Teaching only	2	3	4
Neither	8	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). "General acute care hospitals" refers to Subsection (d) hospitals, critical access hospitals, and short-term acute care hospitals in territories; this table does not include rural emergency hospitals since they do not provide inpatient services. "Number of hospitals" is the number of Medicare provider numbers, rounded to the nearest 10; a provider number can represent multiple hospital locations. "Metropolitan" (urban) counties contain a cluster of 50,000 or more people; "micropolitan" rural 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.

Source: MedPAC analysis of hospital cost-report and Provider of Services data from CMS and census geographic data.

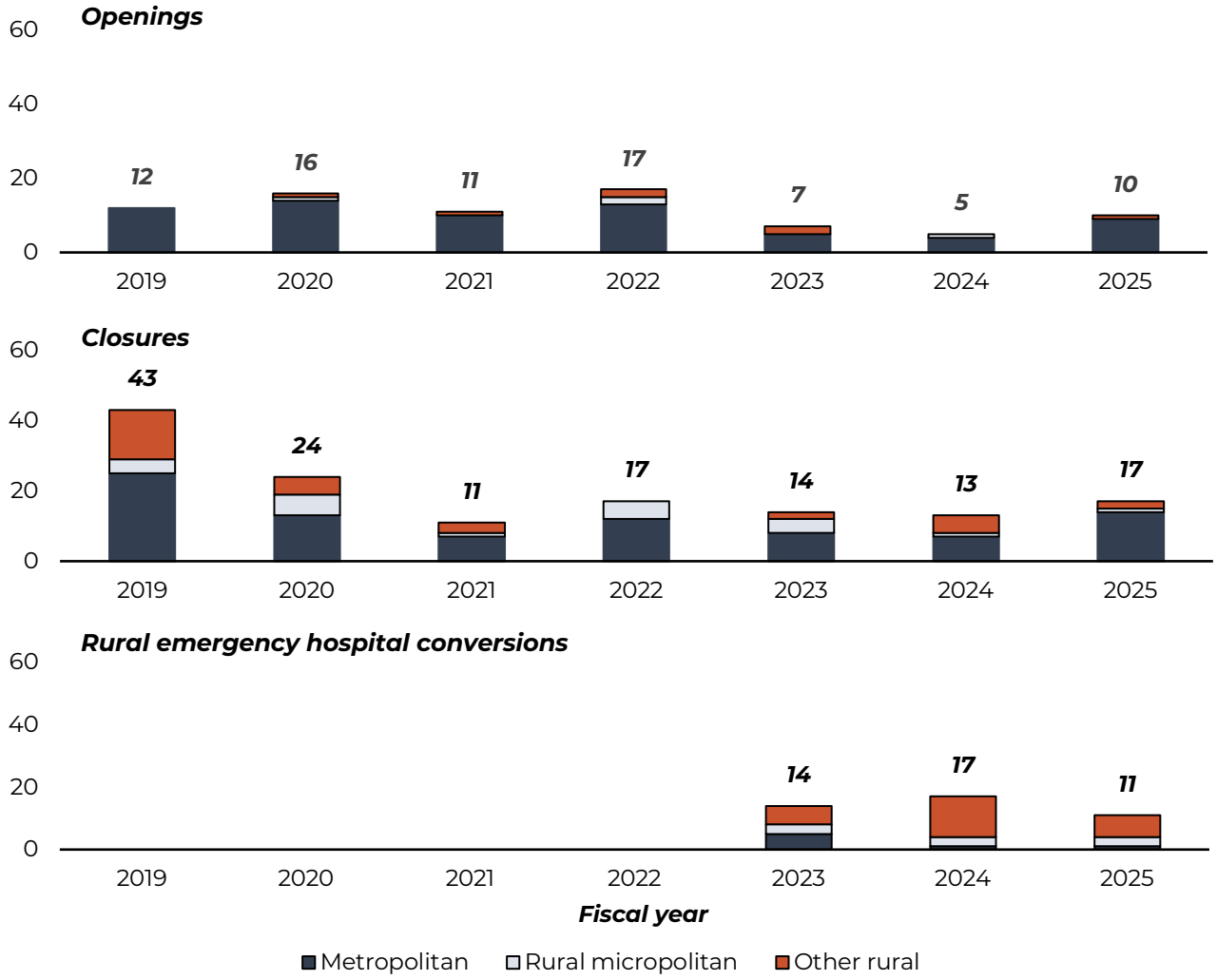
> In FY 2024, there were approximately 4,400 general acute care hospitals that provided at least one inpatient stay. The total number of inpatient stays at these hospitals was 30.8 million, and about a quarter of these stays (6.8 million) were by FFS Medicare beneficiaries.

> For about two-thirds of these hospitals, FFS Medicare paid for inpatient stays under Medicare's IPPS. About 30 percent of hospitals were designated as critical access hospitals (CAHs) by Medicare; FFS Medicare pays for inpatient stays in these hospitals on a cost basis. The remaining 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.

> Nearly all inpatient stays, including FFS Medicare inpatient stays, were provided in IPPS hospitals. Because CAHs have 25 or fewer inpatient beds, only a very small share of inpatient stays were at CAHs.

> Not shown in the table are rural emergency hospitals (REHs). REHs do not furnish inpatient care, and they receive fixed monthly payments from Medicare as well as enhanced payments for emergency and outpatient services.

Chart 6-2 **More general acute care hospitals closed than opened in FY 2025, and others converted to rural emergency hospitals**



Note: FY (fiscal year). "General acute care hospitals" refers to Subsection (d) hospitals, critical access hospitals, short-term acute care hospitals in territories, and rural emergency hospitals. "Openings" refers to a new location that provided inpatient and outpatient services, while "closures" refers to a hospital location that ceased inpatient services and did not convert to a rural emergency hospital. "Metropolitan" (urban) counties contain a cluster of 50,000 or more people; "micropolitan" rural counties contain a cluster of 10,000 to 50,000 people; all other counties are classified as "other rural." The counts of openings and closures do not include the conversion of a short-term acute care hospital to or from a critical access hospital or rural emergency hospital, the relocation of inpatient services from one hospital to another under common ownership within 10 miles, or hospitals that both opened and closed within a five-year period. The number of hospital openings and closures in a given year can change from prior publications as hospitals reopen and newer data become available.

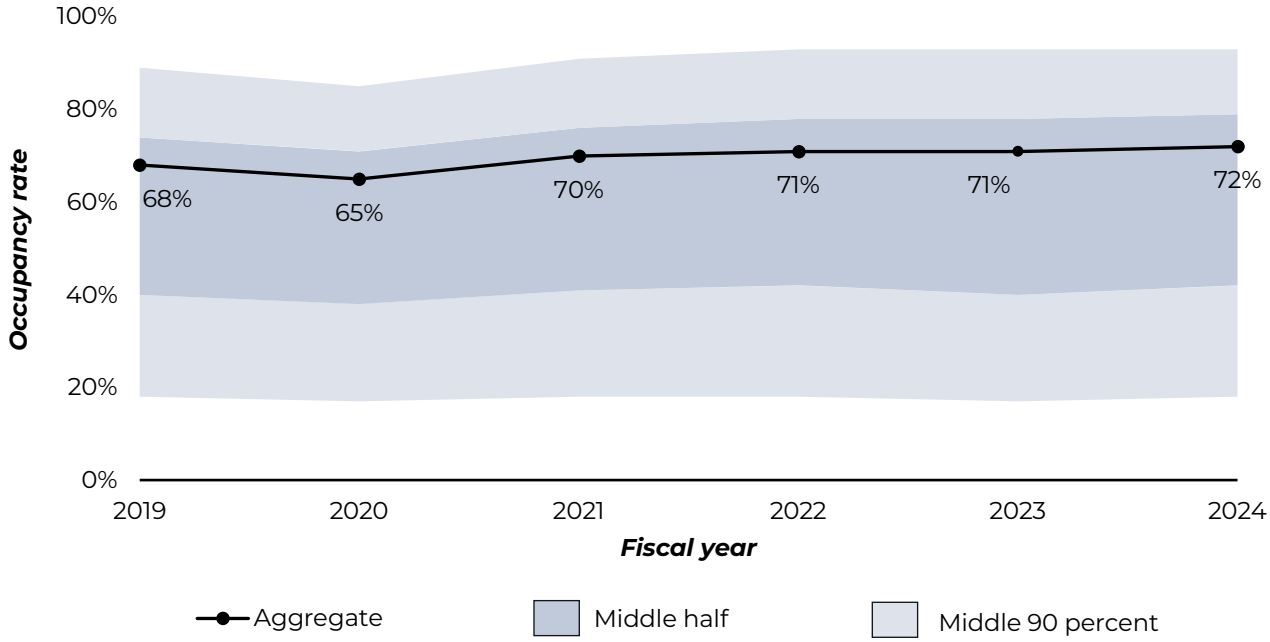
Source: MedPAC analysis of Provider of Services and census geographic data and internet searches.

