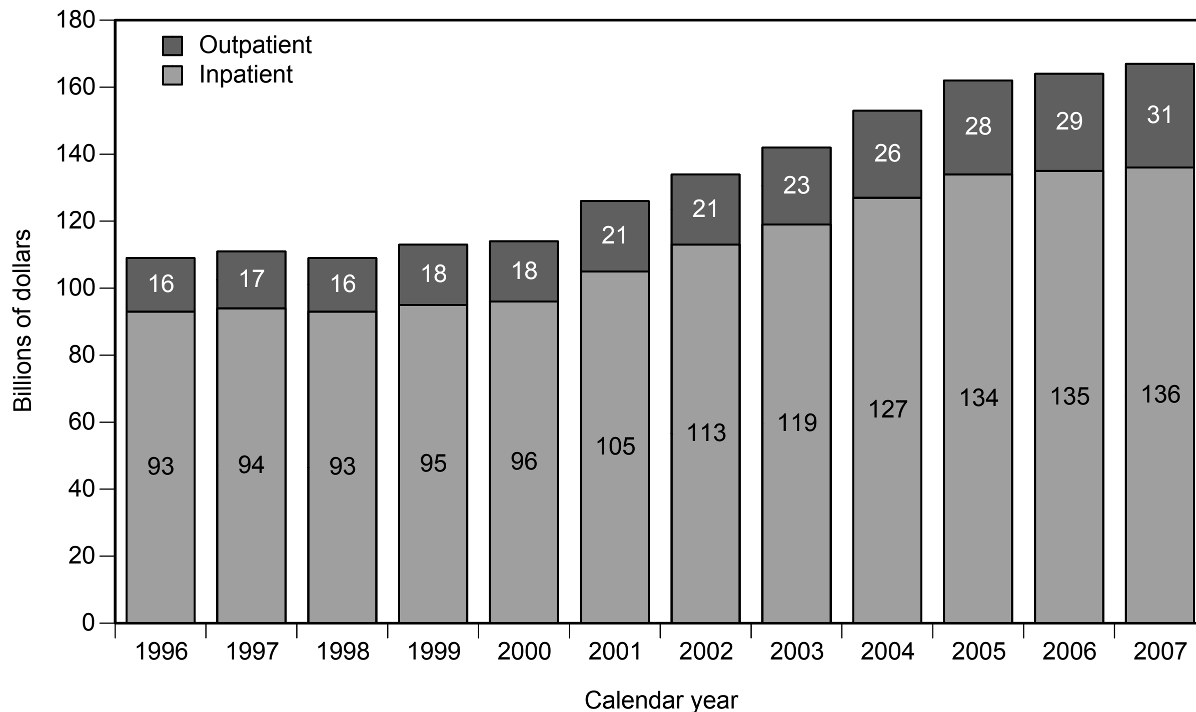
SECTION 7

Acute inpatient services

Short-term hospitals

Specialty psychiatric facilities

Chart 7-1. Growth in Medicare's FFS payments for hospital inpatient and outpatient services, 1996–2007



Note: FFS (fee-fee-service). Analysis includes inpatient services covered by the acute inpatient prospective payment system (IPPS); psychiatric, rehabilitation, long-term care, cancer, and children's hospitals and units; outpatient services covered by the outpatient PPS; and other outpatient services. Payments include program outlays and beneficiary cost sharing. The growth in spending was slowed in 2006 by large increases in the number of Medicare Advantage enrollees, who are not included in these aggregate totals.

Source: CMS, Office of the Actuary.

- Aggregate Medicare fee-for-service (FFS) inpatient spending was $136 billion and outpatient spending was $31 billion in 2007. From 2006 to 2007 inpatient spending increased less than 1 percent while outpatient spending increased by over 6 percent.
- A freeze in inpatient payment rates in the Balanced Budget Act of 1997 (BBA) reduced inpatient spending growth in 1998. Spending increased substantially in 2001 through 2004. Payment growth was relatively slow from 2005 to 2007 because a large number of beneficiaries switched from traditional fee-for-service Medicare to the Medicare Advantage (MA) program.
- Outpatient spending per FFS beneficiary was approximately $880 in 2007, up from $600 in 2002, or a 47 percent increase.

Chart 7-2. Major diagnostic categories with highest volume, fiscal year 2007

MDC number	MDC name	Share of all discharges	Share of medical discharges	Share of surgical discharges
5	Circulatory system	26%	25%	30%
4	Respiratory system	14	19	3
8	Musculoskeletal system and connective tissue	13	5	32
6	Digestive system	10	11	9
1	Nervous system	8	9	5
11	Kidney and urinary tract	7	8	4
18	Infectious and parasitic diseases	4	5	2
10	Endocrine, nutritional, and metabolic diseases and disorders	4	5	2
7	Hepatobiliary system and pancreas	3	3	4
9	Skin, subcutaneous tissue, and breast	3	3	2
Total		92	93	93

Note: MDC (major diagnostic category).

Source: MedPAC analysis of MedPAR data from CMS.

- In fiscal year 2007, 10 major diagnostic categories accounted for 92 percent of all discharges at hospitals paid under the acute inpatient prospective payment system.
- Circulatory system cases accounted for approximately one-quarter of medical cases and 30 percent of surgical cases.
- Respiratory system cases accounted for 19 percent of medical discharges.
- Musculoskeletal system cases accounted for 32 percent of surgical discharges.

Chart 7-3. Number of acute care hospitals and Medicare discharges, by hospital group, 2007

	Hospitals		Medicare discharges	
Hospital group	Number	Share of total	Number (thousands)	Share of total
All PPS and critical access hospitals	4,697	100.0%	11,309	100.0%
PPS hospitals	3,416	72.7	10,866	96.1
Urban	2,445	52.1	9,254	81.8
Large urban	1,346	28.7	5,034	44.5
Other urban	1,099	23.4	4,221	37.3
Rural	971	20.7	1,611	14.3
Rural referral	134	2.9	450	4.0
Sole community	402	8.6	648	5.7
Medicare dependent	161	3.4	185	1.6
Other rural <50 beds	101	2.2	57	0.5
Other rural ≥50 beds	173	3.7	271	2.4
Voluntary	1,995	42.5	7,782	68.8
Proprietary	839	17.8	1,745	15.4
Government	582	12.4	1,338	11.8
Major teaching	282	6.0	1,660	14.7
Other teaching	747	15.9	3,818	33.8
Nonteaching	2,387	50.8	5,388	47.6
Critical access hospitals	1,281	27.3	443	3.9

Note: PPS (prospective payment system). Analysis includes all hospitals covered by Medicare's inpatient PPS along with critical access hospitals. Maryland hospitals are excluded. Large urban areas have populations of more than 1 million. Major teaching hospitals are defined by a ratio of interns and residents to beds of at least 0.25. Other teaching hospitals have a ratio of below 0.25. Data are limited to providers with complete cost reports in the CMS database. See Chart 7-21 for more information about critical access hospitals.

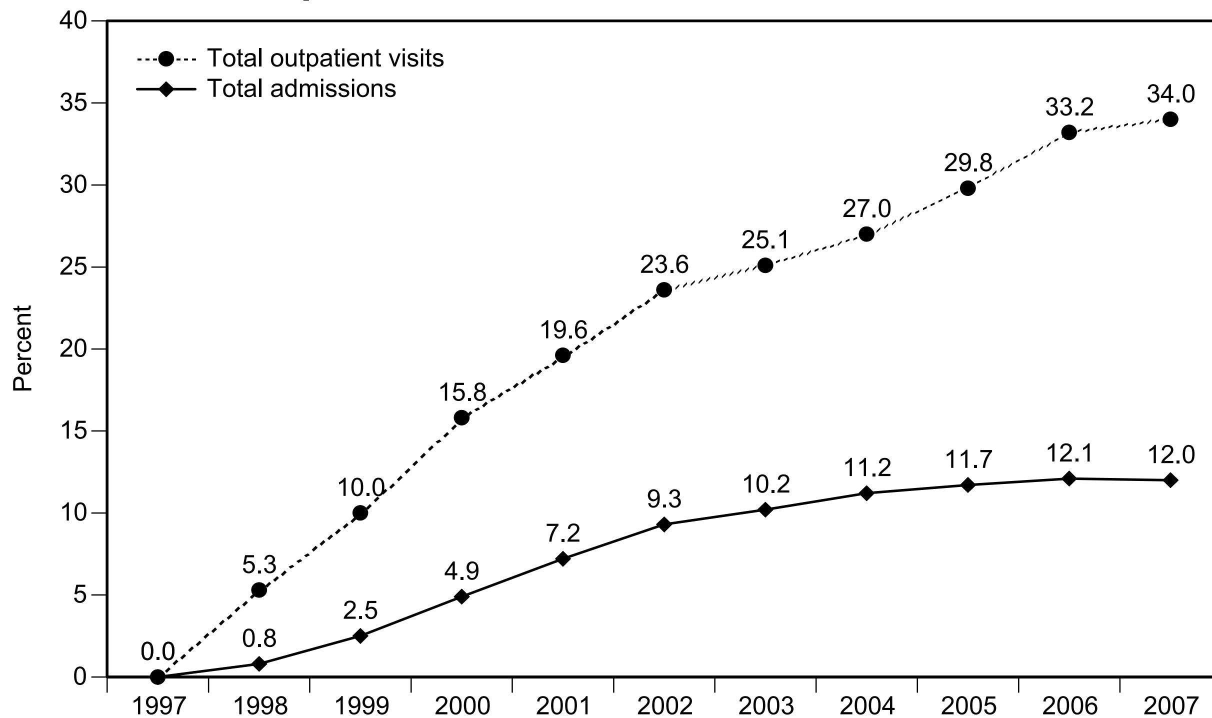
Source: MedPAC analysis of PPS impact files and Medicare cost report data from CMS.

- In 2007, 3,416 hospitals provided 10.9 million discharges under Medicare's acute inpatient prospective payment system (PPS) and 1,281 critical access hospitals provided more than 0.4 million discharges. The number of PPS discharges declined from 2006 primarily due to a shift in Medicare beneficiaries from fee-for-service Medicare to Medicare Advantage plans.

