

SECTION

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**Acute inpatient services**  
**General short-term hospitals**  
**Inpatient psychiatric facilities**

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**Chart 6-1. Urban IPPS hospitals accounted for under half of the 4,700 short-term acute care hospitals but about 80 percent of all-payer and Medicare FFS inpatient stays in 2018**

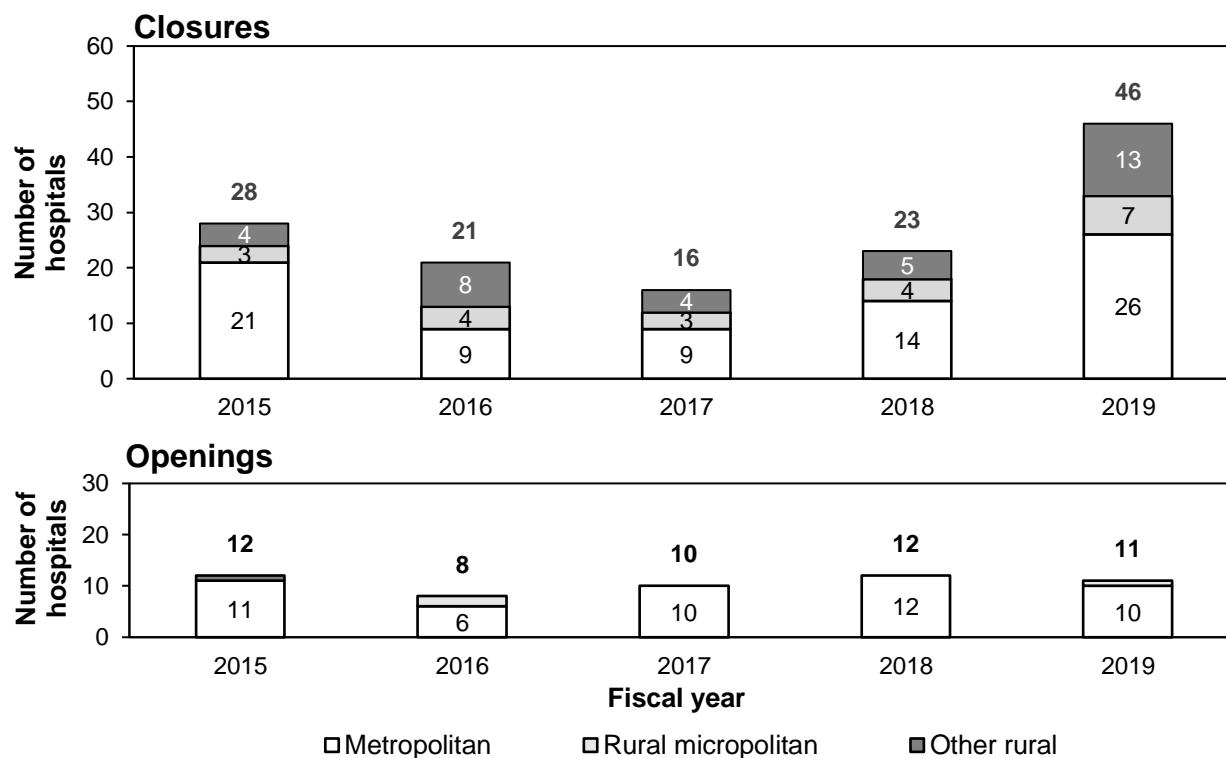
Hospital group	Hospitals		Inpatient stays			
	Number (in thousands)	Share of total	All payer		Medicare FFS	
			Number (in millions)	Share of total	Number (in millions)	Share of total
<b>All short-term acute</b>	<b>4.7</b>	<b>100</b>	<b>31.8</b>	<b>100</b>	<b>9.5</b>	<b>100</b>
IPPS	3.2	68	29.9	94	9.0	94
Metropolitan (urban)	2.1	45	26.3	83	7.6	80
Rural micropolitan	0.3	7	1.6	5	0.5	6
Other rural	0.7	16	2.1	7	0.9	9
For-profit	0.8	17	5	16	1.5	16
Nonprofit	1.9	40	20.9	66	6.4	67
Government	0.5	10	4.0	13	1.1	11
DSH	2.7	57	27.8	87	8.2	86
Non-DSH	0.5	11	2.2	7	0.8	8
Teaching	1.2	25	19.6	62	5.5	58
Nonteaching	2.0	43	10.4	33	3.5	37
Sole community	0.4	10	1.9	6	0.8	8
Medicare dependent	0.2	4	0.3	1	0.1	1
Neither	2.6	55	27.7	87	8.0	85
Critical access	1.3	29	0.6	2	0.3	3
Maryland	<0.1	1	0.6	2	0.2	2
Children's	<0.1	2	0.6	2	<0.1	<1
Cancer	<0.1	<1	0.1	0	<0.1	<1

Note: IPPS (inpatient prospective payment system), FFS (fee-for-service), DSH (disproportionate share hospital). Data are for short-term acute care hospitals in the U.S. (excluding territories) that had a cost report with a midpoint in fiscal year 2018. "Number of hospitals" is the number of Medicare provider numbers; a single provider number can represent multiple hospital locations. Metropolitan (urban) counties contain an urban cluster of 50,000 or more people, and rural micropolitan counties contain a cluster of 10,000 to 50,000 people. Components may not sum to totals due to rounding.

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

- In 2018, there were approximately 4,700 short-term acute care hospitals participating in the Medicare program, including 3,220 paid under the inpatient prospective payment system and 1,350 small, rural hospitals designated as critical access hospitals.
- Metropolitan IPPS hospitals accounted for 45 percent of short-term acute care hospitals but 83 percent of the 31.8 million all-payer inpatient stays and 80 percent of the 9.5 million Medicare FFS inpatient stays.

**Chart 6-2. The number of general, short-term acute care hospitals that ceased inpatient services substantially increased in 2019**

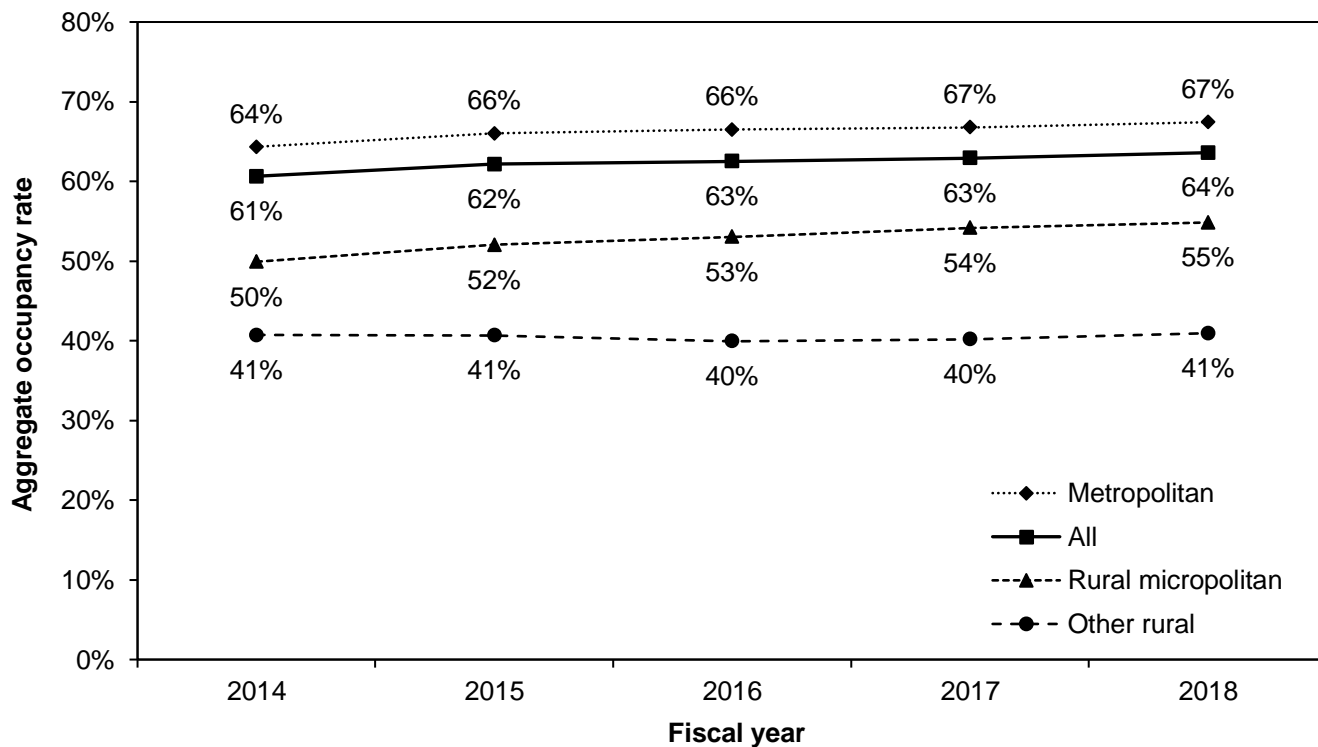


Note: "Closure" refers to a hospital location that ceased inpatient services, while "opening" refers to a new location for inpatient services. The chart does not include the relocation of inpatient services from one hospital to another under common ownership within 10 miles, nor does it include hospitals that both opened and closed within a 5-year time period. Data are for general short-term acute care hospitals in the U.S. paid under the inpatient prospective payment system, designated as critical access hospitals, or covered under the Maryland state waiver. Metropolitan (urban) counties contain an urban cluster of 50,000 or more people, and rural micropolitan counties contain a cluster of 10,000 to 50,000 people. The counts in this chart differ from those previously published for several reasons, including that this chart counts closures and openings based on fiscal year, uses an updated methodology, and is updated to remove hospitals previously counted as closures but that have since reopened.

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

- While hospital closures are still relatively rare events, there was a substantial increase in the number of hospitals that ceased inpatient services in fiscal year 2019, without a corresponding increase in openings.
- In 2019, 46 general short-term acute care hospitals participating in the Medicare program closed, and 11 hospitals opened. Among the 46 closures, 26 were in metropolitan counties, 7 were in rural micropolitan counties, and 13 were in other rural counties.
- The hospitals that closed in 2019 tended to be small (30 had 100 or fewer beds), had low inpatient occupancy rates (approximately 25 percent, on average), and had poor profitability (all-payer margin of -16 percent, on average, in the year before closure) (data not shown).
- Nearly all of the hospital openings from 2015 to 2019 were in metropolitan counties.