> In FY 2025, 10 hospitals opened while 17 closed; another 11 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 2025 were in urban (metropolitan) areas. None of the openings or closures in FY 2025 were critical access hospitals. The majority of REH conversions were in rural nonmicropolitan areas ("other rural" in the chart).

> In FY 2025, the average distance of closures to the next-nearest hospital was 11 miles (data not shown).

Chart 6-3 IPPS hospitals continued to have excess inpatient capacity in aggregate, but some hospitals faced capacity constraints



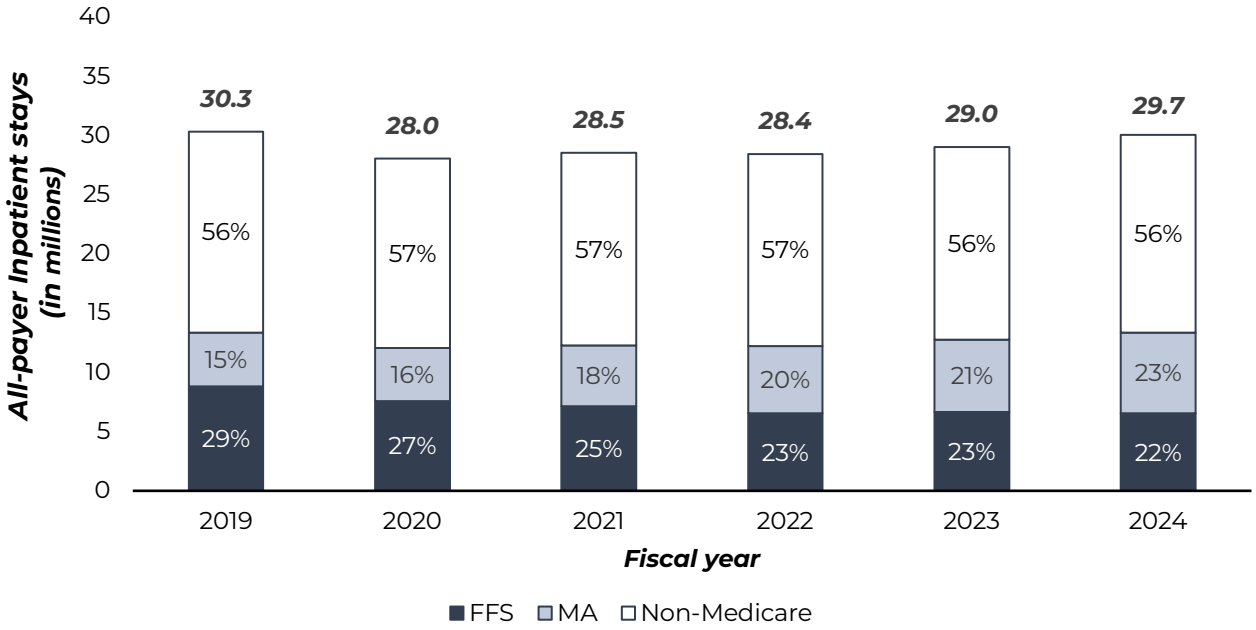
Note: IPPS (inpatient prospective payment systems). "Occupancy rate" refers to the share of bed days that were occupied by a patient (regardless of whether the patient was receiving inpatient, observation, or swing-bed services or the share of time the bed was staffed). Results differ from those published last year because this chart is limited to IPPS hospitals.

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

> IPPS hospitals continued to have available capacity in aggregate. However, there continued to be significant variation within these aggregates, with some hospitals having substantially higher available capacity while others faced capacity constraints.

> In FY 2024, IPPS hospitals' occupancy rate was 72 percent, a small increase from fiscal year 2023. However, 5 percent of hospitals had an occupancy rate under 18 percent, while another 5 percent had an occupancy rate over 93 percent.

Chart 6-4 IPPS hospitals' all-payer inpatient stays in FY 2024 neared the prepandemic level; FFS Medicare share continued to decline

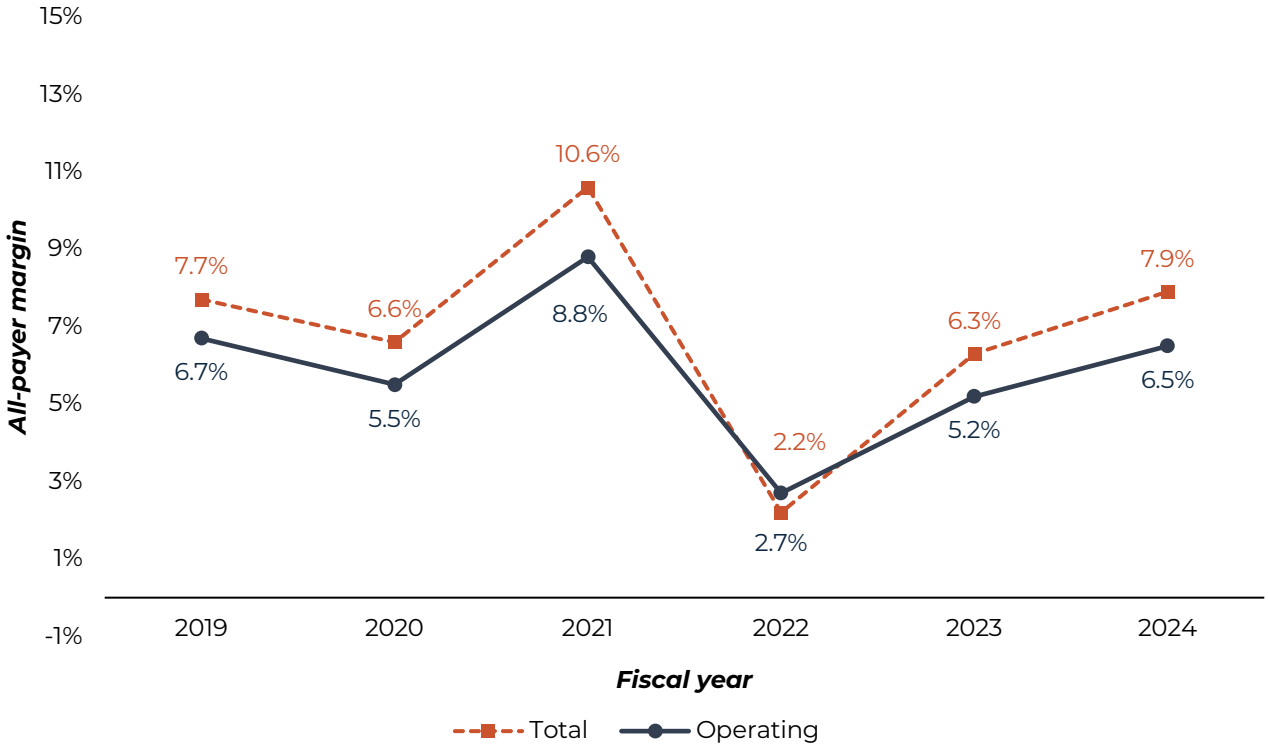


Note: IPPS (inpatient prospective payment systems), FY (fiscal year), FFS (fee-for-service), MA (Medicare Advantage). Results differ from those published last year and the first row of Chart 6-1 because this chart is limited to IPPS hospitals. Components may not sum to 100 percent due to rounding.

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

> In FY 2024, IPPS hospitals reported providing nearly 30 million inpatient stays, which neared the prepandemic level. Medicare beneficiaries continued to account for just under half of these inpatient stays; however, the share from FFS Medicare beneficiaries continued to decline, while the share from MA increased.

Chart 6-5 IPPS hospitals' all-payer total and operating margins increased in FY 2024 to near prepandemic levels



Note: IPPS (inpatient prospective payment systems), FY (fiscal year). "All-payer total margin" is the percentage of revenue from all payers and sources (including coronavirus relief funds) that is left as profit after accounting for all costs. "All-payer operating margin" excludes reported investment and donation income and is therefore often lower than hospitals' total margin but is higher in years when investment losses exceed donation income.

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

> IPPS hospitals' all-payer total and operating margins both increased in FY 2024, to 7.9 percent and 6.5 percent respectively. Both of these levels were similar to those in 2019.

> IPPS hospitals' all-payer operating margin (including coronavirus relief funds) increased 1.3 percentage points in FY 2024 to 6.5 percent, indicating that hospitals had net operating profits that could be used for capital projects. Several factors contributed to this increase, including a one-time increase in revenue from 340B remedy payments and slower growth in hospitals' labor costs (data not shown).

> IPPS hospitals' all-payer total margin increased 1.6 percentage points in FY 2024, driven by a nearly 40 percent increase in reported investment income (data not shown).