- 20 percent of PPS hospitals are covered by three special payment provisions (rural referral, sole community, and small rural Medicare-dependent hospitals) intended to help rural facilities that are not critical access hospitals; these facilities provide about 11 percent of all discharges.

- From 2006 to 2007, the number of PPS hospitals increased by 1 percent, or 41 hospitals. Among the PPS hospital sub-groups, the number of proprietary hospitals increased 7.4 percent, urban hospitals 1.9 percent, and nonteaching hospitals 2.3 percent.

Chart 7-4. Cumulative change in total admissions and total outpatient visits, 1997–2007

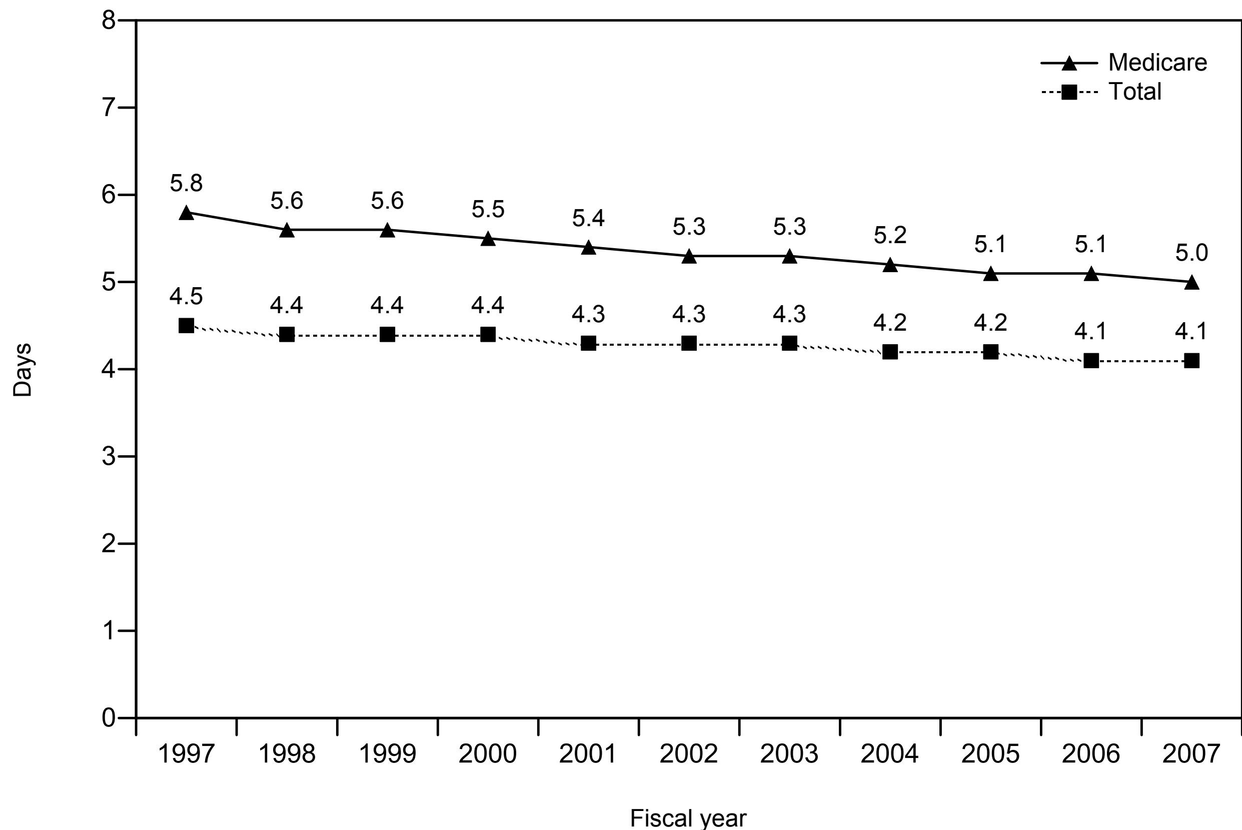


Note: Cumulative change is the total percent increase from 1997 through 2007. Data are admissions (all payers) to and outpatient visits at approximately 5,000 community hospitals.

Source: American Hospital Association, AHA Hospital Statistics.

- Hospital outpatient service use grew much more rapidly from 1997 to 2007 than inpatient service use. Total hospital outpatient visits increased approximately 34 percent from 1997 to 2007, while total admissions grew just 12 percent.
- There were nearly 600 million outpatient visits and over 35 million admissions to community hospitals in 2007.
- In 2007, the overall number of annual admissions declined for the first time since 1994, down less than a tenth of one percentage point, or approximately 32,000 admissions from 2006.

Chart 7-5. Trends in Medicare and total hospital length of stay, 1997–2007

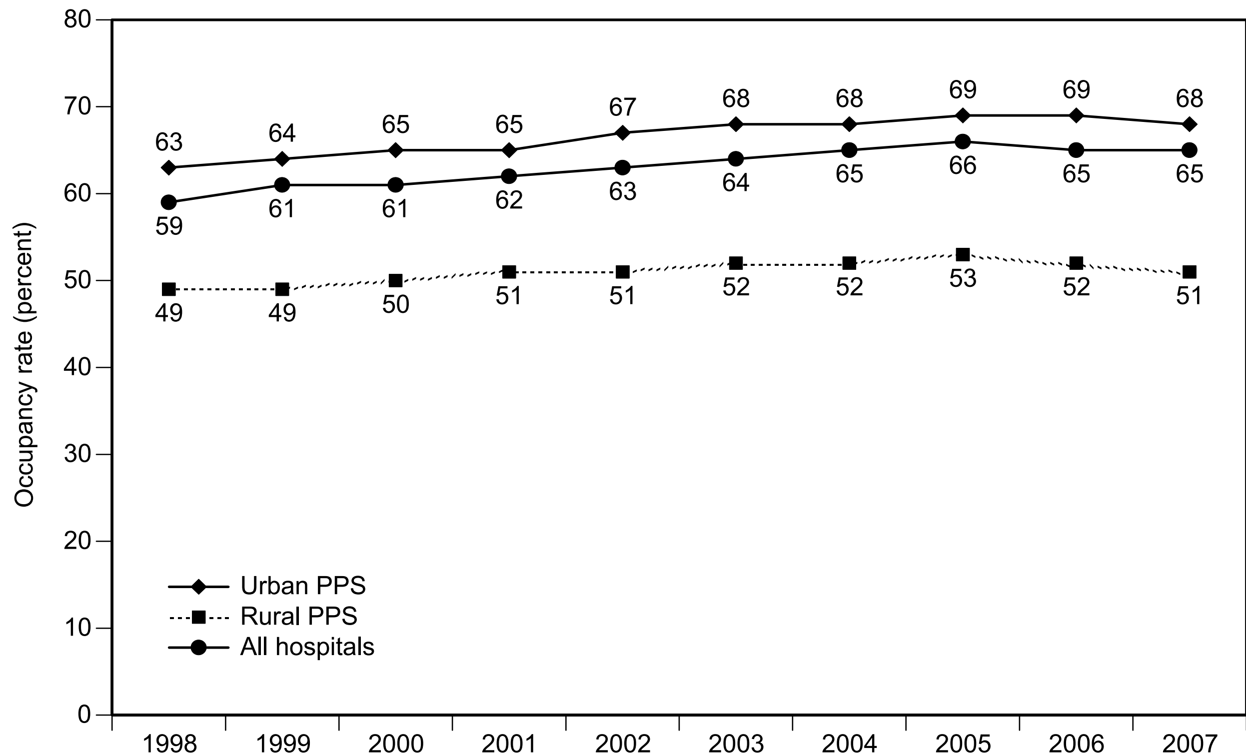


Note: Length of stay is calculated from discharges and patient days for over 3,000 hospitals covered by the acute inpatient prospective payment system. Excludes critical access hospitals.

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

- Length of stay for Medicare inpatients was nearly 1 day longer than for all hospital discharges in 2007.
- Length of stay for Medicare inpatients fell 14 percent, from 5.8 days in 1997 to 5.0 days in 2007, dropping at an average annual rate of 1.8 percent from 1997 to 2001 and 0.9 percent from 2001 to 2007.
- Length of stay for all hospital discharges fell 9 percent, from 4.5 days in 1997 to 4.1 days in 2007, dropping at an average annual rate of 0.8 percent from 1997 to 2001 and 0.3 percent from 2001 to 2007.

Chart 7-6. Hospital occupancy rates, 1998–2007



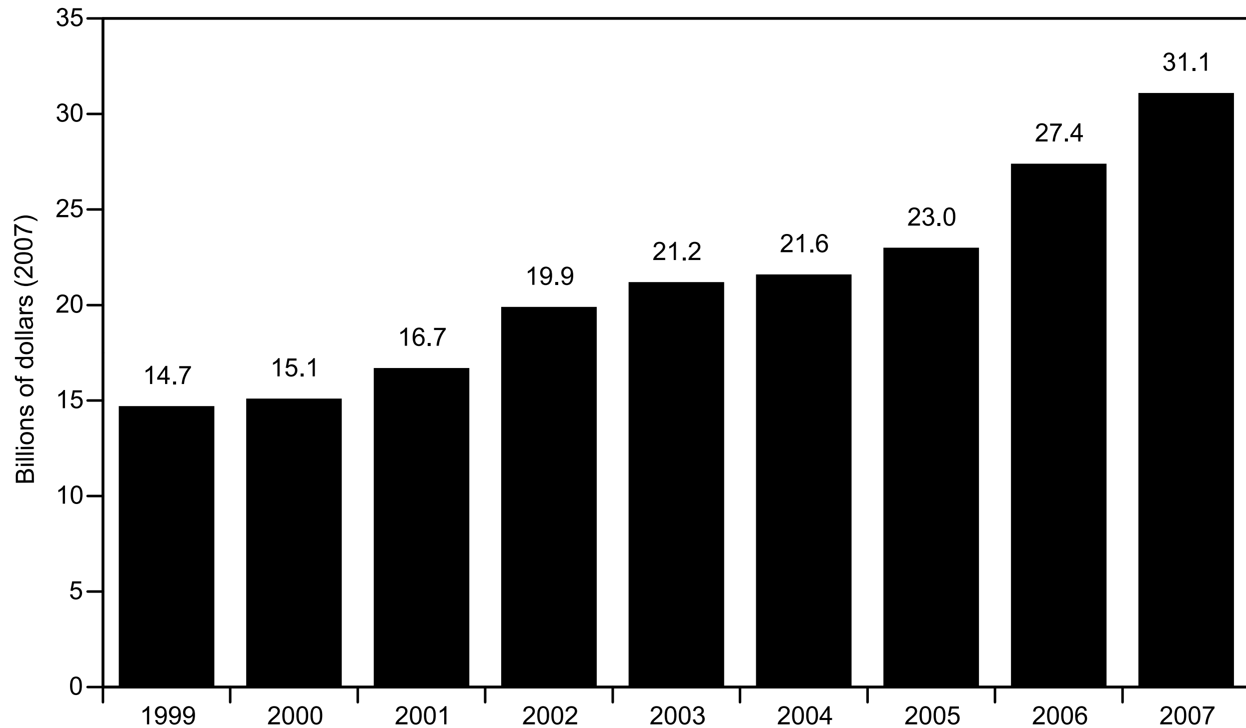
Note: PPS (prospective payment system). Hospital occupancy rate is measured as total inpatient days as a percent of total available bed days in the hospital over the reporting period. Bed days available are based on beds that are set up and staffed for inpatient service (i.e., the units are open and operating), but the beds may not be staffed for a full patient load in each unit on any given day. Hospitals' group designations for the entire 1998–2007 period are based on their status at the end of 2007.