**Chart 6-3. Aggregate occupancy rate at short-term acute care hospitals has increased slightly, but remained much lower at rural hospitals, 2014–2018**

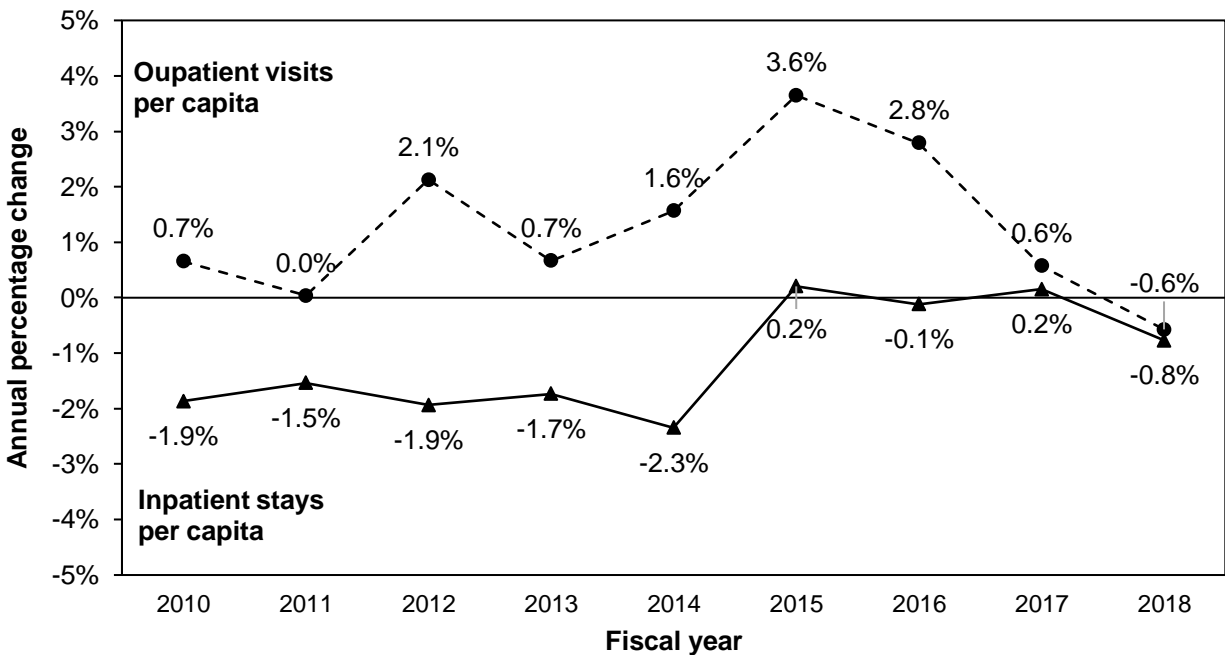


Note: Hospital occupancy rates are defined as total bed days (including swing bed days) and observation bed days used, minus nursery bed days used, divided by total bed days available. Data are for short-term acute care hospitals in the U.S. (excluding territories) that had a cost report with a midpoint in fiscal year 2018. 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 from CMS.

- The aggregate occupancy rate at short-term acute care hospitals increased slightly between 2014 and 2018, from 61 percent to 64 percent.
- Occupancy rates are generally higher for metropolitan hospitals than rural micropolitan or other rural hospitals. However, occupancy rates rose the fastest for rural micropolitan hospitals during this five-year period, with an average annual growth rate of 1.9 percent.
- Increasing occupancy in metropolitan and rural micropolitan areas in part reflects increasing volumes of inpatient days at these hospitals. In contrast, the total number of inpatient days in other rural areas declined, but the aggregate occupancy rate remained relatively steady because available inpatient bed days also declined due to closures and other reductions in beds (data not shown).

**Chart 6-4. Divergent trends in all-payer hospital outpatient visits and inpatient stays per capita narrowed in 2017 and 2018**

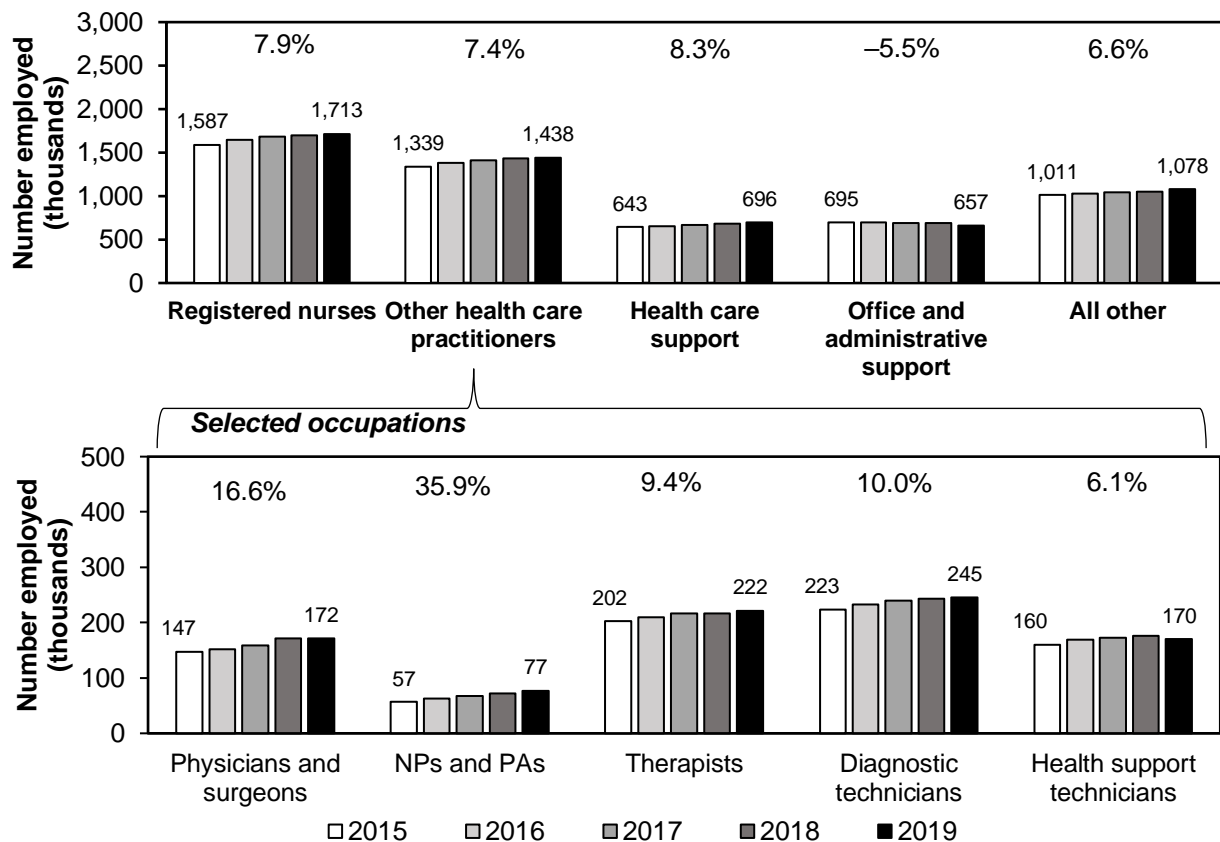


Note: “Outpatient visits” includes all clinic visits, referred visits, observation services, outpatient surgeries, and emergency department visits, regardless of the number of diagnostic and/or therapeutic treatments the patient received during the visit. Data are for community hospitals (nonfederal short-term general and specialty hospitals), estimated from those who responded to the American Hospital Association (AHA) survey. With the 2019 edition of Hospital Statistics, the AHA began using a new methodology to classify facilities as hospitals. As a result of the application of the new, broader hospital definition, the number of community hospitals in each year from 2013 to 2017 increased by approximately 400.

Source: MedPAC analysis of Hospital Statistics data from the American Hospital Association and CMS National Health Expenditure data.

- From 2010 to 2014, there were divergent trends in all-payer hospital outpatient visits and inpatient stays per capita, with growth in outpatient visits and declines in inpatient stays.
- Beginning in 2015, the divergent trends in all-payer outpatient and inpatient growth rates started to narrow, as inpatient stays per capita held relatively steady.
- Starting in 2017, the trends in all-payer outpatient visits and inpatient stays per capita were similar: both grew slightly in 2017 (0.6 percent and 0.2 percent, respectively) and decreased slightly in 2018 (–0.6 percent and –0.8 percent).

**Chart 6-5. Hospital employment growth from 2015 to 2019 was driven by an increase in health care practitioners**

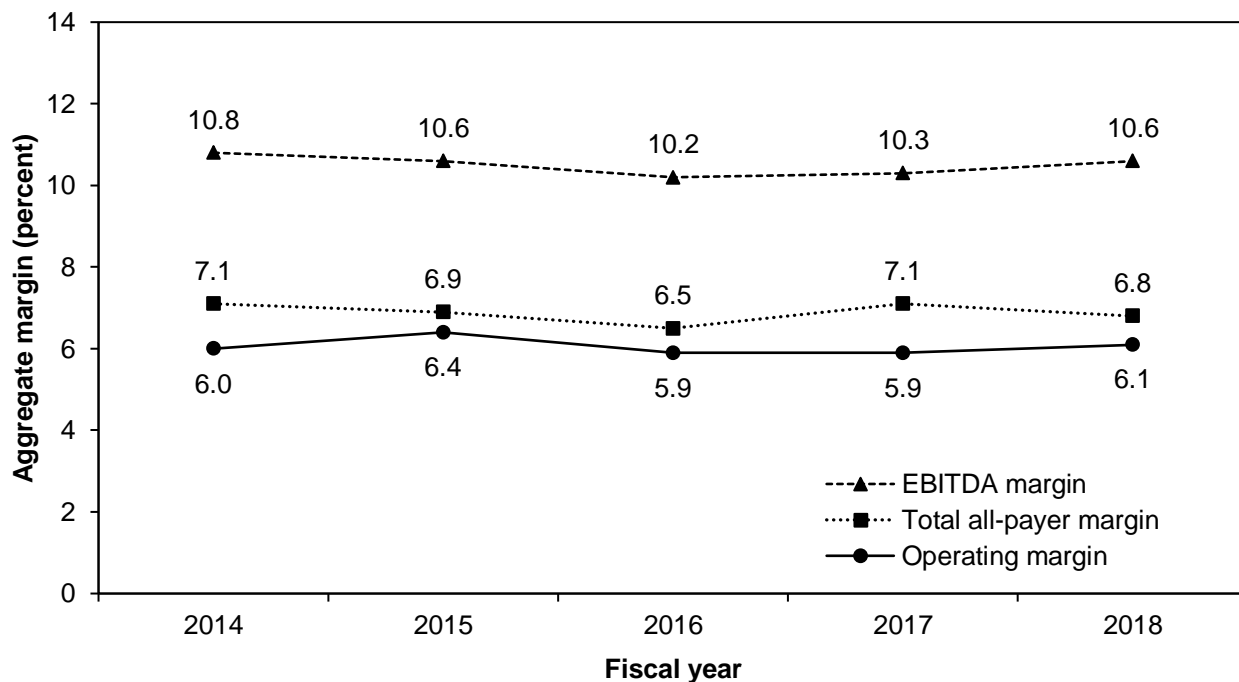


Note: NP (nurse practitioner), PA (physician assistant). Data are for general medical and surgical hospitals. The percentages shown at the top of each category are the cumulative percentage change from 2015 to 2019. Components of other health care practitioners in the bottom chart do not sum to all other health care practitioners in the top chart because only some subsets of practitioner occupations are shown.

Source: MedPAC analysis of Bureau of Labor Statistics, Current Employment Statistics data.