Chart 6-6 IPPS hospitals' all-payer operating margin increased across all hospital categories in FY 2024, though substantial variation persisted

Margin type and hospital category	All-payer operating margin, by fiscal year					
	2019	2020	2021	2022	2023	2024
Including relief funds						
All	6.7%	5.5%	8.8%	2.7%	5.2%	6.5%
Ownership						
For profit	12.3	13.0	15.4	12.8	13.5	14.5
Nonprofit	6.2	4.8	8.3	0.9	4.4	5.9
Geography						
Metropolitan	6.8	5.5	8.8	2.8	5.4	6.6
Rural micropolitan	5.0	5.7	8.8	1.2	2.9	5.3
Other rural	1.3	3.9	7.8	0.9	–0.7	1.5
Excluding relief funds						
All	6.7	2.0	7.4	1.9	4.9	6.4
Ownership						
For profit	12.3	10.7	14.3	12.4	13.3	14.5
Nonprofit	6.2	1.2	6.9	0.1	4.1	5.8
Geography						
Metropolitan	6.8	2.1	7.5	2.1	5.1	6.5
Rural micropolitan	5.0	1.2	6.4	–0.7	2.5	5.1
Other rural	1.3	–1.8	2.9	–2.5	–1.3	1.3

Note: IPPS (inpatient prospective payment systems), FY (fiscal year). "All-payer operating margin" is the percentage of revenue from all payers and sources exclusive of investments and donations that is left as profit after accounting for all costs. "Relief funds" refers to federal or other coronavirus relief funds. "Metropolitan" (urban) counties contain an urban cluster of 50,000 or more people; "micropolitan" rural counties contain a cluster of 10,000 to 50,000 people; all other counties are classified as "other rural." Government-owned hospitals operate in a different financial context from other hospitals, so their margin is not necessarily comparable; therefore, data for government-owned hospitals are not reported separately or included in the ownership rows (but are included in other rows).

Source: MedPAC analysis of hospital cost-report and Provider of Services data from CMS and census geographic data.

> IPPS hospitals' all-payer operating margin continued to vary across hospital categories in FY 2024. For-profit hospitals' all-payer operating margin continued to be substantially higher than nonprofit hospitals' margin; urban (metropolitan) hospitals' all-payer operating margin continued to be higher than rural micropolitan hospitals' or other rural hospitals' margin.

Chart 6-7 IPPS hospitals' FFS Medicare margin increased in FY 2024 but remained substantially negative, and significant variation across hospitals persisted

Hospital category	FFS Medicare margin, by fiscal year					
	2019	2020	2021	2022	2023	2024
Including relief funds						
All	–7.9%	–8.1%	–6.2%	–11.7%	–12.2%	–11.9%
Ownership						
For profit	1.3	4.6	5.7	0.8	0.7	1.6
Nonprofit	–9.4	–10.1	–8.1	–13.4	–13.7	–13.2
Geography						
Metropolitan	–8.3	–8.7	–6.8	–12.1	–12.5	–12.3
Rural micropolitan	–4.5	–2.5	–1.4	–8.1	–9.8	–7.1
Other rural	0.3	5.4	8.0	0.6	–3.8	–3.1
Fiscal pressure						
Low pressure	–10.9	–11.1	–8.8	–13.8	–14.2	–13.7
Medium pressure	–4.5	–4.4	–2.7	–8.0	–9.1	–8.8
High pressure	3.7	6.9	5.8	–3.2	–4.8	–6.2
Excluding relief funds						
All	–7.9	–12.2	–8.2	–12.8	–12.6	–12.1
Ownership						
For profit	1.3	1.9	4.2	0.3	0.4	1.1
Nonprofit	–9.4	–14.6	–10.1	–14.6	–14.2	–13.4
Geography						
Metropolitan	–8.3	–12.7	–8.6	–13.0	–12.9	–12.6
Rural micropolitan	–4.5	–7.6	–4.6	–10.7	–10.4	–7.3
Other rural	0.3	–0.6	2.6	–3.6	–4.7	–3.4
Fiscal pressure						
Low pressure	–10.9	–14.7	–10.5	–14.7	–14.5	–13.9
Medium pressure	–4.5	–8.9	–4.9	–9.3	–9.6	–9.1
High pressure	3.7	0.9	2.4	–4.8	–5.6	–6.6

Note: IPPS (inpatient prospective payment systems), FFS (fee-for-service), FY (fiscal year). "Hospitals" refers to hospitals paid under the IPPS. "FFS Medicare margin" is the percentage of revenue from all FFS Medicare IPPS and outpatient prospective payment system services that is left as profit after accounting for the allowable costs of providing these services to FFS Medicare patients. The FFS Medicare margin includes uncompensated-care payments and revenue and costs of separately payable drugs, including any reported discounts to drug costs under the 340B Drug Pricing Program but not including the remedy payments that hospitals received in 2024 to offset lower payments for 340B drugs acquired in 2018 through 2021 (though higher payments for drugs on reprocessed claims in 2022 are included). "Relief funds" refers to FFS Medicare's share of federal and other coronavirus relief funds (with the share based on FFS Medicare's share of 2019 all-payer operating revenue). "Metropolitan" (urban) counties contain an urban cluster of 50,000 or more people; "micropolitan" rural counties contain a cluster of 10,000 to 50,000 people; all other counties are classified as "other rural." "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. All other hospitals with complete data are classified as "medium pressure." Government-owned hospitals operate in a different financial context from other hospitals, so their margin is not necessarily comparable; therefore, data for government-owned hospitals are not reported separately or included in the ownership rows (but are included in other rows).

Source: MedPAC analysis of hospital cost-report and Provider of Services data from CMS and census geographic data.

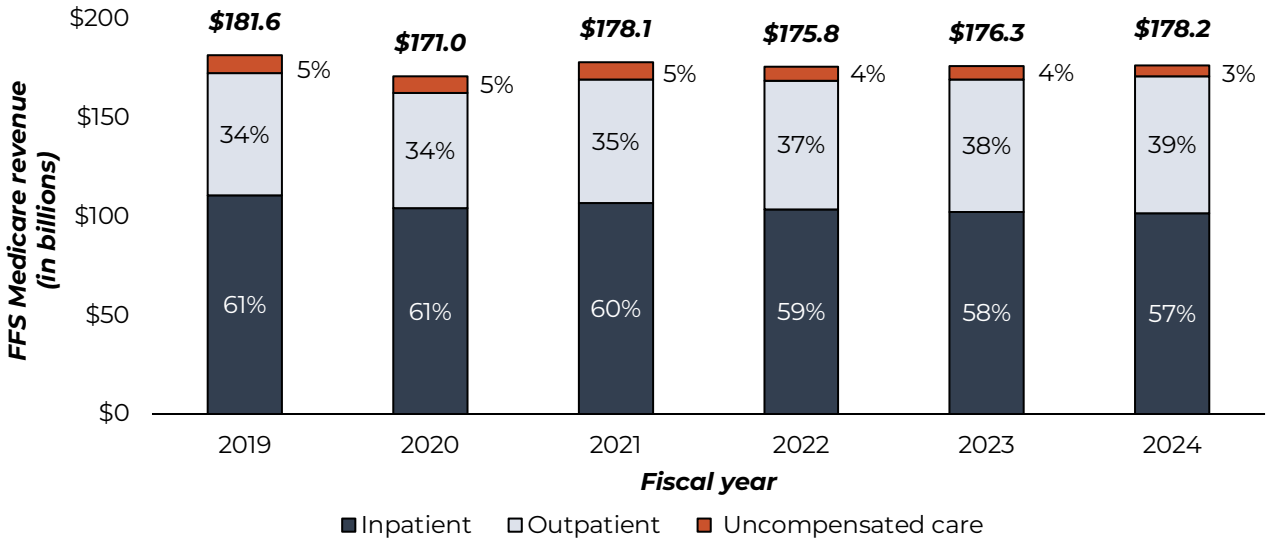
(Chart continued next page)

Chart 6-7 IPPS hospitals' FFS Medicare margin increased in FY 2024 but remained substantially negative, and significant variation across hospitals persisted (continued)

> IPPS hospitals' FFS Medicare margin increased in FY 2024 but continued to be well below hospitals' costs in aggregate, at –12.1 percent (excluding coronavirus relief funds). This FY 2024 margin does not reflect the $9 billion in one-time payments that Medicare paid hospitals in 2024 to offset lower payments for drugs acquired through the 340B Drug Pricing Program from 2018 to 2021. (We focus on IPPS hospitals' FFS Medicare margin exclusive of coronavirus relief funds; however, we also report a version including the FFS Medicare share of coronavirus relief funds because these funds were intended to cover lost revenue and higher costs—including those related to FFS Medicare patients.)

> IPPS hospitals' FFS Medicare margin continued to vary across hospital categories in FY 2024. For-profit hospitals' FFS Medicare margin continued to be substantially higher than nonprofit hospitals' margin; rural hospitals' FFS Medicare margin continued to exceed urban hospitals' margin; and hospitals under high fiscal pressure, and therefore under more pressure to constrain their costs, continued to have a higher margin than hospitals under low pressure.

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



Note: IPPS (inpatient prospective payment systems), FFS (fee-for-service). "Inpatient" refers to revenue for services covered under the IPPS and is reported exclusive of uncompensated-care payments, which are reported separately. "Outpatient" refers to revenue for services covered under the outpatient prospective payment system (OPPS). Hospitals also receive other revenue from providing services to FFS Medicare beneficiaries that are not included in these totals, such as revenue from services provided in nonexcepted off-campus provider-based departments and in post-acute care units. 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 CMS.