Source: MedPAC analysis of data from the American Hospital Association Annual Survey of Hospitals.

- Hospitals' occupancy rates have been rising, with the aggregate occupancy rate climbing from 59 percent in 1998 to 65 percent in 2007.

- Occupancy rates are higher in urban than in rural hospitals; in 2007, occupancy rates stood at 68 percent for urban hospitals and 51 percent for rural hospitals, a 17 percentage point difference.

Chart 7-7. Nonfederal hospital construction spending, 1999–2007

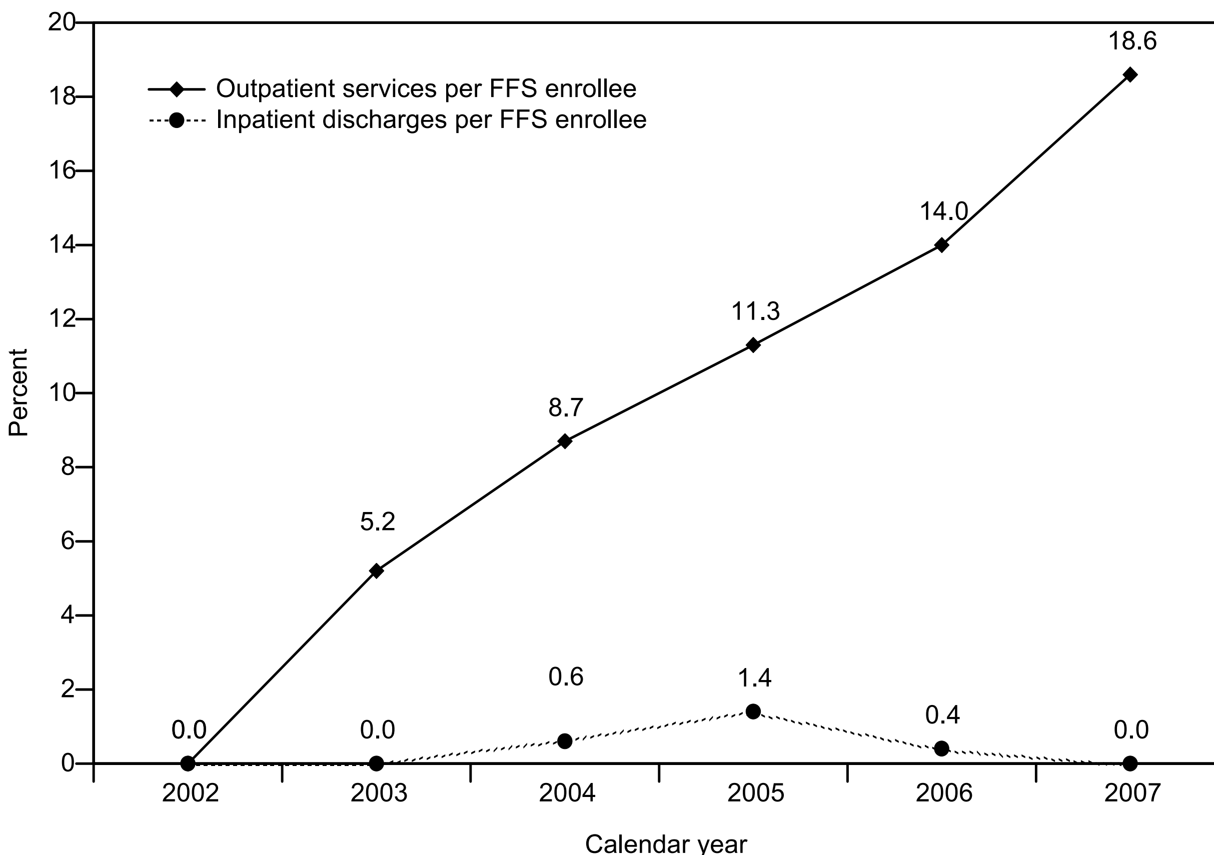


Note: Spending is for nonfederal hospital construction. Data for 2007 is revised by Census Bureau in May 2008. Data are inflated to 2007 dollars using the McGraw-Hill construction cost index.

Source: Census Bureau. http://www.census.gov/const/www/c30index.html. May 2008.

- Hospital construction has increased substantially since 1999, expanding almost 35 percent (in real terms) from 2005 to 2007 to $31 billion, and more than doubling since 2000.

Chart 7-8. Cumulative change in Medicare outpatient services and inpatient discharges per FFS beneficiary, 2002–2007



Note: FFS (fee-for-service). Data are for short-term general and surgical hospitals, including critical access and children's hospitals.

Source: MedPAC analysis of MedPAR and hospital outpatient claims data from CMS.

- From 2002 to 2007 Medicare inpatient discharge volume per FFS beneficiary has remained relatively flat, in part due to shifts of patients to outpatient setting.
- From 2002 to 2007, the number of outpatient services per FFS beneficiary increased nearly 19 percent.

Chart 7-9. Medicare inpatient payments, by source and hospital group, 2007

Hospital group	Percent of total payments					Total payments (millions)
	Base	IME	DSH	Outlier	Additional rural hospital*	
All hospitals	82.3%	4.8%	8.8%	3.6%	0.5%	$105,758
Urban	81.6	5.3	9.1	3.8	0.2	94,370
Rural	88.2	0.7	5.8	1.6	3.7	11,388
Large urban	79.8	6.5	9.7	4.1	0.0	53,828
Other urban	83.9	3.8	8.4	3.5	0.4	40,542
Rural referral	89.5	1.0	7.2	2.3	0.0	3,425
Sole community	86.5	0.9	4.1	1.2	7.3	4,795
Medicare dependent	86.6	0.0	6.8	0.8	5.8	1,171
Other rural <50 beds	91.8	0.1	7.2	0.9	0.0	311
Other rural ≥50 beds	91.0	0.4	6.9	1.7	0.0	1,686
Voluntary	82.9	5.2	7.9	3.5	0.6	77,104
Proprietary	84.8	1.4	10.4	3.0	0.4	15,209
Government	76.1	6.7	12.1	4.5	0.7	13,445
Major teaching	67.1	15.8	11.9	5.1	0.1	23,839
Other teaching	84.3	3.6	8.5	3.4	0.3	37,849
Nonteaching	88.8	0.0	7.4	2.8	1.0	44,069

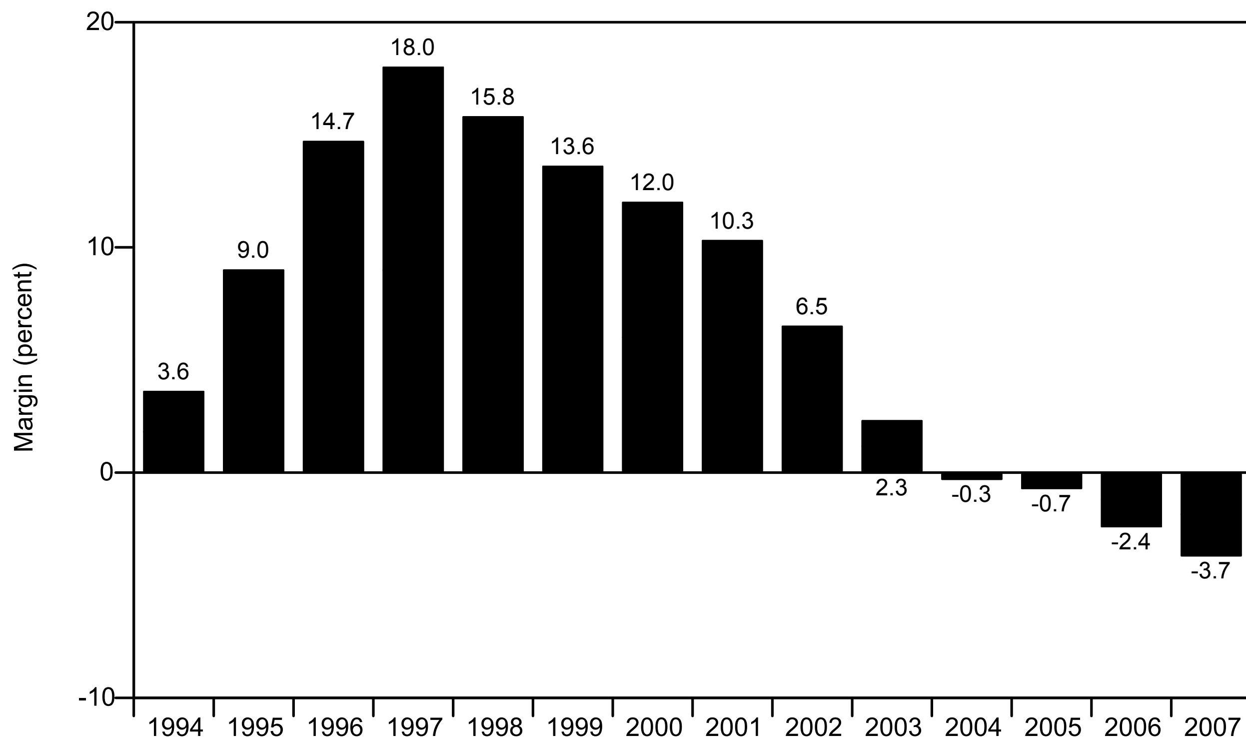
Note: IME (indirect medical education), DSH (disproportionate share). Analysis includes all hospitals covered by Medicare's acute inpatient prospective payment system (PPS). Includes both operating and capital payments but excludes direct graduate medical education payments. Simulated payments reflect 2007 payment rules applied to actual number of cases in 2007. Medicare fee-for-service inpatient payments grew only slightly from 2006 to 2007 due to enrollment shifting from fee-for-service to Medicare Advantage (MA). Due to changes in MA enrollment and in our reporting methodology, this year's table is not exactly comparable to last year's table.