- The Bureau of Labor Statistics survey of employers indicates that general medical and surgical hospitals employed 5.6 million individuals in 2019. Of these, approximately 1.7 million (31 percent) were registered nurses and 1.4 million (26 percent) were other health care practitioners. The remaining 44 percent of hospital employees were in nonpractitioner occupational categories.
- From 2015 to 2019, the number of registered nurses increased 7.9 percent, similar to the rate of all other health care practitioners. However, within the group of other health care practitioners, several occupations grew rapidly. For example, while still a small share of all health care practitioners, the number of nurse practitioners and physician assistants employed by hospitals increased 35.9 percent.
- From 2015 to 2019, the number of hospital staff in several nonpractitioner occupations increased as well. For example, health care support staff (such as nursing assistants and orderlies) increased 8.3 percent.

**Chart 6-6. Short-term acute care hospitals' all-payer financial performance remained strong, 2014–2018**



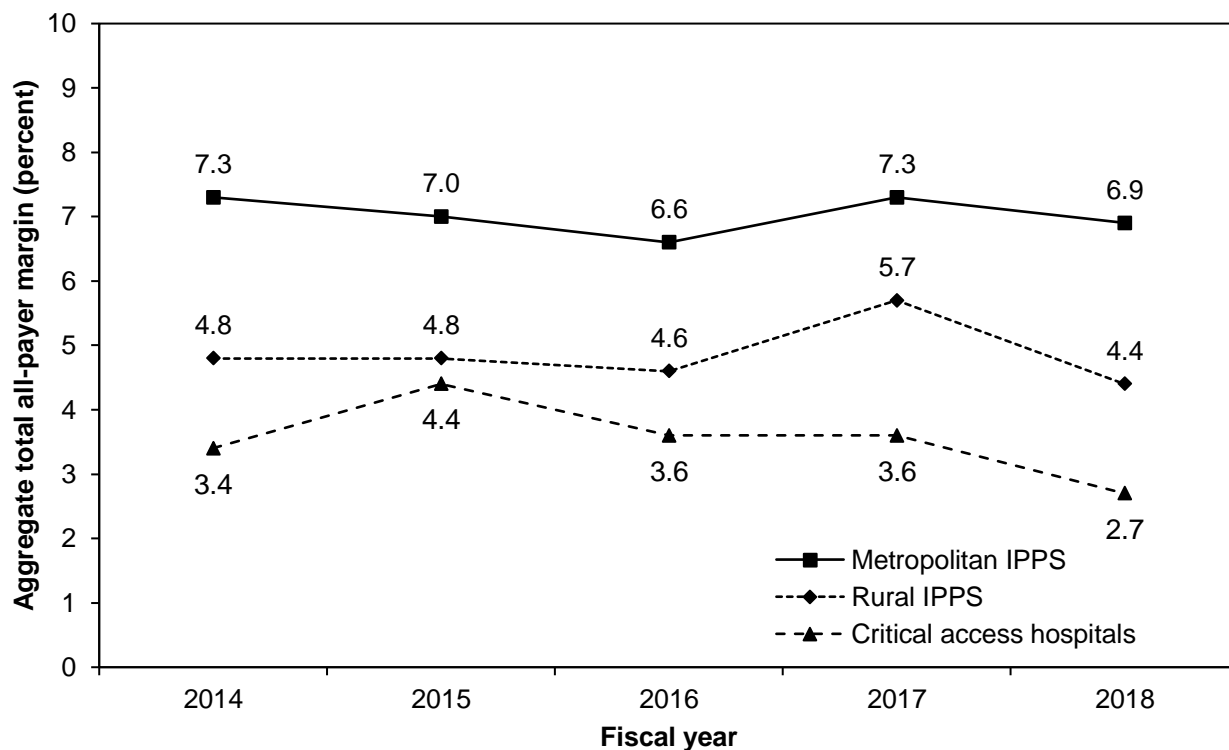
Note: EBITDA (earnings before interest, taxes, depreciation, and amortization). Data are for short-term acute care hospitals in the U.S. covered under the inpatient prospective payment system (excluding territories and those that report all-inclusive rates), that had complete cost reports and non-outlier cost per stay data. Aggregate margin is calculated as revenue minus costs, divided by revenue. "Total all-payer margin" includes all patient care services funded by all payers plus nonpatient revenue such as investment income.

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

- Hospitals' aggregate 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 care, and nonpatient services.
- In 2018, hospitals' aggregate total all-payer margin (which includes investment income) was 6.8 percent, a slight decrease from the all-time high of 7.1 percent in 2017 and 2014.
- Other measures of all-payer profitability also remained strong. Hospitals' cash flow—as measured by EBITDA—has remained steady and strong for the decade, with an aggregate EBITDA margin between 10 percent and 11 percent. Hospitals' operating margin also remained steady and strong.



**Chart 6-7. Urban IPPS hospitals continue to have a higher aggregate total all-payer margin than rural IPPS or critical access hospitals, 2014–2018**

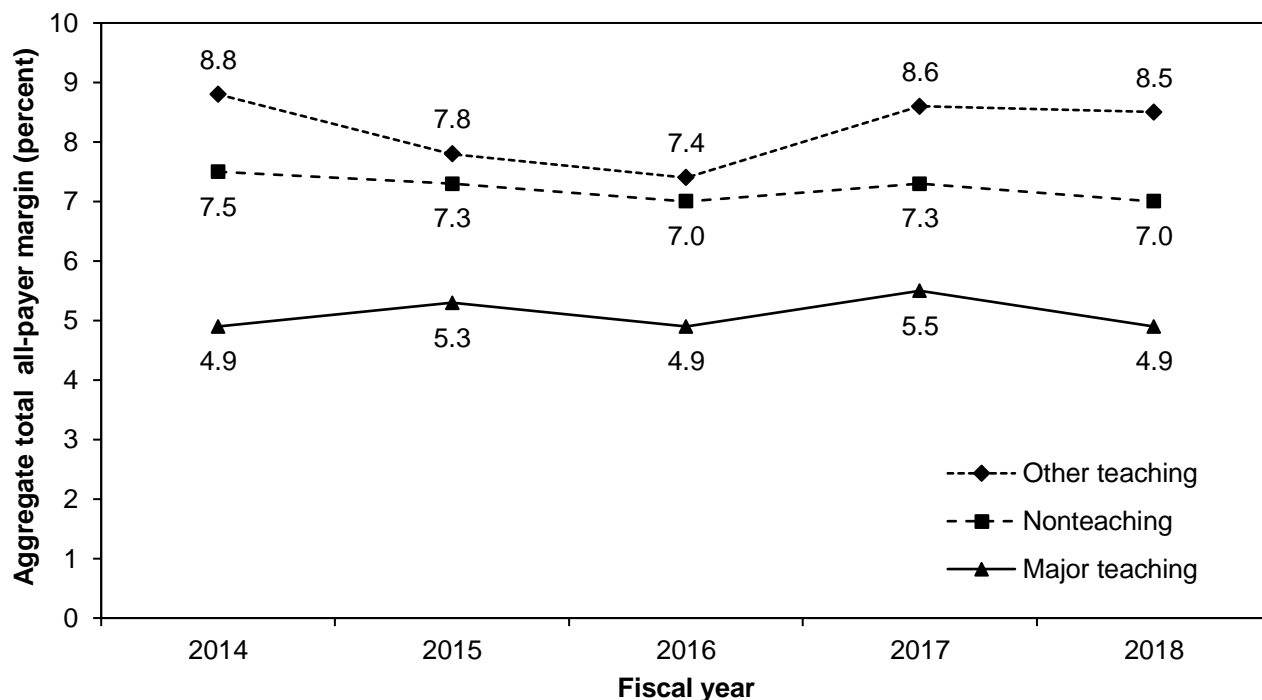


Note: IPPS (inpatient prospective payment system). Data are for short-term acute care hospitals in the U.S. paid under the inpatient prospective payment system (excluding territories and those that report all-inclusive rates) or are designated as critical access hospitals that had complete cost reports and non-outlier cost per stay data. Aggregate margin is calculated as revenue minus costs, divided by revenue. “Total all-payer margin” includes all patient care services funded by all payers, plus nonpatient revenue such as investment income. Metropolitan (urban) counties contain an urban cluster of 50,000 or more people; all other counties are classified as rural.

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

- Metropolitan (urban) IPPS hospitals continue to have a higher aggregate total all-payer margin than rural IPPS hospitals or critical access hospitals.
- From 2017 to 2018, the aggregate total all-payer margin for metropolitan IPPS hospitals decreased slightly from 7.3 to 6.9 percent, while the margin for rural IPPS hospitals decreased from a relative high of 5.7 percent (the highest margin since 2007 (data not shown)) to 4.4 percent.
- From 2017 to 2018, the aggregate total all-payer margin for critical access hospitals also decreased, from 3.6 percent to 2.7 percent (the lowest margin since 2010 (data not shown)).

**Chart 6-8. Major teaching hospitals continue to have a lower aggregate total all-payer margin than nonteaching and other teaching hospitals, 2014–2018**

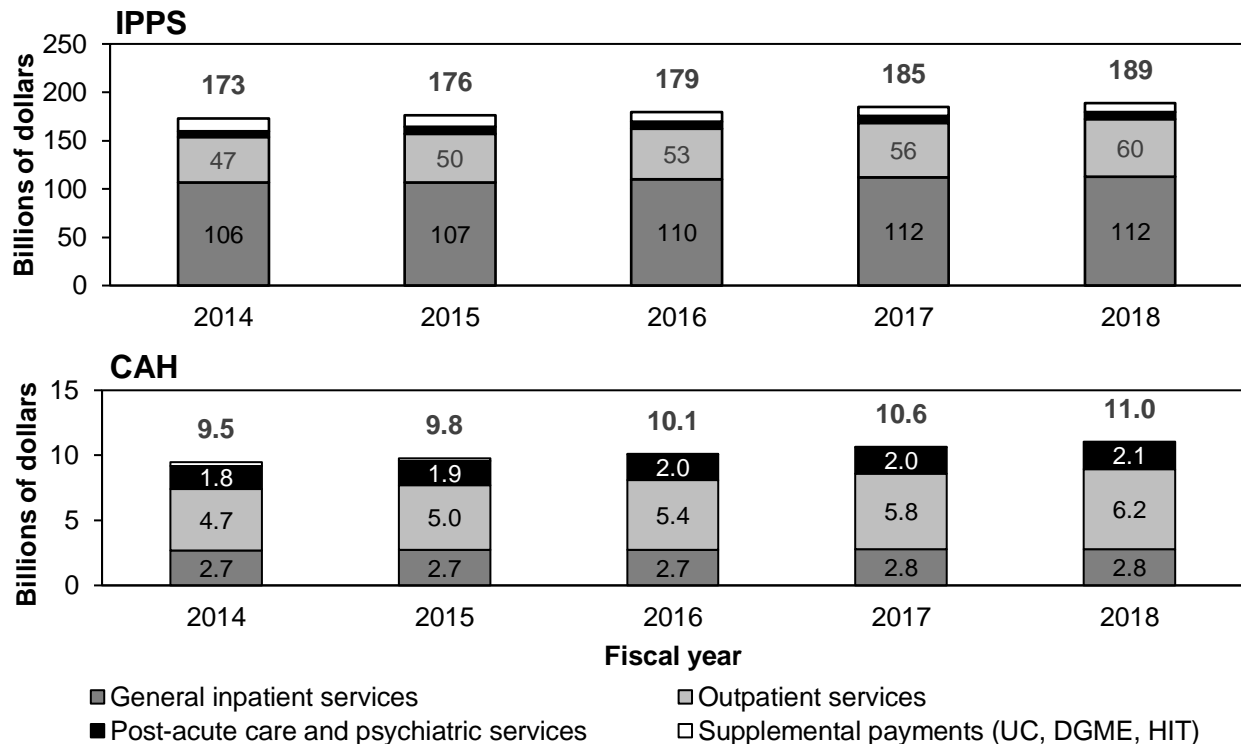


Note: Data are for short-term acute care hospitals in the U.S. covered under the inpatient prospective payment system (excluding territories and those that report all-inclusive rates) that had complete cost reports and non-outlier cost per stay data. Aggregate margin is calculated as revenue minus costs, divided by revenue. Total margin includes all patient care services funded by all payers, plus nonpatient revenue such as investment income. “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 0 and less than 0.25.