> In FY 2024, FFS Medicare (and its beneficiaries) paid IPPS hospitals $178.2 billion for inpatient and outpatient PPS services, slightly below the prepandemic level.

> However, the share of IPPS hospitals' FFS Medicare revenue from OPPS services has been steadily increasing, from 34 percent in FY 2019 to 39 percent in 2024.

Chart 6-9 About 16 percent of IPPS payments in FY 2024 were from adjustments targeted to specific hospitals or services

Hospital group	Share of IPPS payments (excluding uncompensated care)						
	Base PPS	Low income (DSH)	Teaching (IME)	New technology	Outliers	Rural and/or isolated	Quality
IPPS	83.6%	3.2%	7.8%	0.1%	4.3%	1.4%	–0.5%
Ownership							
For profit	88.8	3.3	5.3	0.1	1.9	1.0	–0.5
Nonprofit	84.0	3.0	7.6	0.1	4.3	1.4	–0.5
Government	75.9	4.0	11.5	0.2	6.8	1.9	–0.5
Geography							
Metropolitan	83.6	3.2	8.2	0.1	4.5	0.8	–0.5
Micropolitan	82.8	2.3	3.3	0.1	1.7	10.1	–0.4
Other rural	79.4	2.2	1.1	0.1	0.8	16.8	–0.4
DSH and teaching							
Both	80.7	3.5	10.5	0.1	5.0	0.7	–0.5
DSH only	87.3	0.1	8.3	0.1	3.3	0.9	–0.1
Teaching only	90.9	3.1	0.0	0.1	2.4	3.8	–0.4
Neither	93.9	0.1	0.0	0.1	2.0	2.7	–0.3
Rural and/or isolated							
Sole community	78.3	2.2	3.3	0.1	3.0	13.5	–0.3
Medicare dependent	79.6	1.4	2.0	0.1	1.2	16.0	–0.3
Low volume	79.2	1.8	0.7	0.0	1.0	17.2	–0.3

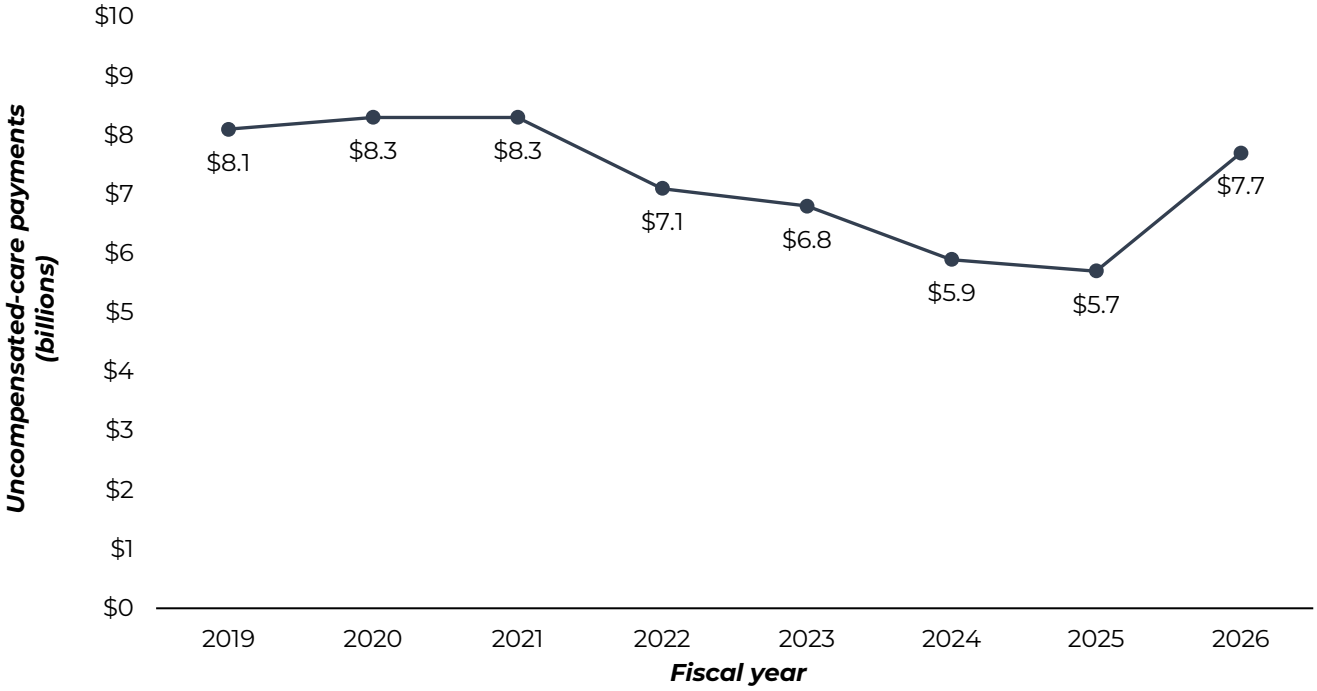
Note: IPPS (inpatient prospective payment systems), FY (fiscal year), DSH (disproportionate share hospital), IME (indirect medical education). "Rural and/or isolated" includes additional payments received by hospitals designated as sole community, Medicare-dependent, and/or low-volume hospitals. "Quality" 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 a cluster of 50,000 or more people; "micropolitan" rural counties contain a cluster of 10,000 to 50,000 people; all other counties are classified as "other rural." The hospitals in the "DSH" and "teaching" rows are defined by receiving inpatient operating DSH and/or IME payments. Columns include applicable inpatient operating or capital prospective payment system payments, inclusive of beneficiary cost-sharing liabilities and exclusive of uncompensated-care payments. Components may not sum to 100 percent due to rounding and not separately showing smaller components of IPPS payments.

Source: MedPAC analysis of hospital cost-report and Provider of Services data from CMS and census geographic data.

> The largest component of IPPS payments are base payments, which are calculated using national operating and capital rates, adjusted for geographic factors and patient case mix. In FY 2024, 83.6 percent of IPPS payments were for base payments.

> The remaining amount—about 16 percent—comprised adjustments targeted to certain hospitals or services. The largest of these targeted payments on an aggregate basis were payments to teaching hospitals for their indirect costs of medical education; in FY 2024, these comprised nearly 8 percent of IPPS payments. However, for certain hospitals, targeted payments comprised a larger share of that group's IPPS payments. For example, among hospitals designated as low-volume hospitals—which can receive an up to 25 percent increase to their otherwise applicable IPPS payments—over 17 percent of their IPPS payments in FY 2024 were from additional payments under this and/or other rural designations.

Chart 6-10 FFS Medicare's uncompensated-care payments to IPPS hospitals increased in FY 2026, approaching the prepandemic level



Note: FFS (fee-for-service), IPPS (inpatient prospective payment systems), FY (fiscal year). "Uncompensated-care payments" are presented postsequestration and inclusive of uncompensated-care supplemental payments to hospitals for Indian Health Service and tribal hospitals and Puerto Rican hospitals. In FY 2026, these supplemental payments totaled $107 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.

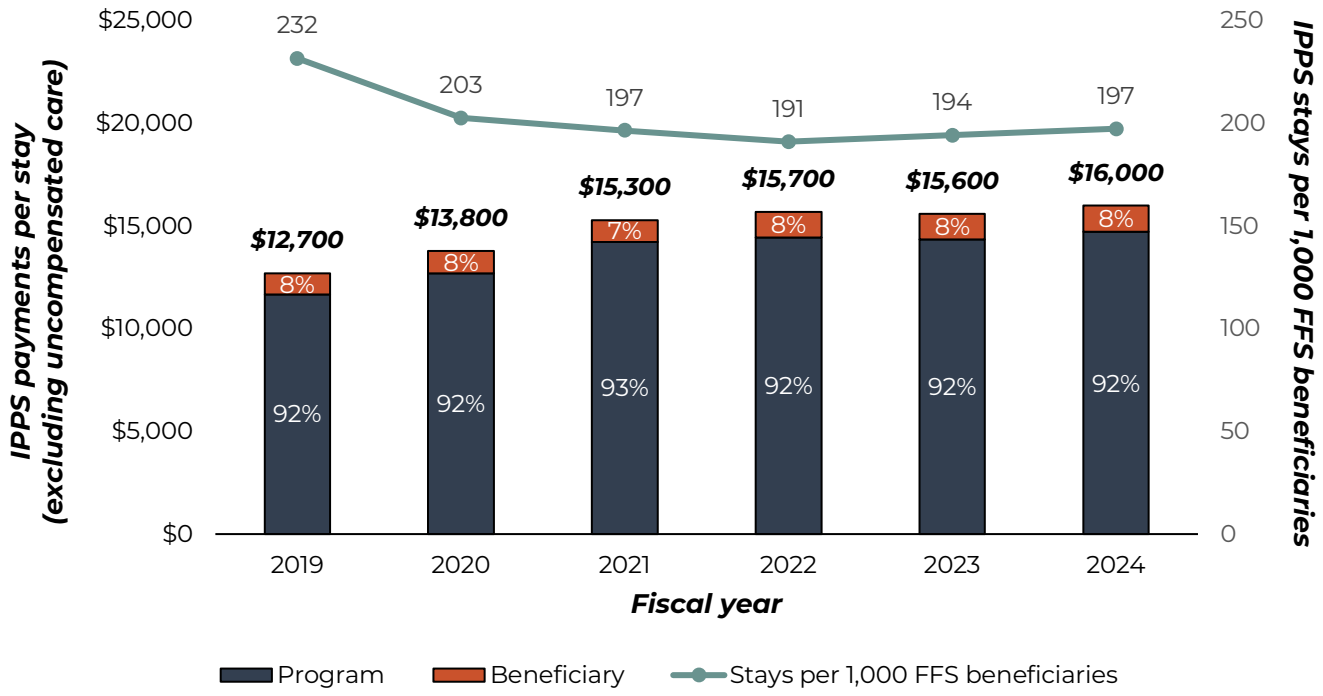
> Aggregate uncompensated-care payments for a fiscal year are set prospectively as the product of two estimates for the upcoming payment year: 75 percent of the operating DSH hospital payments under prior law and the uninsured rate as a percentage of the rate in 2013 (plus an additional reduction from 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 to IPPS hospitals.