*Payments received by sole community and Medicare-dependent hospitals beyond what would have been received under PPS. A few sole community hospitals are located in urban areas.

Source: MedPAC analysis of claims and impact file data from CMS.

- Medicare payments in 2007 to hospitals covered by the acute inpatient prospective payment system totaled almost $106 billion. About $94 billion (89 percent) was paid to hospitals located in urban areas and $11.4 billion went to rural hospitals. This figure does not reflect $2.6 billion in payments to critical access hospitals for inpatient care.
- Special payments—which include indirect medical education, disproportionate share, and outlier payments, as well as additional payments to rural hospitals through the sole community and Medicare-dependent programs—account for 17.7 percent of all inpatient payments. This proportion is higher for urban (18.4 percent) than for rural hospitals (11.8 percent).
- From 2006 to 2007, disproportionate share payments increased as a share of total inpatient payments across nearly all hospital groups, while indirect medical education decreased across nearly all hospital groups. Both changes are the result of specific policy changes implemented for fiscal year 2007.
- Outlier payments accounted for 3.6 percent of total inpatient payments in 2007. The legislative mandate for the level of outlier payments uses a different measure displaying outlier payments as a ratio of outlier payments to base payments plus outlier payments. Measured in this way, CMS's outlier share ratio was 4.6 percent in 2007, near to their annual goal of 5.1 percent.

Chart 7-10. Medicare acute inpatient PPS margin, 1994–2007



Note: PPS (prospective payment system). A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs and exclude critical access hospitals. Medicare acute inpatient margin includes services covered by the acute care inpatient PPS.

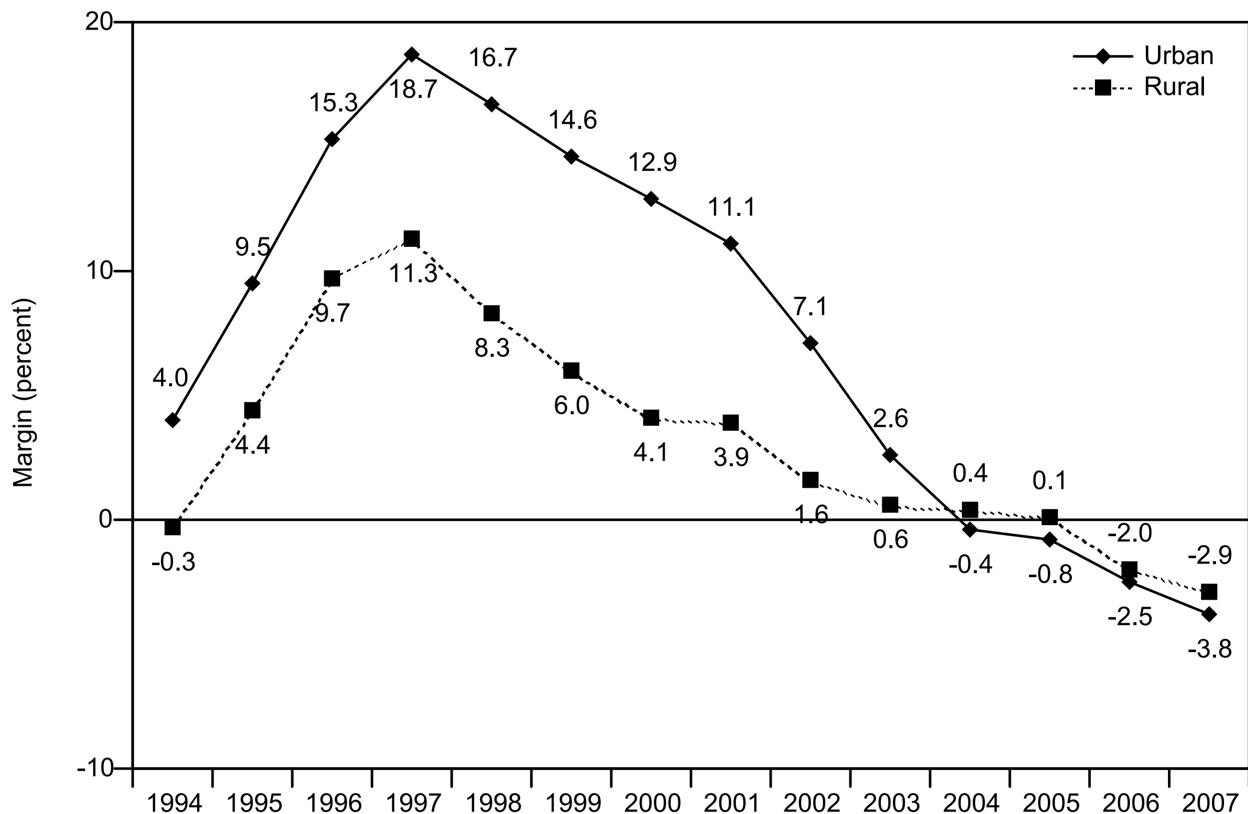
Source: MedPAC analysis of Medicare cost report data (August 2008) from CMS.

- Medicare's acute inpatient margin reflects payments and costs for services covered by Medicare's inpatient hospital prospective payment system (PPS). The inpatient margin may be influenced by how hospitals allocate overhead costs across service lines. Only by combining data for all major services can we estimate Medicare costs without the potential influence of how overhead costs are allocated (see Chart 7-12).

- The Medicare inpatient margin reached a record high of 18.0 percent in 1997. After implementation of the Balanced Budget Act of 1997, however, inpatient margins fell. In 2007, the margin was –3.7 percent, the lowest level since the beginning of the inpatient PPS.

- Medicare inpatient margins vary widely. In 2007, one-quarter of hospitals had Medicare inpatient margins that were 7.8 percent or higher, and another quarter had margins that were –18.2 percent or lower. This amounts to a 26 percentage point difference in performance between the top and bottom quartiles in 2007. Forty percent of hospitals had positive inpatient Medicare margins in 2007.

Chart 7-11. Medicare acute inpatient PPS margin, by urban and rural location, 1994–2007



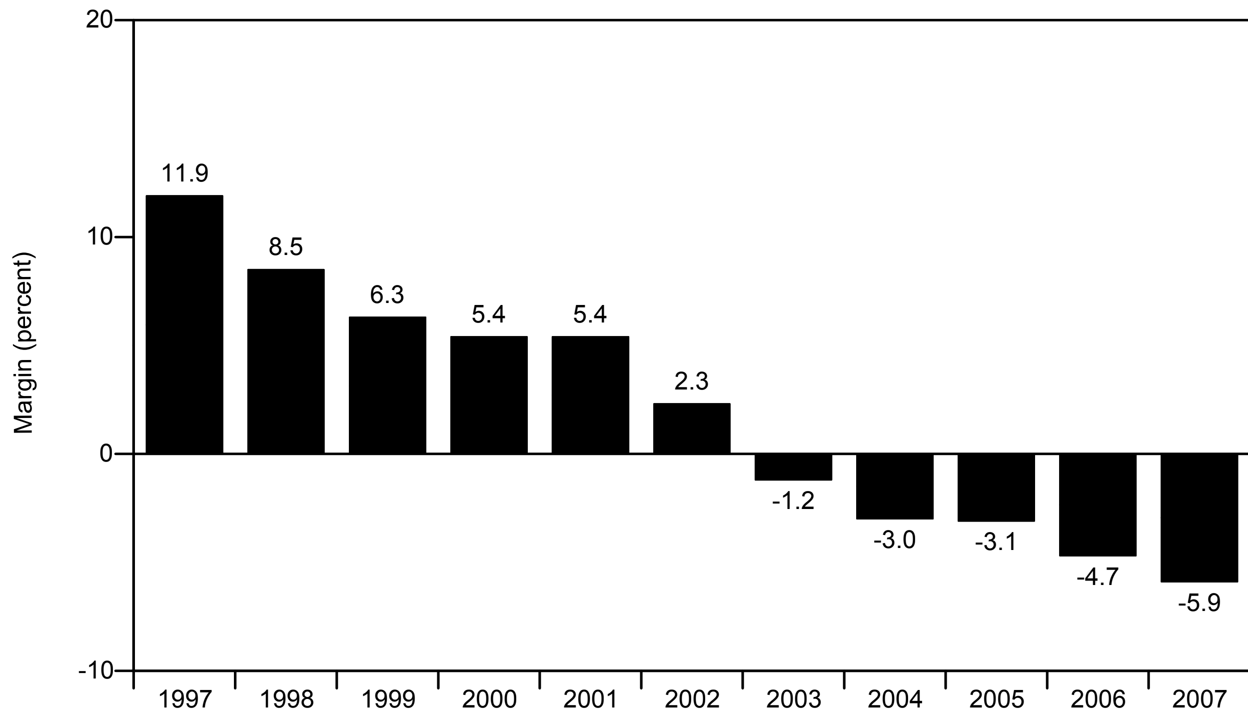
Note: PPS (prospective payment system). A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs and exclude critical access hospitals. Medicare acute inpatient margin includes services covered by the acute care inpatient PPS.