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

- The aggregate total all-payer margin for major teaching hospitals continues to be lower than that for other teaching and nonteaching hospitals. (In contrast, major teaching hospitals have a higher Medicare overall margin than other hospitals, see Chart 6-15.)
- From 2017 to 2018, the aggregate total all-payer margin for major teaching hospitals fell from 5.5 to 4.9 percent. Over this same period, the aggregate total all payer-margin decreased slightly less for nonteaching hospitals (from 7.3 percent to 7.0 percent) and for other teaching hospitals (from 8.6 percent to 8.5 percent).
- While the aggregate total all-payer margin for major teaching, other teaching, and nonteaching hospitals each decreased from 2017 to 2018, they each remained well above levels reported from 1997 to 2012 (data not shown).

**Chart 6-9. Inpatient services are the largest component of Medicare FFS revenue for IPPS hospitals, while outpatient services are the largest and fastest growing for CAHs, 2014–2018**



Note: FFS (fee-for-service), IPPS (inpatient prospective payment system), CAH (critical access hospital), UC (uncompensated care), DGME (direct graduate medical education), HIT (health information technology). Data are for the approximately 3,200 IPPS hospitals and 1,350 CAHs in the U.S. (excluding territories) that had a cost report with a midpoint in fiscal year 2018. Revenue includes payments from the Medicare FFS program (reflective of bad debt) and beneficiary cost sharing for services provided to Medicare FFS beneficiaries and the FFS share of supplemental payments. It does not include Medicare program payments for Medicare Advantage beneficiaries. Post-acute care includes swing bed, rehabilitation, and skilled nursing services. Components may not sum to totals due to rounding.

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

- The approximately 3,200 general short-term acute care hospitals paid under the IPPS received \$189 billion in Medicare FFS revenue in 2018, including \$112 billion for general inpatient services and \$60 billion for outpatient services. From 2014 to 2018, IPPS hospitals' Medicare FFS inpatient revenue increased at an average annual rate of 1.4 percent, while outpatient revenue increased 6.2 percent. These increases were driven by increases in payments per service (data not shown).
- The approximately 1,350 critical access hospitals (CAHs) received \$11 billion in Medicare FFS revenue in 2018, including \$2.8 billion for general inpatient services, \$6.2 billion for outpatient services, and \$2.1 billion in post-acute care services (mainly provided in swing beds). From 2014 to 2018, CAHs' Medicare FFS inpatient revenue increased at an average annual rate of 0.9 percent, while outpatient revenue increased 6.7 percent, and post-acute care revenue increased 4.3 percent. These increases were driven by increases in payments per service (data not shown).

**Chart 6-10. Base PPS payments represented about 84 percent of IPPS hospitals' overall Medicare FFS revenue, 2018**

Hospital group	Share of overall Medicare FFS revenue						
	Base PPS (and short stay <sup>a</sup> )	Low income, teaching <sup>b</sup>	High cost outliers	Rural and/or isolated <sup>c</sup>	Cost pass through	UC and DGME	Bad debt not reimbursed
All inpatient PPS	83.7%	5.6%	3.1%	2.0%	1.4%	5.1%	-0.6%
Metropolitan	83.4	6.2	3.3	1.3	1.5	5.4	-0.5
Rural micropolitan	88.8	2.3	2.4	3.4	0.6	3.0	-0.6
Other rural	84.0	2.0	1.4	7.9	0.8	3.1	-0.8
For profit	88.5	4.2	2.3	1.5	0.5	4.6	-0.8
Nonprofit	84.3	5.5	3.0	2.1	1.2	4.7	-0.5
Government	76.0	7.3	4.1	2.1	3.1	7.8	-0.6
DSH	82.9	5.9	3.1	2.0	1.4	5.5	-0.6
Non-DSH	92.9	1.6	2.6	1.4	0.9	0.5	-0.3
Teaching	80.3	7.6	3.5	1.6	1.8	6.2	-0.5
Nonteaching	90.4	1.6	2.2	2.7	0.5	3.0	-0.6
Sole community	80.2	2.5	2.2	11.5	0.3	2.8	-0.6
Medicare dependent	82.7	1.2	0.9	11.3	0.1	2.4	-0.9
Neither	84.1	6.0	3.2	0.9	1.5	5.4	-0.6
Critical access	1.6	0.0	0.0	0.1	99.3	0.0	-1.1

Note: PPS (prospective payment system), IPPS (inpatient prospective payment system), FFS (fee-for-service), DSH (disproportionate share hospital), UC (uncompensated care), DGME (direct graduate medical education). "Overall Medicare FFS revenue" includes payments from the Medicare FFS program (reflective of bad debt) and beneficiary cost sharing for services provided to Medicare FFS beneficiaries and their share of supplemental payments, across hospital service lines (inpatient, outpatient, and swing bed, rehabilitation, skilled nursing, and psychiatric services). Metropolitan (urban) counties contain an urban cluster of 50,000 or more people, and rural micropolitan counties contain a cluster of 10,000 to 50,000 people. Components may not sum to totals because other types of payments, such as quality, demonstration, and reconciliation payments, are not included in the table.

<sup>a</sup>"Short stay" includes adjustments for short-stay transfers in the inpatient PPS and short-stay outlier payments in the inpatient rehabilitation and psychiatric PPSs.

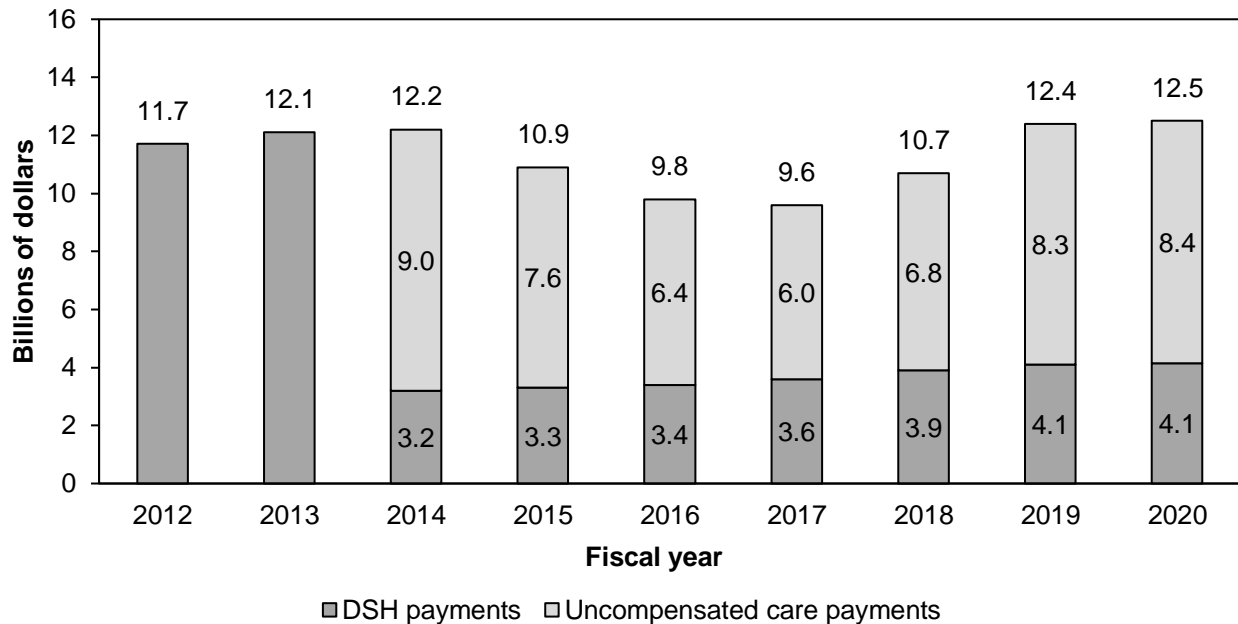
<sup>b</sup>"Low income, teaching" includes the disproportionate share and indirect medical education payments in the inpatient PPS and the low-income adjustment in the inpatient rehabilitation PPS.

<sup>c</sup>"Rural and/or isolated" includes payments above federal inpatient PPS rates from sole community hospital- or Medicare-dependent hospital-specific rates, the low-volume adjustment, and the rural adjustments to the rehabilitation and psychiatric PPSs.

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

- Base PPS payments accounted for about 84 percent of IPPS hospitals' aggregate overall Medicare FFS revenue, while PPS low-income and teaching adjustments, outlier payments, rural and/or isolated payments, cost-based pass-through amounts, supplemental payments, and bad debt accounted for the remaining 16 percent. However, the share of Medicare FFS revenue from different payment types varied substantially across different groups of IPPS hospitals.
- Cost-based reimbursement for CAHs results in payments significantly above what CAHs would be paid under the hospital PPSs, and it results in higher beneficiary cost sharing. (CAHs can have some PPS payments if they operate distinct-part rehabilitation or psychiatric hospitals that are reimbursed for those services under the respective PPSs.)

**Chart 6-11. Since implementation of uncompensated care payments in 2014, DSH payments have slowly increased, while uncompensated care payments have varied**



Note: DSH (disproportionate share). Payments represent CMS's estimated operating DSH payments and uncompensated care payments, before sequestration. Chart does not include capital DSH payments.

Source: CMS IPPS final rules.

- In each of 2012 and 2013, IPPS hospitals received approximately \$12 billion in aggregate operating DSH payments. The traditional DSH payment formula is based on hospitals' share of Medicaid patients and Medicare patients with Supplemental Security Income (SSI) and therefore results in increased DSH payments as Medicaid expands.
- Beginning in 2014, a policy change reduced operating DSH payments but added uncompensated care payments. Specifically, beginning in 2014, IPPS hospitals' operating DSH payments were calculated as 25 percent of the DSH payment the hospital would have received under the traditional DSH formula in effect before 2014. At the same time, a fixed pool of uncompensated care payments was created, set each year at 75 percent of the estimated aggregate operating DSH payments IPPS hospitals would have received under the traditional formula, less a percentage reduction in the uncompensated care pool that is proportional to the decline in the rate of uninsured since 2013. This uncompensated care pool is distributed to DSH-eligible IPPS hospitals based on each hospital's share of aggregate uncompensated care.
- Since the policy change, aggregate operating DSH payments have been slowly increasing, from \$3.2 billion in 2014 to \$4.1 billion in 2020. However, the amount of uncompensated care payments has varied, consistent with trends in the share of the population with Medicaid and without health insurance.