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

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

> In FY 2026, uncompensated-care payments increased substantially to $7.7 billion dollars, approaching the prepandemic level. This growth was driven in part by an estimated increase in the uninsured rate, from 7.6 percent in 2025 to 8.7 percent in 2026 (data not shown).

Chart 6-11 Medicare's IPPS payments per stay in FY 2024 were well above prepandemic level, but stays per capita remained well below prepandemic level



Note: IPPS (inpatient prospective payment systems), FY (fiscal year), FFS (fee-for-service). "IPPS payments" includes FFS Medicare program payments and beneficiaries' cost-sharing liabilities and excludes uncompensated-care payments. "FFS beneficiaries" is limited to those who resided in the U.S. and had Part A. Dollars are nominal, not adjusted for inflation.

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

> IPPS payments per stay increased in FY 2024 to $16,000, well above the prepandemic level of $12,700. The beneficiary cost-sharing liability share remained at around 8 percent.

> In contrast, IPPS stays per FFS Medicare beneficiary in FY 2024 remained well below the prepandemic level. In FY 2024. there were 197 stays per 1,000 FFS Medicare beneficiaries, compared with 232 in FY 2019.

> Since both the number of IPPS stays per FFS Medicare beneficiary and the number of FFS Medicare beneficiaries have declined from FY 2019 to FY 2024, aggregate IPPS payments also declined, falling to $105 billion in FY 2024 (data not shown).

Chart 6-12 Seven major diagnostic categories continued to account for over four-fifths of IPPS stays

Major diagnostic category	Share of IPPS stays, by fiscal year					
	2019	2020	2021	2022	2023	2024
Circulatory	21%	20%	20%	20%	21%	20%
Infectious and parasitic	11	12	12	12	12	13
Musculoskeletal	14	12	11	11	11	11
Respiratory	12	13	15	14	12	12
Nervous	8	8	8	8	9	9
Digestive	10	10	10	10	10	9
Kidney and urinary	8	7	7	8	8	8
Other	17	18	17	17	17	17

Note: IPPS (inpatient prospective payment systems). Components may not sum to 100 percent due to rounding.

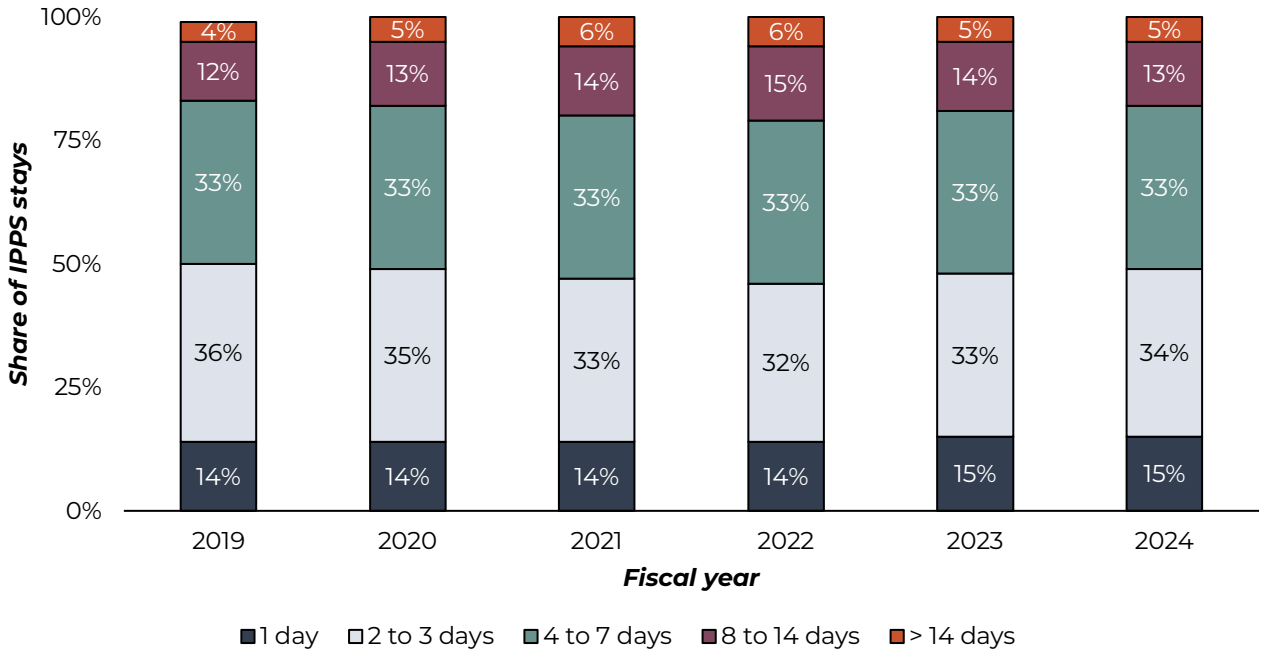
Source: MedPAC analysis of Medicare Provider Analysis and Review and IPPS final-rule data from CMS.

> Under the IPPS, inpatient stays are categorized into one of about 800 Medicare severity diagnosis-related groups (MS–DRGs), primarily based on the patient's principal diagnosis. Each MS–DRG belongs to 1 of about 25 major diagnostic categories (MDCs).

> In fiscal year (FY) 2024, seven MDCs continued to account for about four-fifths of IPPS stays, and the most common MDC continued to be diseases of the circulatory system, at about 20 percent.

> The distribution of IPPS payments and inpatient days was similar to that of inpatient stays, with the same top seven major diagnostic categories (though in slightly different order). For example, in FY 2024, diseases of the circulatory system comprised the largest share of IPPS payments and days, at 23 percent and 18 percent respectively (data not shown).

Chart 6-13 Stays between 2 and 7 days continued to account for majority of IPPS stays



Note: IPPS (inpatient prospective payment systems). Length of stay calculated as the difference between the discharge and admission date or one day if the dates are the same. Components may not sum to 100 percent due to rounding.

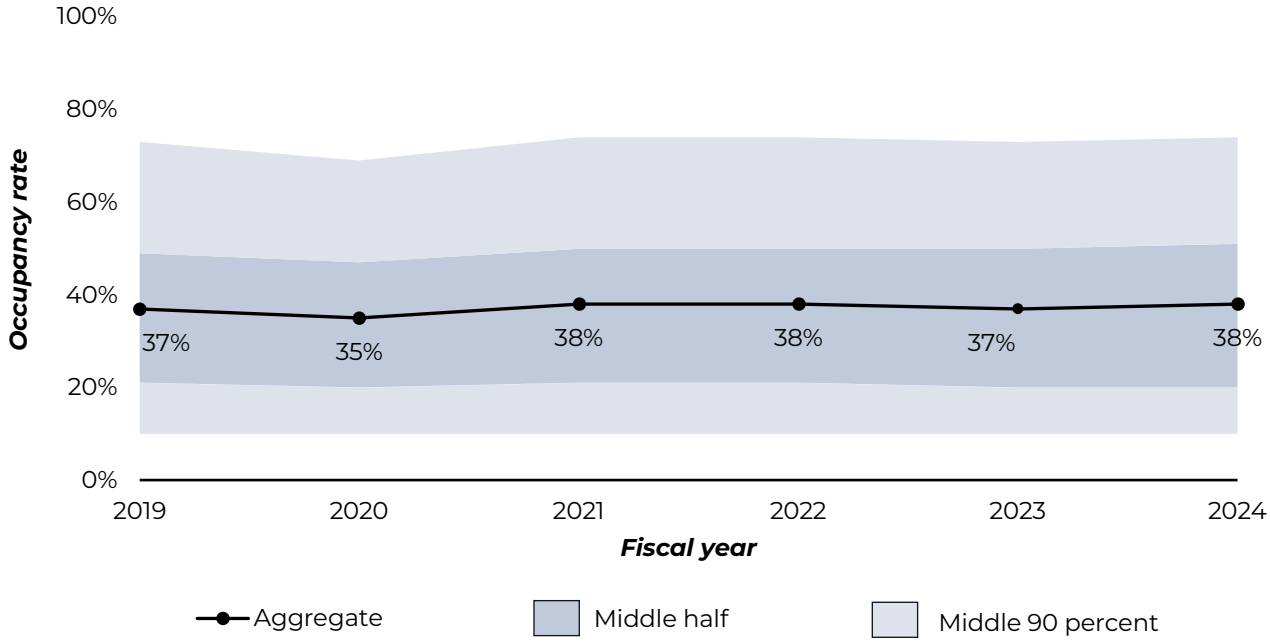
Source: MedPAC analysis of Medicare Provider and Review data from CMS.