Source: MedPAC analysis of Medicare cost report data (August 2008) from CMS.

- Urban hospitals historically had much higher Medicare inpatient margins than rural hospitals, but this difference narrowed earlier in this decade and today urban hospital margins are lower than rural hospitals.

- The gap between urban and rural hospitals' inpatient margins grew between 1994 and 2000. One factor in this divergence in this period is that urban hospitals had greater success in controlling cost growth, at least partly in response to pressures from managed care. From 2001 through 2004, the difference narrowed and from 2004 to 2007 rural hospitals' inpatient margins were slightly higher than those of urban hospitals. This change is the result of payment policies targeted at raising rural hospital payments, and growth in the number of critical access hospitals, which removed many rural hospitals with low margins from the prospective payment system.

Chart 7-12. Overall Medicare margin, 1997–2007



Note: A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs and exclude critical access hospitals. Overall Medicare margins cover the costs and payments of acute inpatient, outpatient, inpatient psychiatric and rehabilitation unit, skilled nursing facility, and home health services, as well as graduate medical education and bad debts. Data on overall Medicare margins before 1997 are unavailable.

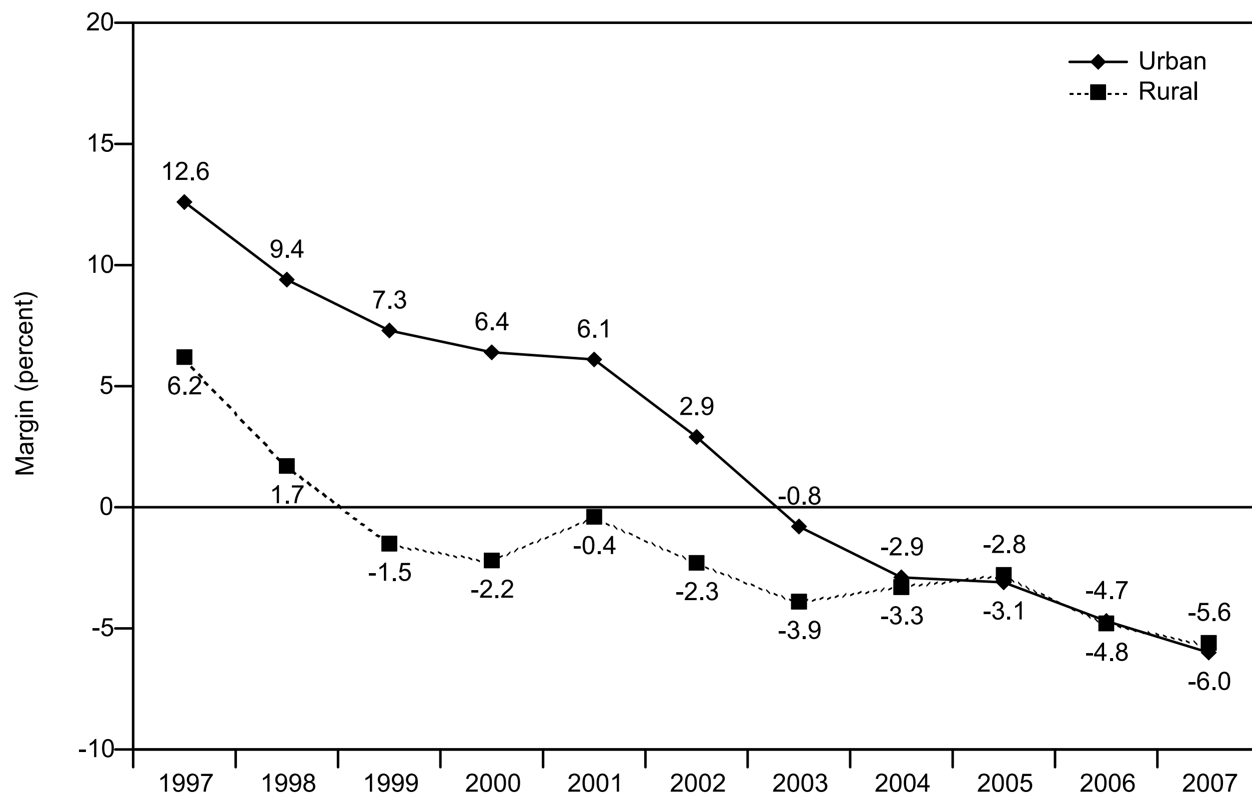
Source: MedPAC analysis of Medicare cost report data (August 2008) from CMS.

- The overall Medicare margin incorporates payments and costs for acute inpatient, outpatient, skilled nursing, home health care, and inpatient psychiatric and rehabilitative services, as well as direct graduate medical education and bad debts. The overall margin is available only since 1997, but it follows a trend similar to that of the inpatient margin.

- The overall Medicare margin in 1997 was 11.9 percent. In fiscal year 2007, it was –5.9 percent.

- In 2007, one-quarter of hospitals had overall Medicare margins of 3.8 percent or higher, and another quarter had margins of –17.9 percent or lower. Between 1997 and 2007, the difference in performance between the top and bottom quartile widened from 14 percent to nearly 22 percent. About 34 percent of hospitals had positive overall Medicare margins in 2007, accounting for 36 percent of Medicare inpatient discharges.

Chart 7-13. Overall Medicare margin, by urban and rural location, 1997–2007



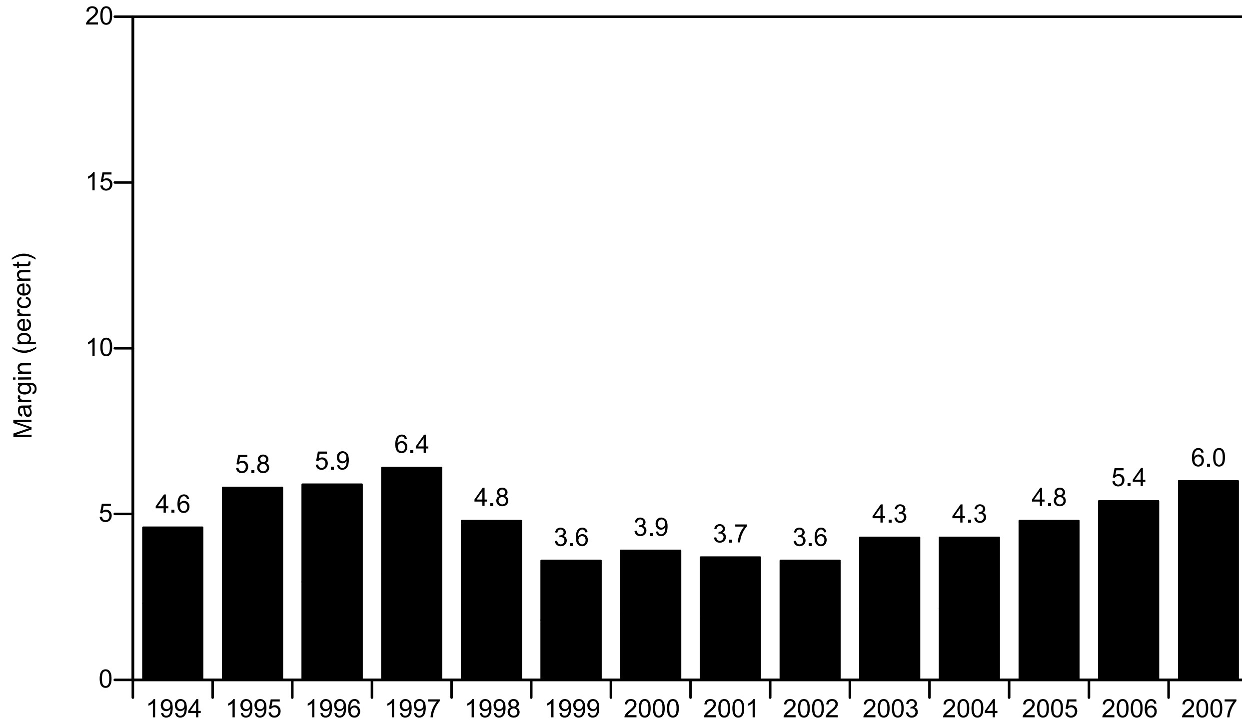
Note: A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs and exclude critical access hospitals. Overall Medicare margins cover the costs and payments of acute hospital inpatient, outpatient, inpatient psychiatric and rehabilitation unit, skilled nursing facility, and home health services, as well as direct graduate medical education and bad debts. Data on overall Medicare margins before 1997 are unavailable.

Source: MedPAC analysis of Medicare cost report data (August 2008) from CMS.

- As with inpatient margins, overall Medicare margins historically were higher for urban hospitals than for rural hospitals, but since 2004 overall Medicare margins for urban and rural hospitals have been similar, with rural hospitals having slightly higher margins in 2007.

- The difference in margins between the two groups grew between 1997 and 2000 but has since narrowed, with rural hospital margins similar to those of urban hospitals in each of the past four years. In 1997, the overall margin for urban hospitals was 12.6 percent, compared with 6.2 percent for rural hospitals. In 2007, the overall margin for urban hospitals was –6.0 percent, compared with –5.6 percent for rural hospitals. Policy changes made in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 targeted to rural hospitals helped to narrow the difference in overall Medicare margins between urban and rural hospitals.