**Chart 6-12. Financial pressure led to lower hospital costs per discharge, 2015–2017**

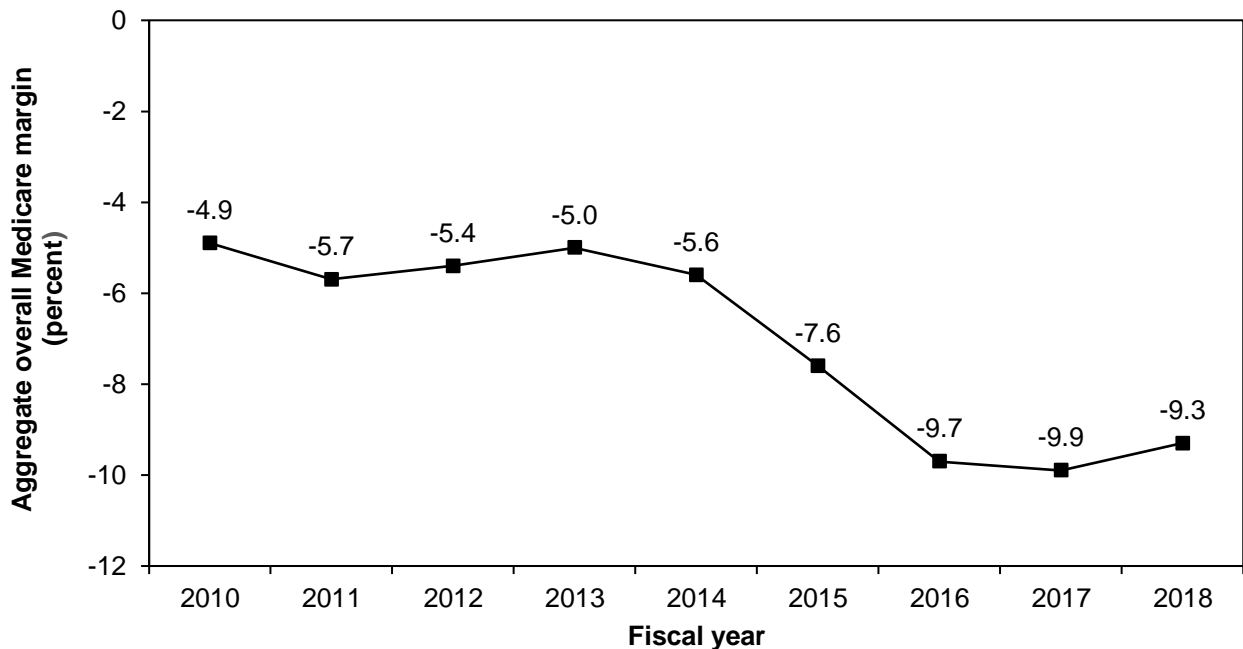
	Level of financial pressure, 2015–2017		
	High pressure (non-Medicare margin ≤ 1%)	Medium pressure	Low pressure (non-Medicare margin > 5%)
Number of hospitals	666	337	1,729
<b>Financial characteristics, 2018 (medians)</b>			
Non-Medicare margin (private, Medicaid, uninsured)	–4%	3%	14%
Standardized cost per discharge (as a share of the national median)			
For-profit and nonprofit hospitals	0.96	0.97	1.02
Nonprofit hospitals	0.97	0.99	1.04
For-profit hospitals	0.90	0.92	0.94
Annual growth in cost per discharge, 2016–2018	2%	2%	2%
Overall 2018 Medicare margin (medians)	–1%	–4%	–10%
<b>Patient characteristics (medians)</b>			
Total hospital discharges in 2018	3,347	6,483	7,872
Medicare share of inpatient days	39%	37%	37%
Medicaid share of inpatient days	8%	7%	6%
Medicare case-mix index	1.43	1.53	1.65

Note: Standardized costs are adjusted for hospital case mix, wage index, outliers, transfer cases, interest expense, and the effects of teaching and low-income Medicare patients on hospital costs. The sample includes short-term acute care hospitals paid under the inpatient prospective payment system that had complete cost reports on file with CMS by October 2019. “High-pressure” hospitals are defined as those with a median non-Medicare profit margin of 1 percent or less from 2015 to 2017 and a net worth (assets minus liabilities) that grew by less than 1 percent per year over that period if the hospital’s Medicare profits had been zero. “Low-pressure” hospitals are defined as those with a median non-Medicare profit margin greater than 5 percent from 2015 to 2017 and a net worth that grew by more than 1 percent per year over that period if the hospital’s Medicare profits had been zero. “Medium-pressure” hospitals are those that fit into neither the high- nor the low-pressure categories.

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

- Hospitals under higher financial pressure had 4 percent lower standardized costs per discharge than the national median. For-profit hospitals tended to constrain their costs more than nonprofit hospitals. The median for-profit hospital had costs that were 6 percent below the average even when they were not under financial pressure.
- Hospitals with lower volume, lower case mix, and higher Medicaid and Medicare shares of discharges are more likely to be under financial pressure.
- One limitation of this analysis is that it measures only hospital inpatient costs. To the extent that hospitals with strong profit margins direct their resources toward non-inpatient expenditures (such as the purchase or subsidization of physician practices), those costs would not be included in our standardized costs per discharge.

**Chart 6-13. Aggregate overall Medicare margin for short-term acute care hospitals increased slightly from 2017 to 2018**

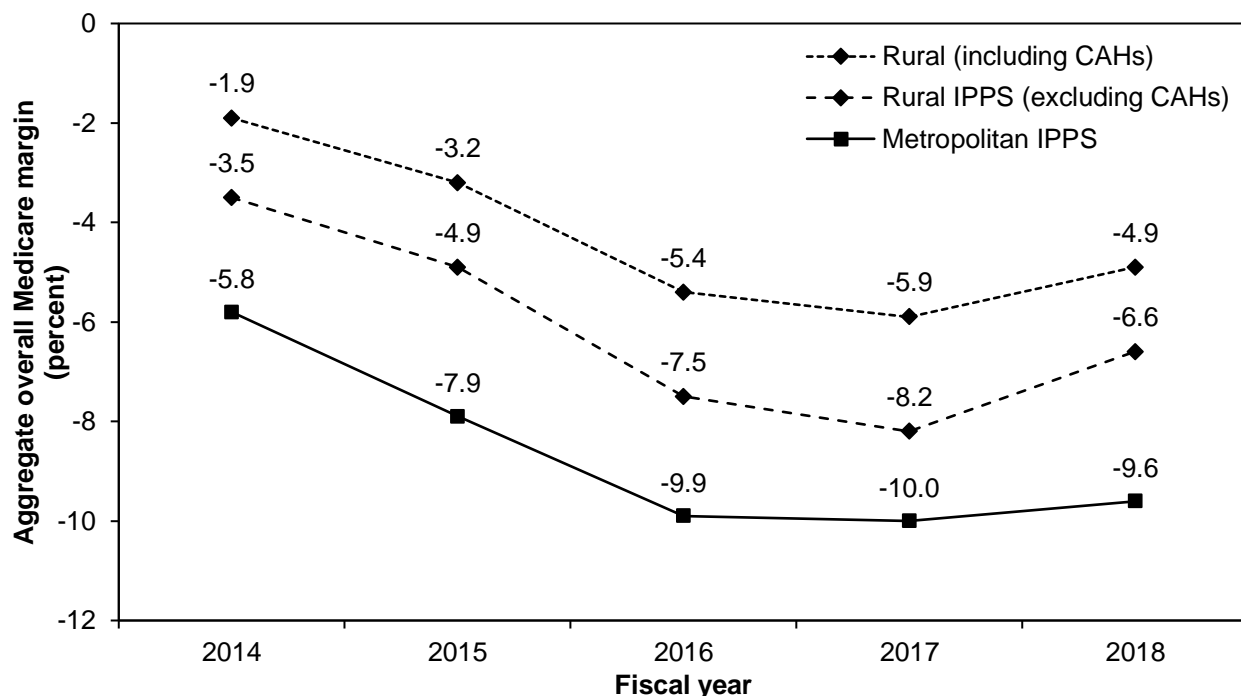


Note: Data are for short-term acute care hospitals in the U.S. covered under the inpatient prospective payment system (IPPS) (excluding territories and those that report all-inclusive rates), that had complete cost reports and non-outlier cost per stay data. Aggregate margin is calculated as revenue minus costs, divided by revenue. Margins are based on Medicare-allowable costs. The overall Medicare margin includes the costs and payments of acute inpatient, outpatient, inpatient psychiatric, rehabilitation, skilled nursing facility, and home health services, as well as graduate medical education, bad debts, health information technology, and uncompensated care payments.

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

- The aggregate 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, bad debts, Medicare payments for health information technology, and—starting in 2014—uncompensated care payments.
- From 2017 to 2018, the aggregate overall Medicare margin for IPPS hospitals increased from –9.9 percent to –9.3 percent. However, the margin remains well below levels from 2010 to 2013.
- The range of overall Medicare margins at individual IPPS hospitals varied substantially. For example, in 2018, 25 percent of hospitals had an overall Medicare margin of 1.8 percent or higher, and another 25 percent had a margin of –19.2 percent or lower (data not shown).

**Chart 6-14. Rural short-term acute care hospitals continue to have a higher aggregate overall Medicare margin than urban hospitals**