> IPPS stays can be very short (a minimum of one day) or very long, but a majority last between two and seven days. The average length of an IPPS stay was 5.3 days in fiscal year (FY) 2024 (data not shown).

> The distribution of lengths of stay has been relatively steady since FY 2019, including during the pandemic.

> The distribution of IPPS payments and inpatient days were different from that of inpatient stays, with the longer stays representing a larger share of IPPS payments and days than of stays. For example, in FY 2024, IPPS stays of greater than 14 days comprised 5 percent of stays but 14 percent of IPPS payments and 23 percent of days (latter data not shown).

Chart 6-14 CAHs continued to have substantial excess inpatient capacity in aggregate, but some CAHs neared capacity



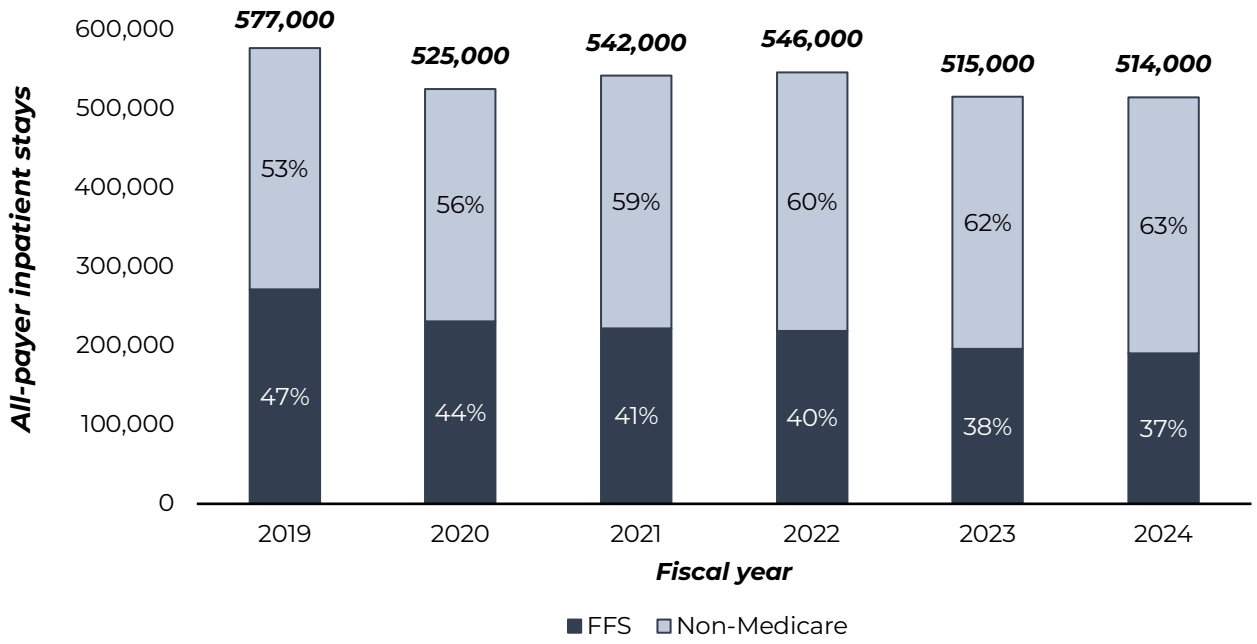
Note: CAH (critical access hospital). "Occupancy rate" refers to share of bed days that were occupied by a patient (regardless of whether the patient was receiving inpatient, observation, or swing-bed services or the share of time that the bed was staffed).

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

> CAHs continued to have substantial available capacity in aggregate. However, there continued to be significant variation within these aggregates, with some hospitals having substantially higher available capacity while others neared capacity constraints.

> In FY 2024, CAHs' occupancy rate was 38 percent, similar to prior years. However, 5 percent of hospitals had an occupancy rate under 10 percent, while another 5 percent had an occupancy rate over 74 percent.

Chart 6-15 CAHs' all-payer inpatient stays continued to decline in FY 2024, as did the FFS Medicare share

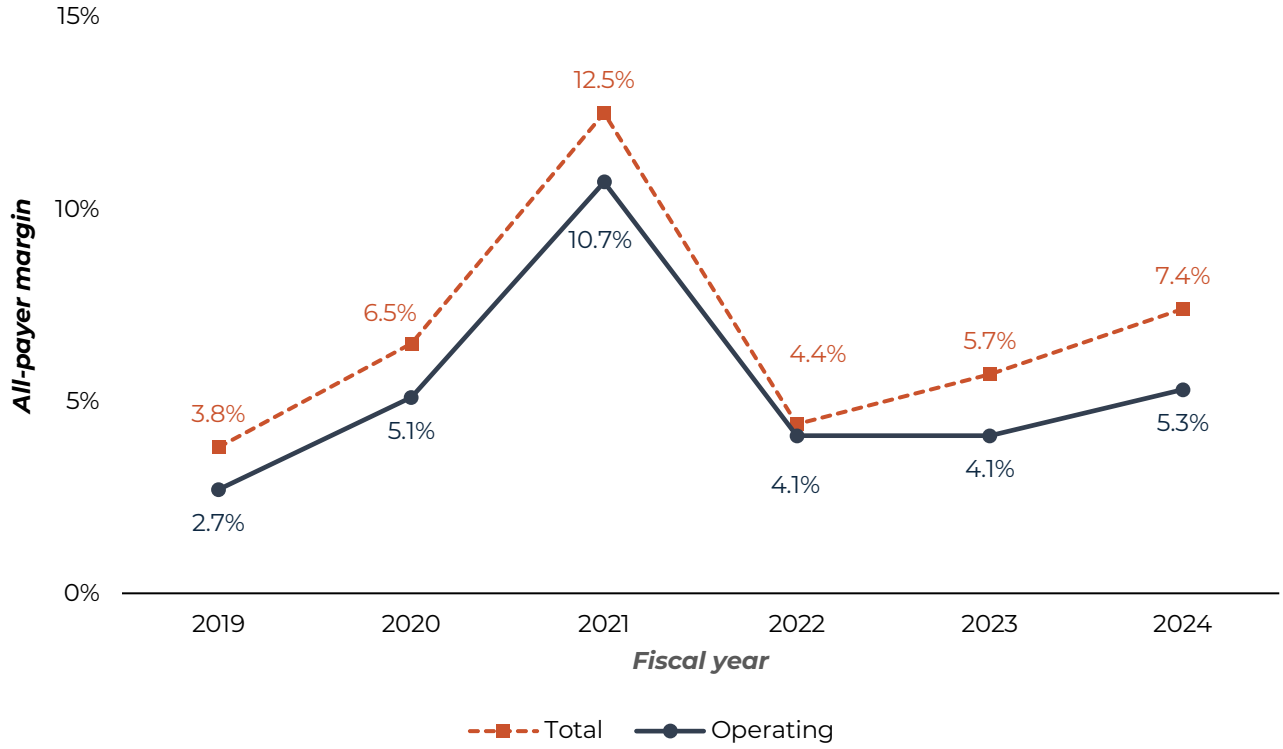


Note: CAH (critical access hospital), FY (fiscal year), FFS (fee-for-service). "Inpatient stays" refers to acute inpatient stays (and does not include observation or swing-bed stays). The Medicare Advantage (MA) share of inpatient stays is not shown because many CAHs did not separately report MA stays on their cost reports.

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

> In FY 2024, CAH hospitals provided about 514,000 inpatient stays, well below the level in 2019 and below the pandemic low in 2020. The share from FFS Medicare has also been declining, consistent with the increasing share of Medicare beneficiaries enrolling in MA. However, the FFS share of 37 percent was still a much higher share than in IPPS hospitals (22 percent) (see Chart 6-4).