Chart 7-14. Hospital total margin, 1994–2007

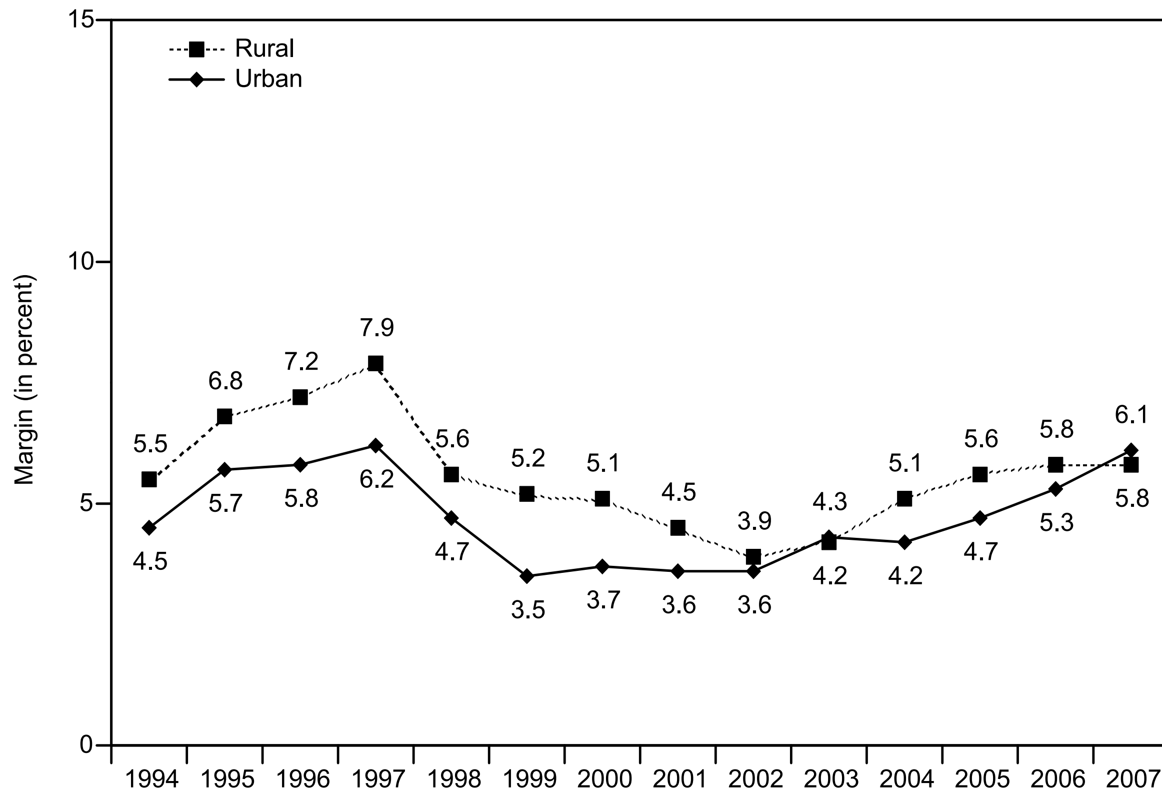


Note: A margin is calculated as revenue minus costs, divided by revenue. Total margin includes all patient care services funded by all payers, plus nonpatient revenue. Analysis excludes critical access hospitals.

Source: MedPAC analysis of Medicare cost report data (August 2008) from CMS.

- The total hospital margin for all payers—Medicare, Medicaid, other government and private payers—reflects the relationship of all hospital revenues to all hospital costs, including inpatient, outpatient, post-acute, and nonpatient services.
- The total hospital margin peaked in 1997 at 6.4 percent, before declining to under 4 percent in the 1999 to 2002 period. In 2007, the total margin climbed for the third year in a row to 6.0 percent, its highest level in 10 years. Total margins rose despite declines in overall Medicare margins over this same period.
- The decline in total margins from 1997 to 1999 reflected a drop in both Medicare and private payer margins. Medicare overall margins from 1997 through 2001 were higher than the corresponding total margins.
- In 2007, 75 percent of hospitals had positive total margins.
- The total margin varies much less than the Medicare inpatient or overall Medicare margin. In 2007, one-quarter of prospective payment system hospitals had total margins that were 9.2 percent or higher, while another quarter had margins that were –0.1 percent or lower, a spread of just 9 percentage points compared to a 22 percentage point spread for overall Medicare margins and a 26 percentage point spread for Medicare inpatient margins.

Chart 7-15. Hospital total margin, by urban and rural location, 1994–2007

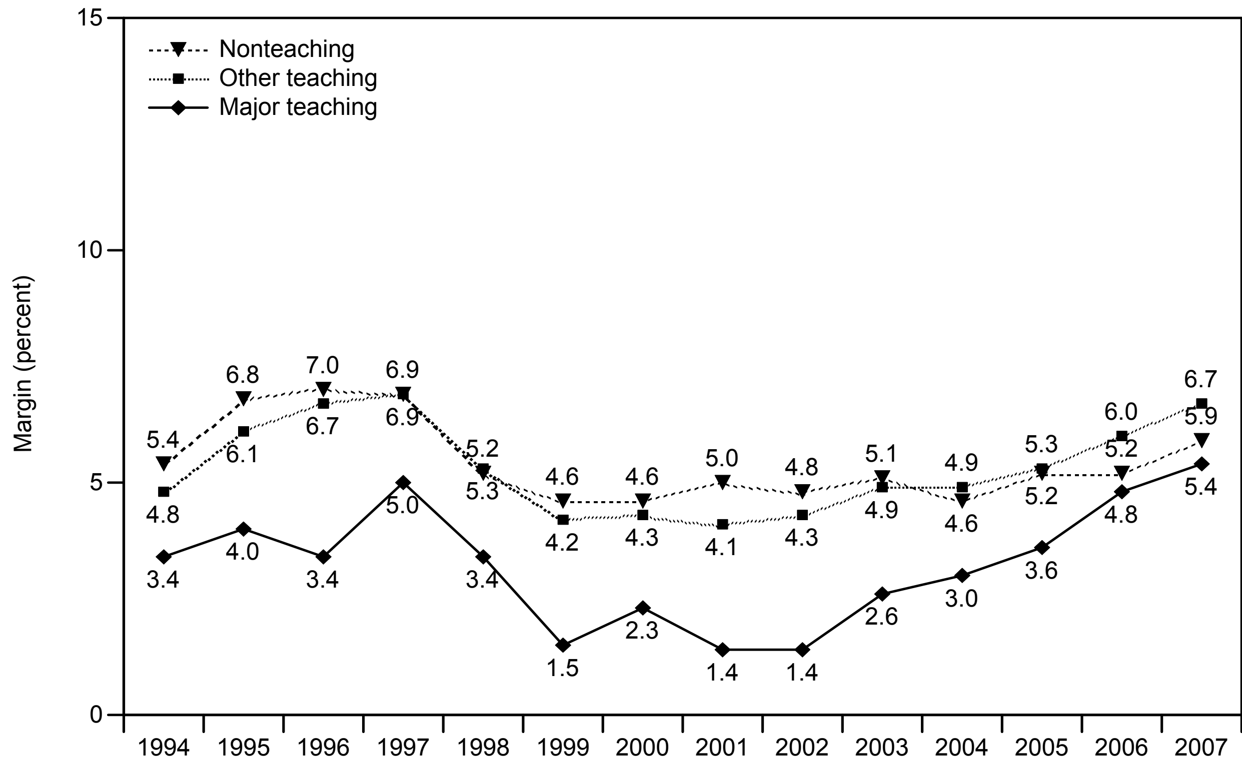


Note: A margin is calculated as revenue minus costs, divided by revenue. Total margin includes all patient care services funded by all payers, plus nonpatient revenue. Analysis excludes critical access hospitals.

Source: MedPAC analysis of Medicare cost report data (August 2007) from CMS.

- In 2007, for only the second year in the last 14 years urban hospitals had higher total (all payer) margins than rural hospitals.
- In 2007, total margins were 6.1 percent for urban and 5.8 percent for rural hospitals. The 6.1 percent total margin for urban hospitals is just shy of the highest margin they have achieved (6.2 percent in 1997) in the last 14 years.

Chart 7-16. Hospital total margin, by teaching status, 1994–2007



Note: Major teaching hospitals are defined by a ratio of interns and residents to beds of 0.25 or greater, while other teaching hospitals have a ratio of greater than zero and less than 0.25. A margin is calculated as revenue minus costs, divided by revenue. Total margin includes all patient care services funded by all payers, plus nonpatient revenue. Analysis excludes critical access hospitals.

Source: MedPAC analysis of Medicare cost report data (August 2008) from CMS.

- The pattern of total margins by teaching status is the opposite of the pattern for the Medicare inpatient and overall Medicare margins. The total margins of major teaching hospitals have consistently been lower than those for other teaching and nonteaching hospitals. In 2007, the total margin of nonteaching hospitals stood at 5.9 percent compared with 5.4 percent for major teaching hospitals.

- In 2007, major teaching hospitals' total (all payer) margins reached their highest level in more than two decades, and increased for the fifth consecutive year.

- The difference in margins between major teaching and nonteaching hospitals remained narrow for the second consecutive year, at 0.5 percentage points. Other teaching hospitals had the highest margin of any group and reached their highest level in a decade in 2007.

Chart 7-17. Medicare margins by teaching and disproportionate share status, 2007

Hospital group	Share of hospitals	Share of inpatient payments	Medicare inpatient margin	Overall Medicare margin
All hospitals	100%	100%	–3.7%	–5.9%
Major teaching	8	23	7.4	1.1
Other teaching	22	36	–4.9	–6.4
Nonteaching	70	42	–8.9	–9.3
Both IME and DSH	26	51	1.6	–2.3
IME only	5	7	–11.3	–11.3
DSH only	53	31	–5.9	–7.1
Neither IME nor DSH	17	10	–17.8	–16.0

Note: IME (indirect medical education), DSH (disproportionate share).

Source: MedPAC analysis of 2007 Medicare cost report data from CMS.

- Major teaching hospitals have the highest Medicare inpatient and overall Medicare margins. Their better financial performance is due largely to the additional payments they receive from the indirect medical education (IME) and disproportionate share (DSH) adjustments.

- Hospitals that receive neither IME nor DSH payments have the lowest Medicare margins. In 2007, the Medicare inpatient margins of these hospitals were more than 25 percentage points below those of major teaching hospitals and overall Medicare margins were more than 17 percentage points lower.