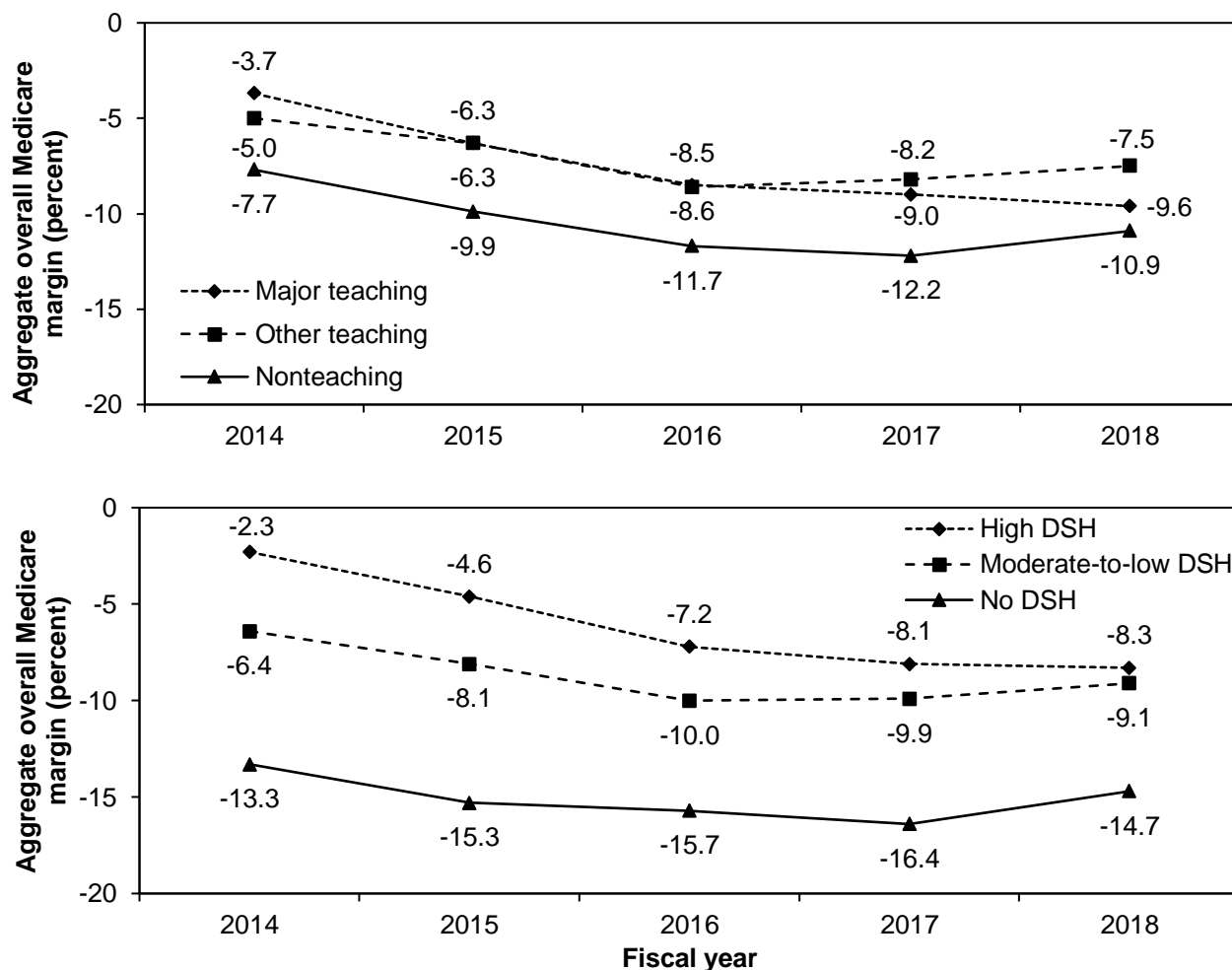
Note: CAH (critical access hospital), IPPS (inpatient prospective payment system). Data are for short-term acute care hospitals in the U.S. covered under the inpatient prospective payment system (excluding territories and those that report all-inclusive rates), that had complete cost reports and non-outlier cost per stay data. Aggregate margin is calculated as revenue minus costs, divided by revenue. Margins are based on Medicare-allowable costs. The overall Medicare margin includes the costs and payments of acute inpatient, outpatient, inpatient psychiatric, rehabilitation, skilled nursing facility, and home health services, as well as graduate medical education, bad debts, health information technology, and uncompensated care payments. Metropolitan (urban) counties contain an urban cluster of 50,000 or more people; all other counties and all CAHs are classified as rural.

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

- Since 2005, the aggregate overall Medicare margin for short-term acute care hospitals in rural counties has exceeded that for hospitals in metropolitan counties (not all data shown). The higher rural margins reflect special rural add-on payments (see Chart 6-10), including the introduction of low-volume add-on payments in 2013.
- In 2018, the difference between the aggregate overall Medicare margin at metropolitan and rural hospitals was 3.0 percentage points when compared with rural IPPS hospitals and 4.7 percentage points when compared with rural IPPS and critical access hospitals.



**Chart 6-15. Teaching and disproportionate share short-term acute care hospitals continue to have higher aggregate Medicare margins than other hospitals**

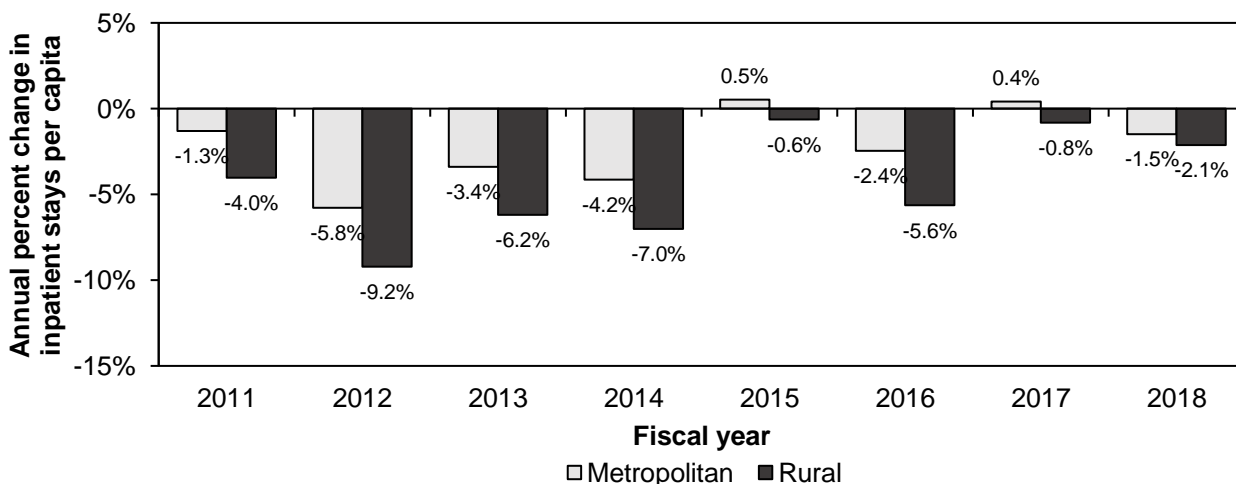
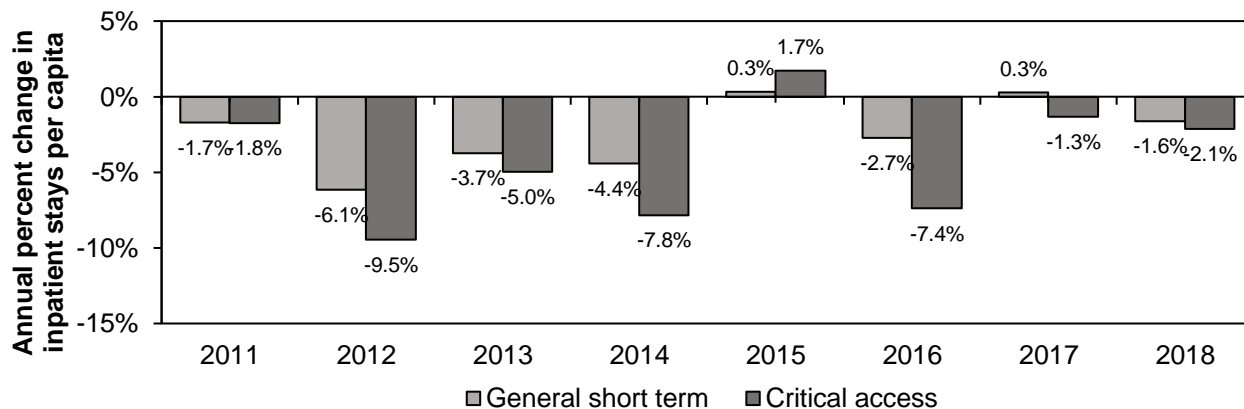


Note: DSH (disproportionate share). Data are for short-term acute care hospitals in the U.S. covered under the inpatient prospective payment system (excluding territories and those that report all-inclusive rates) that had complete cost reports and non-outlier cost per stay data. Aggregate margin is calculated as revenue minus costs, divided by revenue. Medicare margin is based on Medicare-allowable costs. The overall Medicare margin includes the costs and payments of acute inpatient, outpatient, inpatient psychiatric, rehabilitation, skilled nursing facility, and home health services, as well as graduate medical education, bad debts, health information technology, and uncompensated care payments.

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

- Both teaching hospitals and those that treat a large share of low-income patients (referred to as “disproportionate share hospitals”) continue to have higher aggregate overall Medicare margins than other hospitals. Their better financial performance under Medicare is largely due to the additional payments they receive from the indirect medical education and DSH adjustments to their inpatient payments, as well as supplemental uncompensated care payments.

**Chart 6-16. Decline in Medicare FFS inpatient stays per capita has slowed, with larger declines at critical access and rural hospitals**

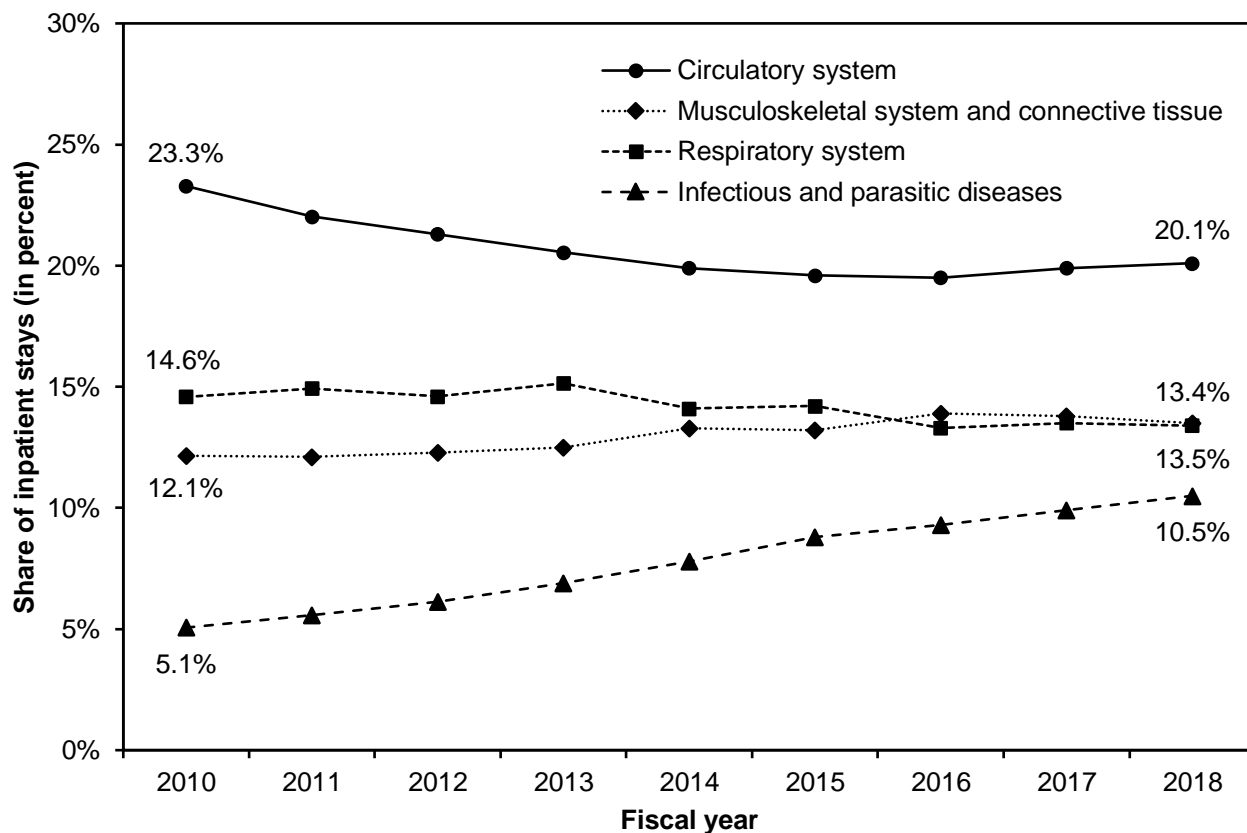


Note: FFS (fee-for-service). Data are for short-term acute care hospitals in the U.S. (exclusive of territories). "General short-term hospital" refers to short-term acute care hospitals paid under the inpatient prospective payment system or the Maryland state waiver. Metropolitan (urban) counties contain an urban cluster of 50,000 or more people; all other counties are classified as rural.