Chart 6-16 CAHs' all-payer total and operating margins in FY 2024 exceeded prepandemic levels

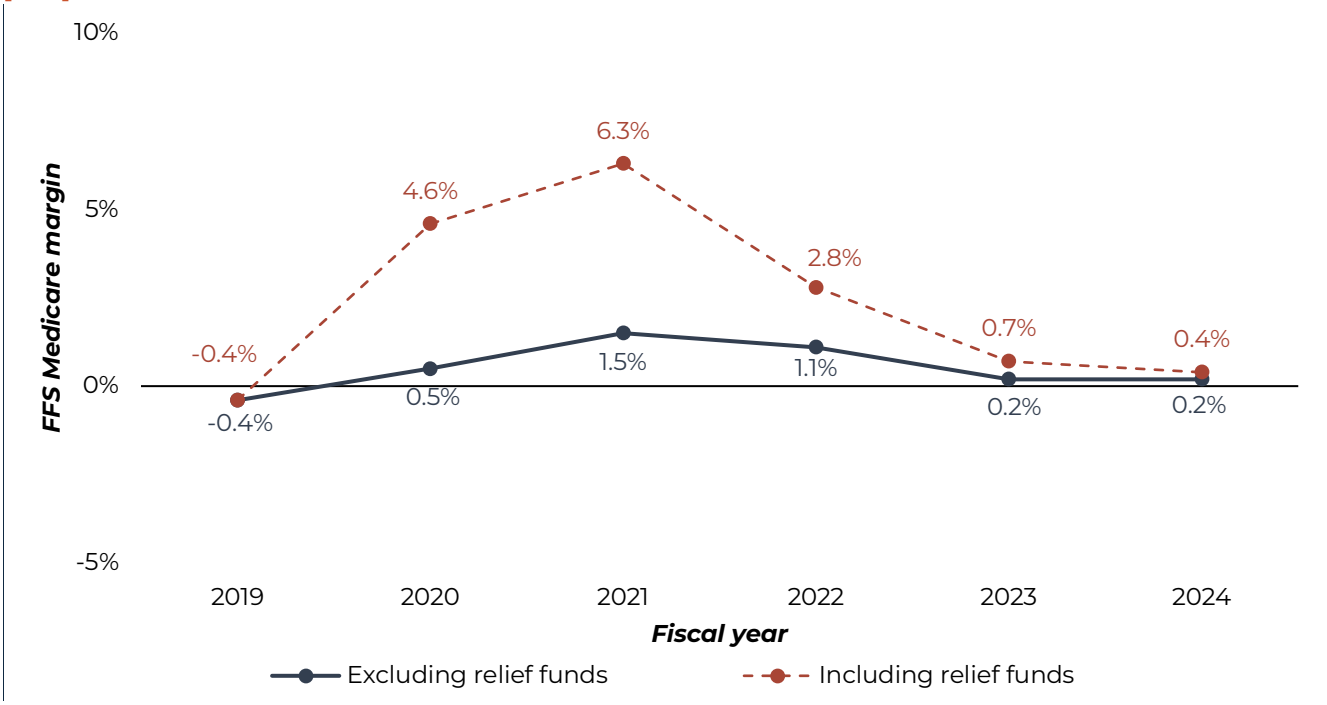


Note: CAH (critical access hospital), FY (fiscal year). "All-payer total margin" is the percentage of revenue from all payers and sources (including coronavirus relief funds) that is left as profit after accounting for all costs. "All-payer operating margin" excludes reported investment and donation income and is therefore often lower than hospitals' total margin but is higher in years when investment losses exceed donation income.

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

> CAHs' all-payer total and operating margins both increased in FY 2024, reaching 7.4 percent and 5.3 percent, respectively. Both of these levels exceeded the prepandemic levels in FY 2019.

Chart 6-17 CAHs' FFS Medicare margin in FY 2024 slightly exceeded the prepandemic level



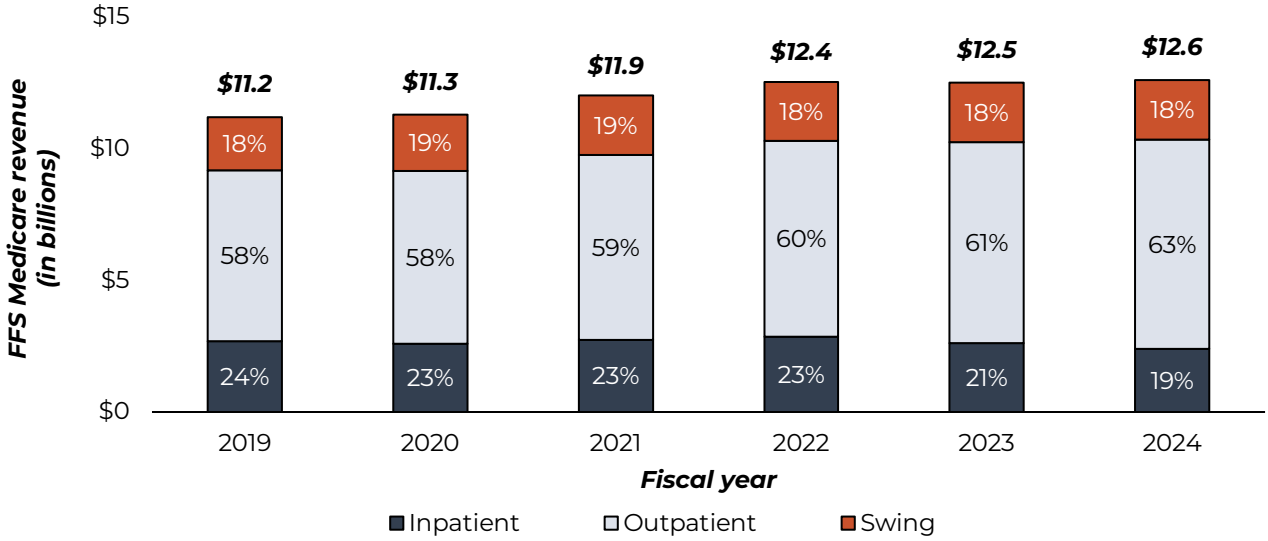
Note: CAH (critical access hospital), FFS (fee-for-service), FY (fiscal year). "FFS Medicare margin" includes inpatient, outpatient, and skilled nursing swing-bed services; the margin assigns all inpatient general routine costs equally per day across all days (regardless of whether the bed was used for inpatient, observation, or swing-bed nursing or skilled nursing care).

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

> FFS Medicare pays CAHs for inpatient, outpatient, and swing-bed services at 101 percent of their allowable costs. The calculation of allowable costs assumes that CAHs' general inpatient costs of using inpatient beds to provide nursing facility care equals state Medicaid rates, which is likely an underestimate and more reflective of state Medicaid policies than CAHs' costs, and then divides the remaining costs by inpatient, observation, and swing-bed skilled nursing days.

> Using an alternative calculation of allowable costs—that assigns a CAH's general inpatient routine costs equally across all days the bed was occupied—results in a FFS Medicare margin (excluding relief funds) of 0.2 percent in FY 2024. This figure is above the prepandemic level but below the level in FYs 2020 through 2022 when the sequestration on FFS Medicare payments was partially or fully suspended. (We focus on CAHs' FFS Medicare margin exclusive of coronavirus relief funds; however, we also report a version including the FFS Medicare share of coronavirus relief funds because these funds were intended to cover lost revenue and higher costs—including those related to FFS Medicare patients.)

Chart 6-18 CAHs' FFS Medicare revenue has been slowly increasing, driven by growth in outpatient services



Note: CAH (critical access hospital), FFS (fee-for-service). "Inpatient" refers to revenue for inpatient stays. "Outpatient" refers to revenue for outpatient services. "Swing" refers to skilled nursing services provided in inpatient beds, referred to as "swing beds." Hospitals also receive other revenue from providing services to FFS Medicare beneficiaries that are not included in these totals, such as revenue from services provided in clinics and in post-acute care units. Components may not sum to 100 percent due to rounding.

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

> In FY 2024, FFS Medicare (and its beneficiaries) paid CAHs about $12.6 billion for inpatient, outpatient, and swing services (skilled nursing services provided in an inpatient bed). CAHs' FFS Medicare revenue from these services has been steadily increasing despite a decline in the overall number of FFS Medicare beneficiaries.

> The growth in CAHs' FFS Medicare revenue has been driven by an increase in outpatient services, which grew from 58 percent in fiscal year (FY) 2019 to 63 percent in FY 2024. This outpatient share of FFS Medicare revenue is much higher than for IPPS hospitals (39 percent) (see Chart 6-8).

Chart 6-19 Total number of Medicare-certified inpatient psychiatric facilities continued to decline in FY 2024, while the share of freestanding facilities increased

	Fiscal year						Average annual percentage change	
Type of IPF	2019	2020	2021	2022	2023	2024	2019–2023	2023–2024
All	1,610	1,570	1,530	1,510	1,470	1,430	–2.2%	–2.8%
Share of all								
Urban	80%	80%	81%	81%	81%	82%	0.4	0.8
Rural	20	20	19	19	19	18	–1.9	–3.4
Teaching	37	37	38	38	38	39	1.2	0.9
Nonteaching	63	63	62	62	62	61	–0.7	–0.6
Hospital-based units	65	64	63	61	61	59	–1.8	–2.4
Nonprofit	39	39	39	38	38	37	–0.9	–2.4
For profit	14	14	13	13	12	12	–3.7	–6.1
Government	12	11	11	11	10	11	–2.7	2.3
Freestanding	35	36	37	39	39	41	3.2	3.6
Nonprofit	5	5	5	5	5	5	0.9	7.2
For profit	20	21	22	23	24	26	4.4	5.8
Government	9	10	10	10	10	10	1.7	–3.3

Note: FY (fiscal year), IPF (inpatient psychiatric facility). "Average annual percent 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.