Chart 7-18. Financial pressure leads to lower costs

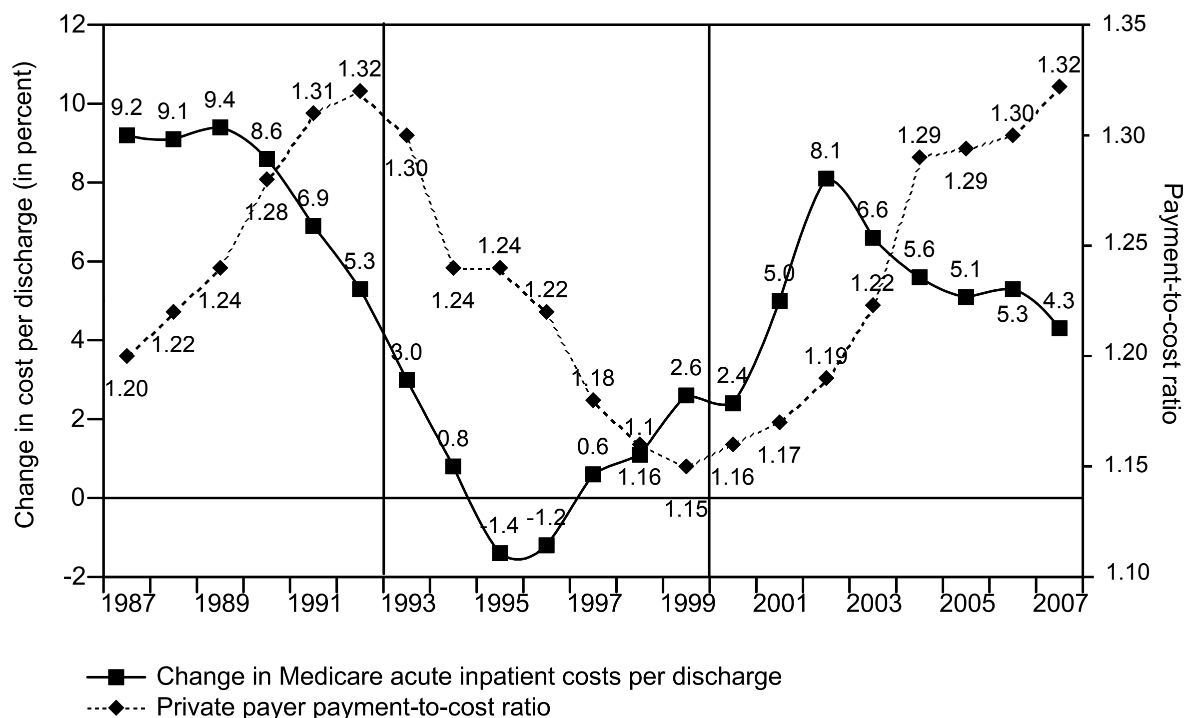
	Level of financial pressure 2002 to 2007		
	High pressure (non-Medicare margin <1%)	Medium pressure	Low pressure (non-Medicare margins >5%)
Number of hospitals	837	413	1,700
Financial characteristics, 2007			
Non-Medicare margin (private, Medicaid, uninsured)	–2.4%	4.5%	13.5%
Standardized cost per discharge			
Median of for profit and nonprofit	$5,800*	$6,000	$6,400
Nonprofit hospital	5,700*	6,000	6,500
For-profit hospital	5,900*	6,000	6,000
Annual growth in cost per discharge 2004 to 2007	4.8%*	4.9%	5.0%
Overall 2007 Medicare margin	4.2%	–3.8%	–11.7%
Patient characteristics (medians)			
Total hospital discharges in 2007	5,424*	7,478	7,312
Medicare share of inpatient days	45%	44%	46%
Medicaid share of inpatient days	13%*	12%	10%
Medicare case mix index	1.27*	1.33	1.38

Note: Standardized costs are adjusted for hospital case mix, wage index, outliers, transfer cases, interest expense, and the effect of teaching and low-income Medicare patients on hospital costs. The sample includes all hospitals that had complete cost reports on file with CMS by August 31, 2008.
*Indicates significantly different from low-pressure hospitals using $p = 0.01$ and a Wilcoxon rank test. A Wilcoxon rank test is used to limit the influence of the few hospitals that report very large costs per discharge.

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

- Higher financial pressure tends to lead to lower cost growth and lower costs per discharge. Hospitals with lower volume, lower case mix, and higher Medicaid charges are more likely to be under financial pressure.

Chart 7-19. Change in Medicare hospital inpatient costs per discharge and private payer payment-to-cost ratio, 1987–2007



Note: Data are for community hospitals and cover all hospital services. Imputed values were used for missing data (about one-third of observations). Most Medicare and Medicaid managed care patients are included in this private insurer category.

Source: MedPAC analysis of Medicare Cost Report files from CMS and CMS's rules for the acute inpatient prospective payment system and American Hospital Association Annual Survey of Hospitals.

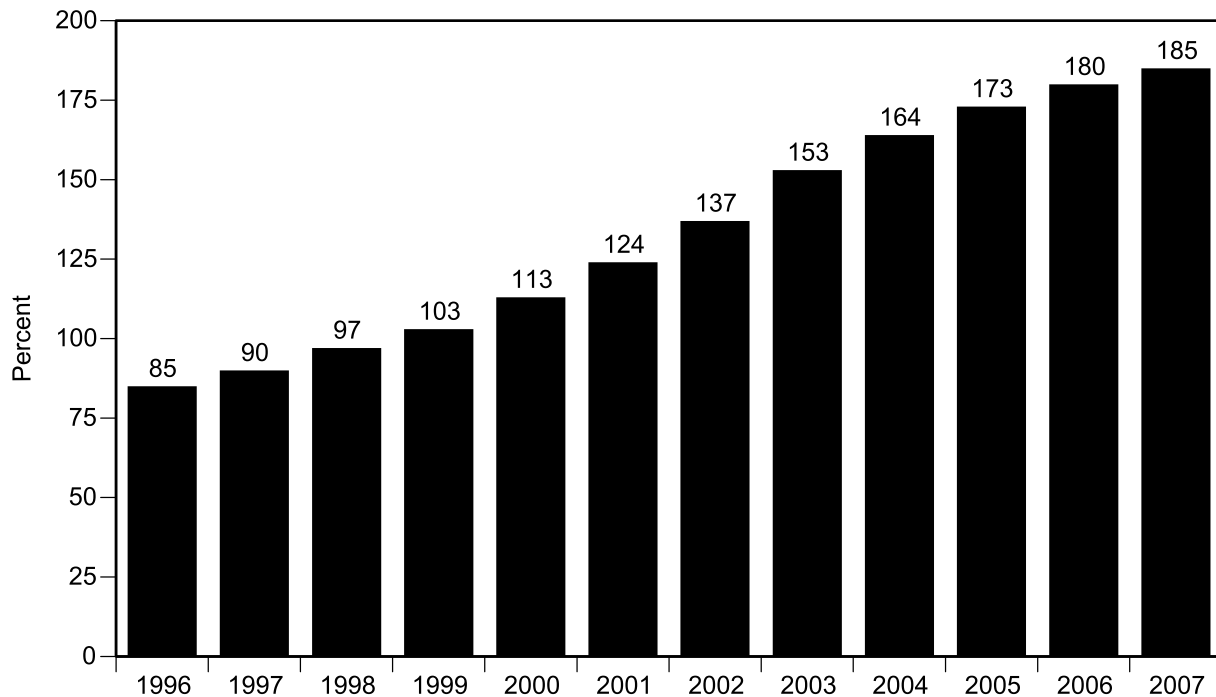
- The pattern of growth in Medicare costs per discharge makes it clear that hospitals have responded strongly to the incentives posed by the rise and fall of financial pressure from private payers over three periods.

- During the first period, 1987 through 1992, private payers' payments rose much faster than the cost of treating their patients (seen in the chart as a steep increase in the payment-to-cost ratio). This suggests an almost complete lack of pressure from private payers. Medicare costs per discharge rose 8.3 percent per year through these years, more than 3 percentage points a year above the increase in Medicare's market basket index.

- As HMOs and other private insurers exerted more pressure during the second period, 1993 through 1999, the private payer payment-to-cost ratio dropped substantially. The rate of cost growth plummeted to only 0.8 percent per year, which was more than 2 percentage points below the average increase in the market basket.

- As pressure from private payers waned after 1999, the private payer payment-to-cost ratio rose sharply, and hospital cost growth exceeded growth in the market basket by 2 percentage points a year. In 2005 through 2007 the growth in private payer profit margins slowed, and in 2007 cost growth more closely matches market basket.

Chart 7-20. Markup of charges over costs for all patient care services, 1996–2007

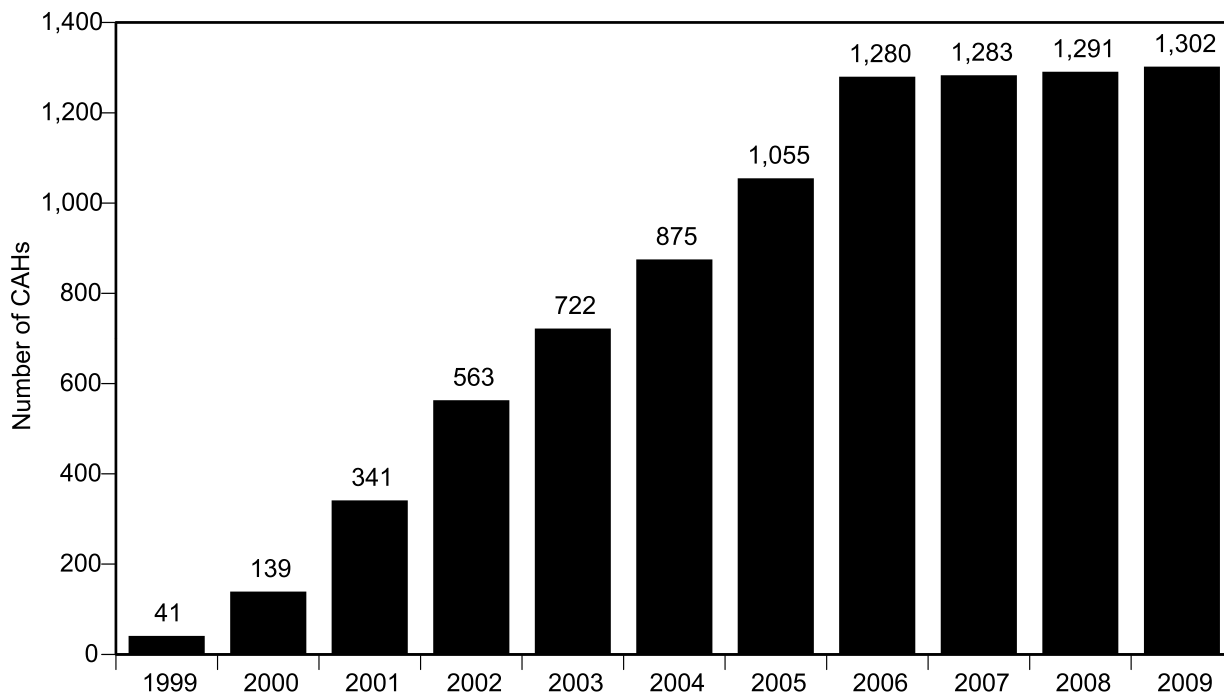


Note: Analysis includes all community hospitals.