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

- The number of inpatient stays per 1,000 Medicare FFS beneficiaries has decreased from 306 in 2010 to 250 in 2018, declining sharply in the early years of this period but at a slowing rate in more recent years (data not shown).
- The magnitude of the decrease in inpatient stays per capita varied across types of hospitals, with larger declines at critical access hospitals and rural hospitals.
- From 2017 to 2018, the number of inpatient stays per capita fell 2.1 percent at critical access hospitals, compared with 1.6 percent at general acute care hospitals. During the same time period, the number of inpatient stays per capita fell 2.1 percent at rural hospitals, compared with 1.5 percent at metropolitan hospitals.

**Chart 6-17. Circulatory system diagnoses remain the most common reason for Medicare FFS beneficiaries' inpatient stays at short-term acute care hospitals, but the share has decreased, 2010–2018**

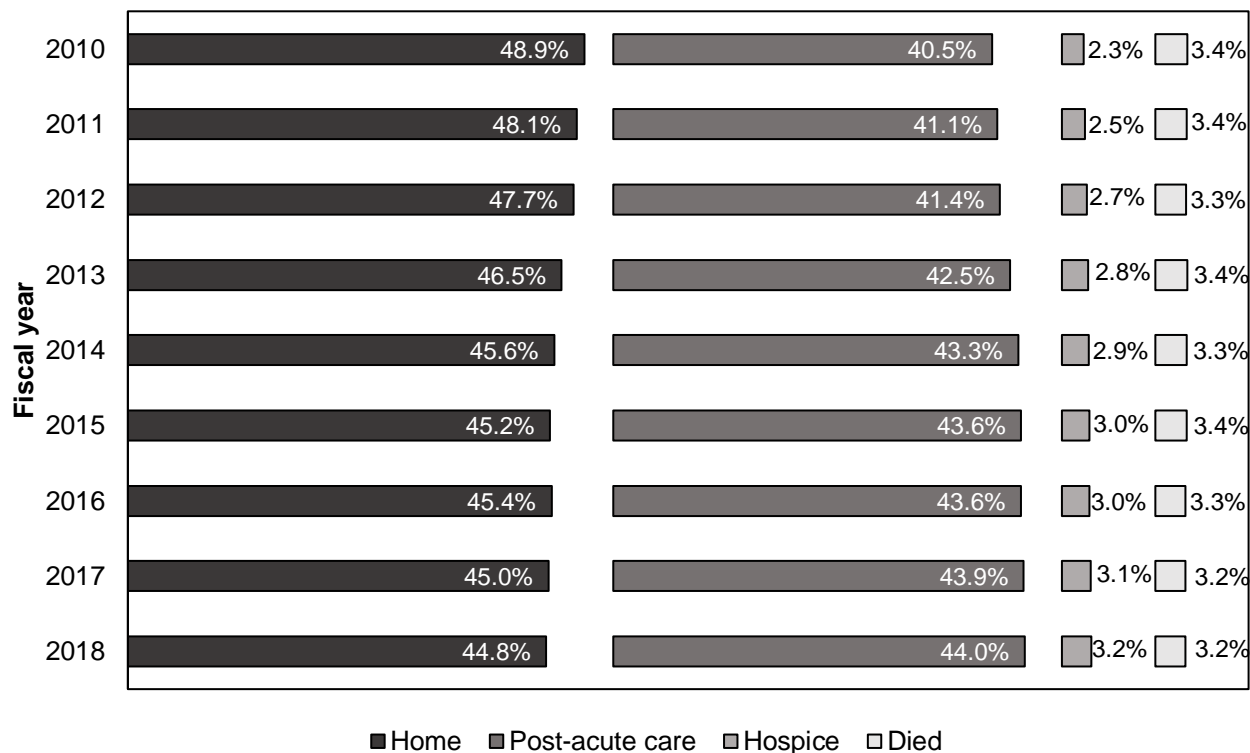


Note: FFS (fee-for-service). Data are for short-term acute care hospitals in the U.S. (exclusive of territories).

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

- In 2018, four major diagnostic categories accounted for over 57 percent of all Medicare FFS inpatient stays at short-term acute care hospitals.
- The circulatory system was the most common major diagnostic category among Medicare FFS inpatient stays; however, its share declined from about 23 percent to 20 percent from 2010 to 2018. Circulatory system diagnoses include heart failure and cardiac arrhythmia.
- From 2010 to 2018, the major diagnostic category with the largest increase was infectious and parasitic diseases, which increased from about 5 percent to nearly 11 percent of Medicare FFS inpatient stays, due to growth in the number of FFS beneficiaries hospitalized with septicemia (severe sepsis).

**Chart 6-18. A growing share of Medicare FFS beneficiaries' inpatient stays at short-term acute care hospitals are immediately followed by post-acute care or hospice, 2010–2018**

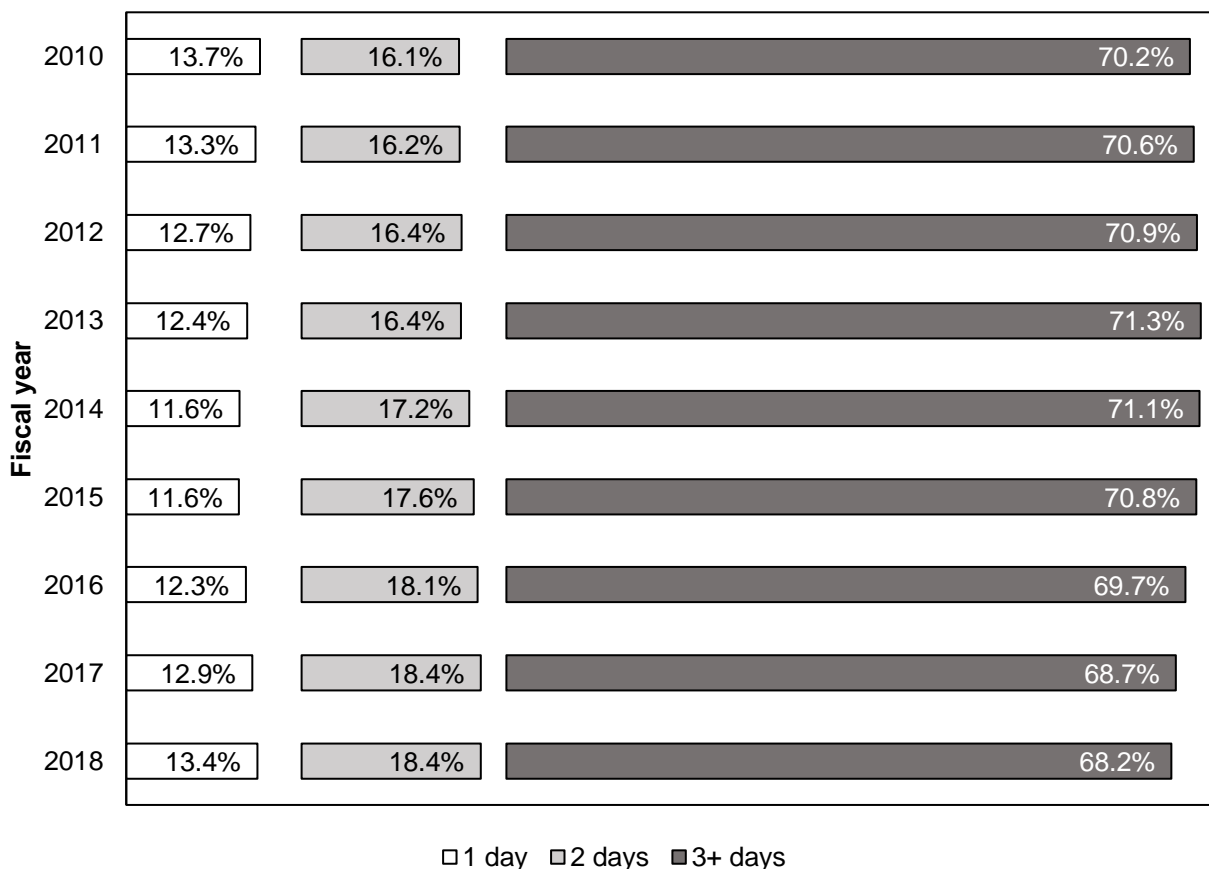


Note: FFS (fee-for-service). Data are for short-term acute care hospitals in the U.S. (exclusive of territories). Components do not sum to 100 percent because beneficiaries discharged to other destinations are not shown.

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

- From 2010 to 2018, the share of inpatient stays in which the Medicare FFS beneficiary was discharged home under self-care consistently declined, while the shares discharged to post-acute care and hospice consistently increased.
- In conjunction with the decline in Medicare FFS inpatient stays per capita, these trends could reflect in part a shift of care for less severe conditions to outpatient settings, with the remaining inpatient stays consisting of sicker patients. The increase in the share discharged to hospice also reflects increased use of hospice care in end-of-life planning.

**Chart 6-19. Share of Medicare FFS beneficiaries' short stays at short-term acute care hospitals decreased from 2010 to 2014 but then began to increase again**

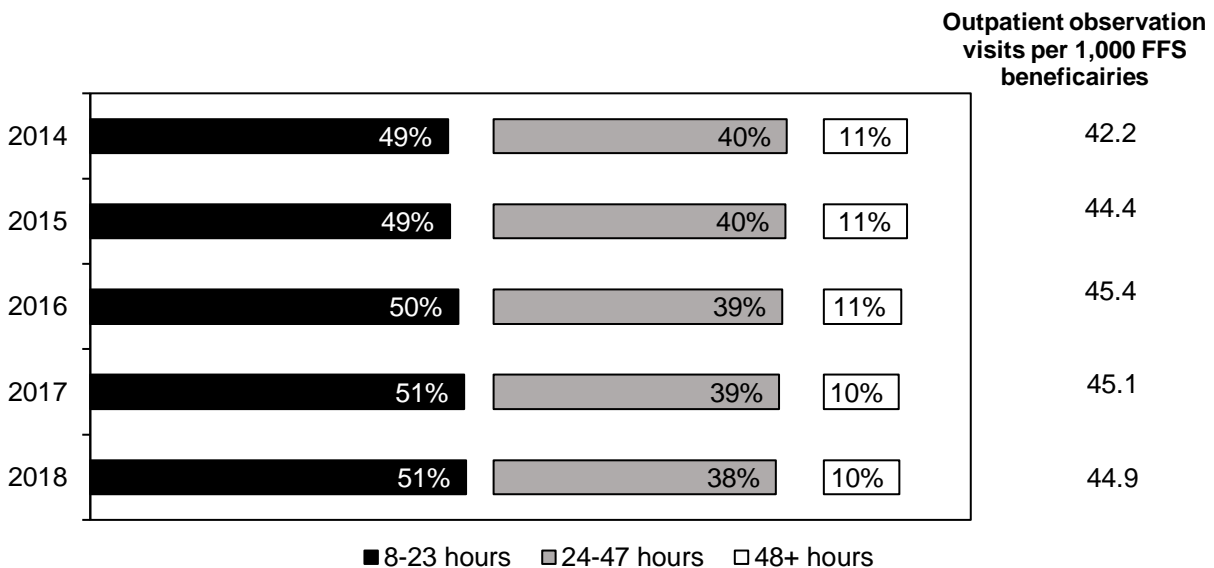


Note: FFS (fee-for-service). Data are for short-term acute care hospitals in the U.S. (exclusive of territories). Components may not sum to 100 percent due to rounding.