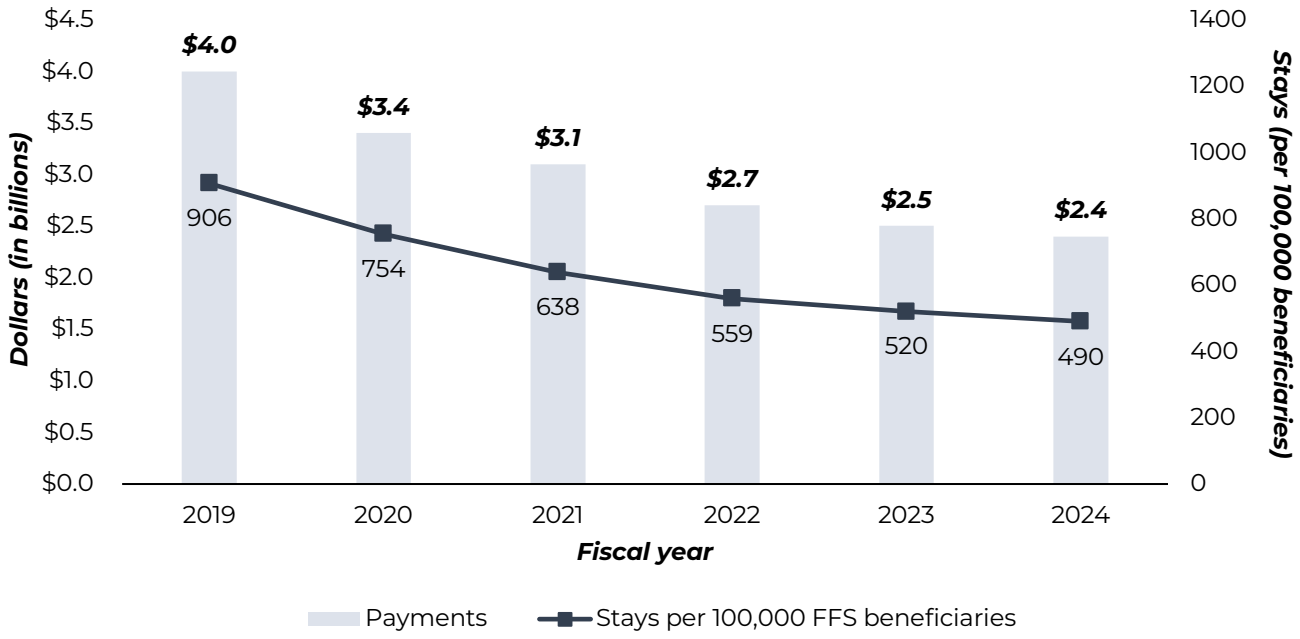
> In FY 2024, compared with the prior year, the number of IPFs nationwide decreased to 1,430 from 1,470 (2.8 percent decrease). This decline was similar to the decline observed from 2019 to 2023 (2.2 percent annually).

> Most IPFs are in urban areas (82 percent in FY 2024). Between FY 2019 and FY 2024, the share of IPFs in urban areas grew slightly and the share of IPFs in rural areas fell.

> In FY 2024, a majority of IPFs (59 percent) were hospital-based units; however, from FY 2019 to FY 2024, the share of hospital-based IPFs declined by 2.0 percent annually, while the share of freestanding IPFs grew by 3.3 percent annually (data not shown).

> Over a quarter of IPFs in FY 2024 were freestanding and for profit, up from about one-fifth of IPFs in 2019.

Chart 6-20 FFS Medicare inpatient psychiatric facility stays per capita and payments continued to decline in FY 2024



Note: FFS (fee-for-service), FY (fiscal year). 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 2024, FFS Medicare inpatient stays in IPFs decreased by 12 percent per year, on average, declining from 906 stays per 100,000 Medicare FFS beneficiaries to 490. Total (FFS Medicare plus beneficiary) payments for IPF PPS services decreased from $4.0 billion to $2.4 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 before 2020 and continued into 2024. 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 2024, about 30 percent of FFS Medicare inpatient psychiatric stays occurred in general acute care hospitals (the remaining 70 percent occurred in IPFs) (data not shown).

Chart 6-21 A growing share of FFS Medicare beneficiaries' stays at IPFs were for schizophrenia, FY 2019–2024

Psychiatric MS–DRG grouping	Fiscal year						Average annual percentage change
	2019	2020	2021	2022	2023	2024	2019–2024
Share of total							
Psychosis	73.4%	74.4%	74.8%	75.1%	76.0%	76.8%	0.9%
Mood disorders	38.6	37.5	36.9	36.8	37.0	37.7	–0.5
Schizophrenia and other non-mood psychotic disorders	34.8	36.9	37.9	38.3	38.9	39.1	2.4
Organic disturbances	7.0	6.9	6.8	7.0	6.0	5.7	–3.9
Alcohol/drug dependency	6.4	6.2	6.2	5.7	5.3	4.9	–5.2
Neurosis	4.5	4.2	3.9	4.0	4.1	4.0	–2.6
Nervous system disorder	5.9	5.4	5.3	5.2	5.5	5.5	–1.4
Other psychiatric	1.8	1.9	2.0	2.0	2.0	2.0	2.5
Other nonpsychiatric	1.0	1.0	1.0	0.9	1.1	1.1	2.3

Note: FFS (fee-for-service), IPF (inpatient psychiatric facility), FY (fiscal year), MS–DRG (Medicare severity diagnosis-related group). 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 2024, nearly 77 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 2019 and FY 2024, the share of patients with non-mood psychotic disorders increased annually by 2.4 percent. Over the same time, the share of patients with mood disorders declined slightly.

> Between FY 2019 and FY 2024, patients with organic disturbances (which include diagnoses such as dementia) and alcohol/drug dependency MS–DRGs declined annually by 3.9 percent and 5.2 percent, respectively. 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 6-19).

Chart 6-22 FFS Medicare beneficiaries using IPFs tended to be disabled, under age 65, low income, and non-White compared with all FFS beneficiaries, FY 2024

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	51	37	91
Disabled	49	63	9
ESRD	0.1	<0.1	0.2
Female	49	45	53
Male	51	55	47
<45	24	33	3
45–64	26	31	7
65–79	36	28	68
80+	14	8	23
Non-Hispanic White	71	66	78
Black	15	18	8
Asian/Pacific Islander	2	2	4
Hispanic	7	8	6
American Indian/Alaska native	1	1	<1
Other or unknown	4	6	4
Urban	81	84	81
Rural	19	17	19
Dual eligibility or LIS during year			
No	36	24	85
Yes	64	76	15

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 2024, 63 percent qualified for Medicare because of a disability, compared with 9 percent across all FFS beneficiaries. Beneficiaries who used IPF care also tended to be younger and were more likely to have low incomes.

> About one-quarter of Medicare FFS beneficiaries who used an IPF in FY 2024 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 6-23 Medicare beneficiaries near or reaching the lifetime coverage limit on care in freestanding IPFs were highly vulnerable, 2024

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	820,330	10,060	39,240
Current eligibility status and demographics (percentage)			
Aged	45%	34%	33%
Disabled	55	66	67
ESRD	<1	<1	<1
Female	49	39	39
Male	51	61	61
<45	16	17	16
45–64	41	51	53
65–79	34	29	25
80+	9	2	6
Non-Hispanic White	69	63	62
Black	18	25	27
Asian/Pacific Islander	2	2	2
Hispanic	8	7	7
American Indian/Alaska native	1	1	1
Other or unknown	2	1	1
Urban	83	87	86
Rural	17	13	14
Dual eligibility or LIS during year (percentage)			
No	28	13	15
Yes	72	87	85

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 enrolled in Medicare for at least one month in 2024 and stayed for at least one day in a freestanding IPF from the time of Medicare enrollment through July 31, 2025. "Within 15 days of reaching the coverage limit" refers to Medicare beneficiaries who were enrolled in Medicare for at least one month in 2024 and were within 15 days of reaching the 190-day coverage limit in freestanding IPFs as of July 2025. "Reached the coverage limit" refers to Medicare beneficiaries who were enrolled in Medicare for at least one month in 2024 and had reached or exceeded the 190-day limit as of July 2025. 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 other hospitals.

> In 2024, 820,330 Medicare (fee-for-service and Medicare Advantage) beneficiaries had at least one day in a freestanding IPF since first enrolling in Medicare. Of these beneficiaries, 49,300 (10,060 + 39,240) were within 15 days of reaching the 190-day limit or had reached the limit as of the end of July 2025. 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).