Source: American Hospital Association Annual Survey of Hospitals.

- The markup of charges over costs rose from about 85 percent in 1996 to about 185 percent in 2007. Charges are now almost three times costs.
- Since few patients pay full charges, rapid charge growth may have little impact on hospital financial performance. However, this growth may significantly impact uninsured patients, who may pay full charges. More rapid growth in charges than costs may reflect hospital attempts to maximize revenue from private payers (who often structure their payments as a discount off charges). The unusually large increases in charges in 2002 and 2003 may have resulted from some hospitals manipulating Medicare outlier payments. Toward the end of fiscal year 2003, Medicare revised its outlier policy in an attempt to curb hospitals' opportunity to increase their outlier payments through excessive increases in their charges.

Chart 7-21. Number of critical access hospitals, 1999–2009

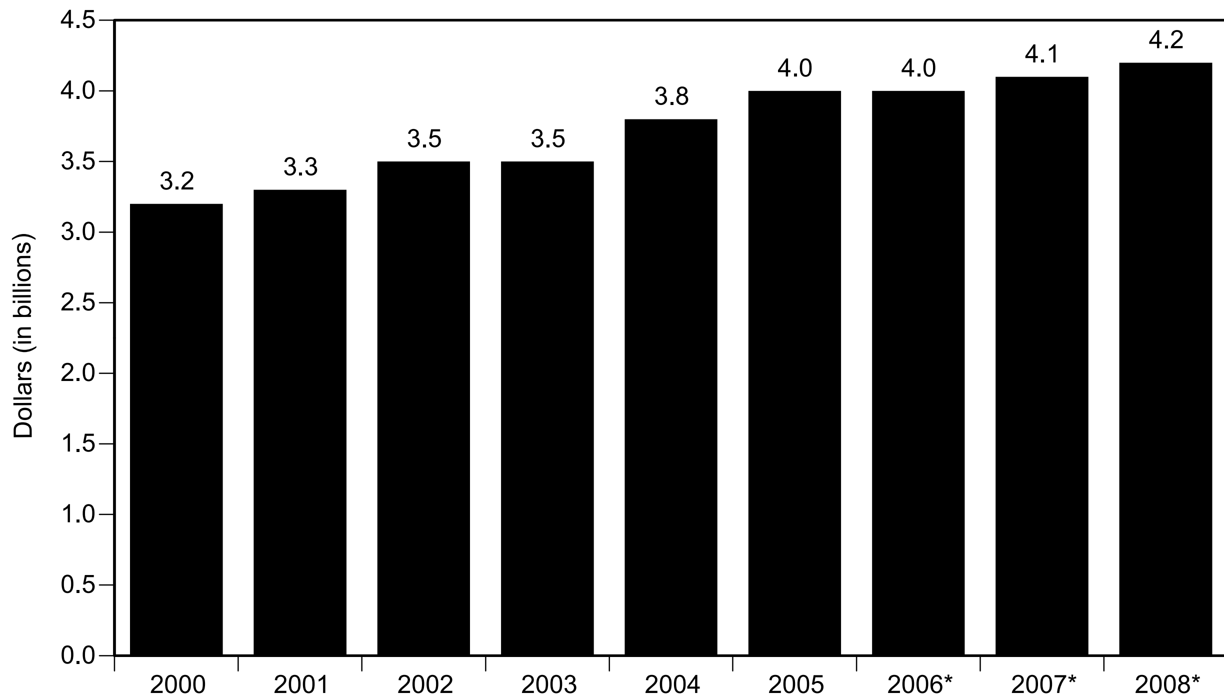


Note: CAH (critical access hospital).

Source: The Medicare Rural Hospital Flexibility Program and CMS.

- The number of critical access hospitals (CAHs) grew steadily from 1999 through 2006, but has since leveled off.
- The increase in CAHs is in part due to a series of legislative changes that made conversion to CAH status easier and expanded the services that qualify for cost-based reimbursement. Currently, CAHs are paid their Medicare costs plus 1 percent for inpatient services, outpatient services (including laboratory and therapy services), and post-acute services in swing beds.
- Prior to 2006, a hospital could convert to CAH status if it was (1) 35 miles by primary road or 15 miles by secondary road from the nearest hospital, or (2) their state waived the distance requirement by declaring the hospital a "necessary provider." Starting in 2006, states could no longer waive the distance requirement. While most existing CAHs fail the distance test, they are grandfathered into the program. Among small rural hospitals that have not converted, most would not meet the distance requirement. Therefore, we expect the number of CAHs to remain fairly constant.

Chart 7-22. Medicare payments to inpatient psychiatric facilities (in billions), 2000–2008



Note: *Estimated spending. The rate of growth in spending was slowed somewhat from 2006 to 2008 by large increases in the number of Medicare Advantage enrollees, who are not included in these aggregate totals.

Source: CMS, Office of the Actuary.

- The inpatient psychiatric facility prospective payment system started January 1, 2005.
- Medicare program spending for beneficiaries' care in inpatient psychiatric facilities grew an estimated 3.3 percent per year between 2000 and 2008.
- Inpatient psychiatric care is also furnished in scatter beds in acute care hospitals and paid under the acute care inpatient prospective payment system. Medicare payments for these services are not included here.

Chart 7-23. Inpatient psychiatric facilities, 2000–2008

	2000	2001	2002	2003	2004	2005	2006	2007	2008
Freestanding hospitals	491	477	473	466	463	478	478	488	493
Hospital-based units									
PPS hospital units	1,862	1,838	1,815	1,795	1,743	1,699	1,668	1,650	1,635
CAH units	N/A	N/A	N/A	N/A	34	78	83	85	86
Total	2,353	2,315	2,288	2,261	2,240	2,255	2,229	2,221	2,214

Note: PPS (prospective payment system), CAH (critical access hospital), N/A (not available).

Source: CASPER reports from CMS, as of December each year.

- Inpatient psychiatric facilities—both freestanding and hospital-based facilities—provide acute hospital care to beneficiaries with mental illnesses and alcohol- or drug-related problems.

- In recent years, the number of critical access hospitals with Medicare-certified psychiatric units has grown substantially because of new authority granted in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. After declining from 2000 to 2004, the number of freestanding psychiatric hospitals has grown as well. The number of psychiatric units in hospitals covered by the acute inpatient prospective payment system has declined, however. Overall, the total number of certified psychiatric facilities has fallen 5.9 percent since 2000.

Chart 7-24. One diagnosis accounted for almost three-quarters of IPF cases in 2007

Diagnoses	Discharges	Percentage
Psychosis	331,671	72.8%
Degenerative nervous system disorders	37,533	8.2
Organic disturbances & mental retardation	26,221	5.8
Depressive neurosis	16,010	3.5
Alcohol/drug use without rehabilitation	11,838	2.6
Alcohol/drug use with comorbid conditions	10,394	2.3
Neurosis except depressive	5,312	1.2
Acute adjustment reaction	3,406	0.7
Disorders of personality	2,239	0.5
Childhood disorders	1,924	0.4
Alcohol/drug use without comorbid conditions	1,635	0.4
Alcohol/drug use–leave AMA	1,068	0.2
Procedure with principal diagnosis of mental illness	740	0.2
Non-traumatic stupor & coma	450	0.1
Other mental disorders	366	0.1
Non-psychiatric diagnoses	4,573	1.0
Total	455,380	100.0

Note: IPF (inpatient psychiatric facility), AMA (against medical advice). Columns may not sum due to rounding.

Source: MedPAC analysis of MedPAR data from CMS.

- A majority of patients in inpatient psychiatric facilities (IPFs) receive the diagnosis of psychosis.
- Inpatient psychiatric care is also furnished in scatter beds in acute care hospitals. Patients with psychosis made up a smaller share of scatter bed cases in 2007.

Web links. Acute inpatient services

Short-term hospitals

- Chapter 2A of the MedPAC March 2009 Report to the Congress provides additional detailed information on hospital margins.

  http://www.medpac.gov/chapters/Mar09_Ch02a.pdf

- MedPAC provides basic information about the acute inpatient prospective payment system in its Payment Basics series.

  http://www.medpac.gov/documents/MedPAC_Payment_Basics_ 08_hospital.pdf

- MedPAC provides information on the outlier payment issue in Medicare Hospital Outlier Payment Policy.

  http://www.medpac.gov/publications/other_reports/outlier%20memo.pdf

- CMS provides information on the hospital market basket.

  http://www.cms.hhs.gov/MedicareProgramRatesStats/downloads/info.pdf

- CMS published the proposed acute inpatient PPS rule in the May 22, 2009 *Federal Register*.

  http://gpo.gov/fdsys/pkg/FR-2009-05-22/pdf/E9-10458.pdf

Inpatient psychiatric facilities

- MedPAC provides basic information about the inpatient psychiatric facility (IPF) prospective payment system in its Payment Basics series.

  http://www.medpac.gov/documents/MedPAC_Payment_Basics_08_psych.pdf

- CMS provides information on the inpatient psychiatric facility prospective payment system.

  http://www.cms.hhs.gov/InpatientPsychFacilPPS/

- CMS describes updates to the inpatient psychiatric facility prospective payment system for the rate year beginning July 1, 2009 in the May 1, 2009 *Federal Register.*

  http://edocket.access.gpo.gov/2009/pdf/E9-9962.pdf