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

- The share of Medicare FFS beneficiaries that were one- or two-day stays decreased from 2010 to 2014, but then began to increase again.
- As the Commission has previously noted, growth in the number of one-day stays starting in 2015 could be due to the reduced likelihood that CMS's recovery audit contractors (RACs) would deny payment for one-day stays. In 2015, CMS ceased patient status reviews (which previously resulted in challenges to one-day stay claims). The result was that from 2014 to 2015, claims challenged by the RACs as overpayments fell by 91 percent (data not shown).
- From 2017 to 2018, the share of Medicare FFS beneficiaries' inpatient stays that were only one day increased from 12.9 to 13.4 percent, while the share of two-day stays held steady at 18.4 percent, and stays of three or more days decreased from 68.7 to 68.2 percent.

**Chart 6-20. Number of Medicare FFS outpatient observation visits per capita decreased slightly in 2017 and 2018, and nearly half remained longer than 24 hours**

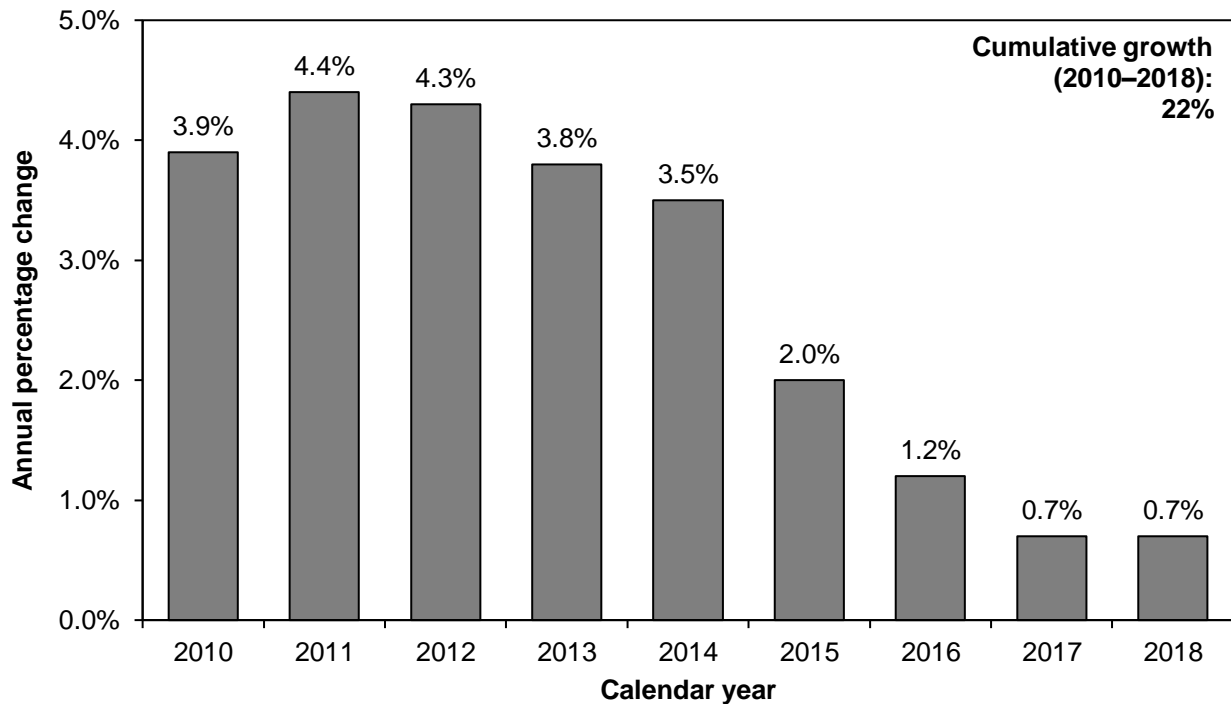


Note: FFS (fee-for-service). Observation visits are separately payable visits with a length of stay of at least eight hours. Data for outpatient observation visits include short-term acute care hospitals in the U.S. (exclusive of territories) paid under the inpatient prospective payment system or under the Maryland state waiver. "Outpatient observation visits" per capita refers to outpatient services per Medicare FFS Part B beneficiary. Years are calendar years.

Source: MedPAC analysis of outpatient standard analytical file data from CMS.

- Hospitals use observation care to determine whether a patient should be hospitalized for inpatient care, transferred to an alternative treatment setting, or sent home. On April 1, 2002, Medicare began providing separate payments to hospitals for some observation services. Previously, the observation services were packaged into the payments for the emergency department or clinic visits that occurred with observation care.
- In 2018, Medicare FFS beneficiaries had approximately 1.5 million outpatient observation visits, equivalent to 44.9 outpatient observation visits per 1,000 Medicare FFS beneficiaries.
- From 2014 to 2016, the number of Medicare FFS outpatient observation visits per capita increased by 3.2 visits. However, this slow growth reversed starting in 2016, with a decrease of 0.5 visits from 2016 to 2018.
- The decision on whether to discharge or admit a patient can usually be made in less than 24 hours; however, the Medicare benefit does not limit the length of outpatient observation stays. In each of 2014 to 2018, nearly half of outpatient observation visits were longer than 24 hours, including 10 percent that spanned more than 48 hours.

**Chart 6-21. Growth in Medicare FFS hospital outpatient services per capita has slowed, 2010–2018**

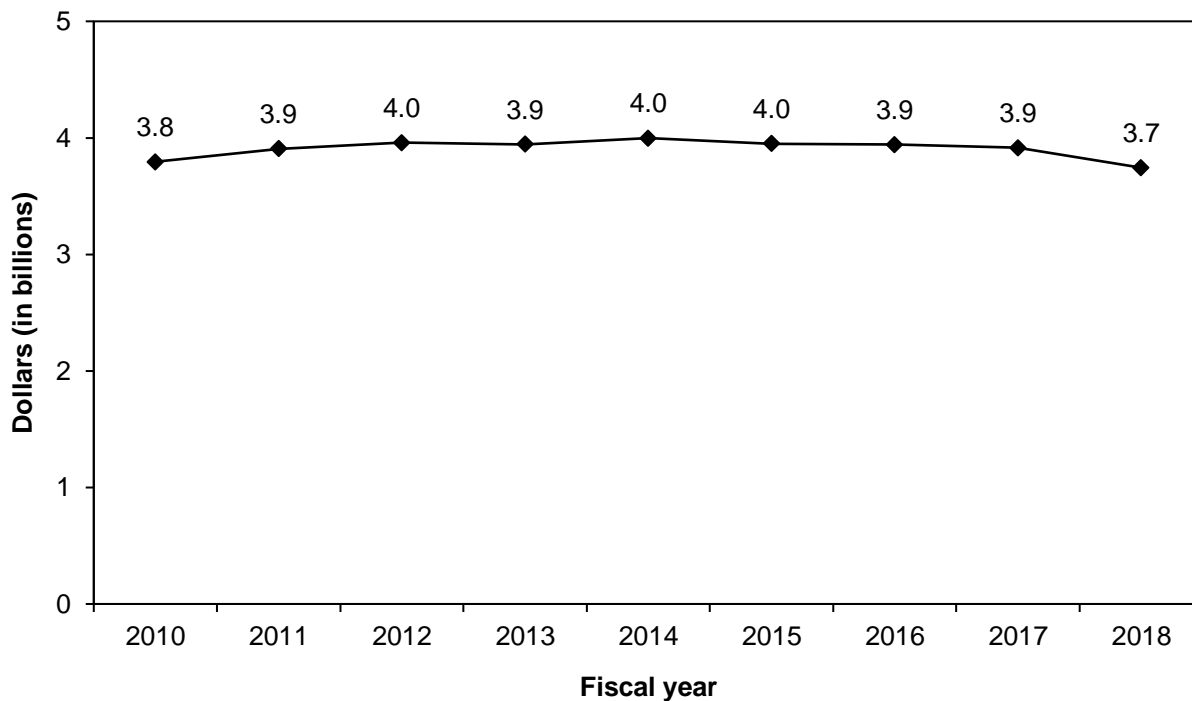


Note: FFS (fee-for-service). Data for outpatient services include all hospitals paid under the outpatient prospective payment system, including short-term acute care hospitals, long-term care hospitals, rehabilitation hospitals, and psychiatric hospitals. "Outpatient services per capita" refers to outpatient services per Medicare FFS Part B beneficiary.

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

- In 2018, Medicare FFS beneficiaries received approximately 150 million outpatient services at hospitals paid under the outpatient prospective payment system, equivalent to 4.5 outpatient services per Medicare FFS Part B beneficiary (data not shown).
- From 2010 to 2018, the number of Medicare outpatient visits per FFS beneficiary increased 22 percent.
- However, the rate of growth has slowed over time, with outpatient services per FFS beneficiary growing only 0.7 percent in both 2017 and 2018.

**Chart 6-22. Medicare FFS payments to inpatient psychiatric facilities decreased in 2018**



Note: FFS (fee-for-service). These fiscal year–incurred data represent only program spending; they do not include beneficiary cost sharing. Spending for inpatient psychiatric care furnished in scatter beds in acute care hospitals (and paid for under the acute care inpatient prospective payment system) is not included in this chart.

Source: CMS Office of the Actuary.

- Medicare pays for inpatient psychiatric facility (IPF) care under the IPF prospective payment system.
- Medicare program spending for FFS beneficiaries' care in IPFs decreased less than 1 percent per year, on average, from 2010 to 2018.
- However, from 2017 to 2018, Medicare program spending for IPF stays decreased 4.4 percent, reflective of a 6.3 percent decrease in IPF stays (data not shown).



**Chart 6-23. A growing share of Medicare-certified inpatient psychiatric facilities are for profit, 2011–2018**

Type of IPF	2011	2014	2017	2018	Average annual change		
					2011–2014	2014–2017	2017–2018
All	1,567	1,591	1,601	1,576	0.5%	0.2%	–1.6%
Urban	1,234	1,254	1,268	1,246	0.5	0.4	–1.7
Rural	332	336	331	326	0.4	–0.5	–1.5
Freestanding	440	476	516	520	2.7	2.7	0.8
Hospital-based units	1,127	1,115	1,085	1,056	–0.4	–0.9	–2.7
Nonprofit	766	740	736	718	–1.1	–0.2	–2.4
For profit	421	493	522	521	5.4	1.9	–0.2
Government	380	358	343	337	–2.0	–1.4	–1.7

Note: IPF (inpatient psychiatric facility). Data are from facilities that submitted valid Medicare cost reports in the given fiscal year. Components may not sum to totals due to missing data.

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

- Between 2011 and 2014, the number of IPFs that filed Medicare cost reports grew, on average, 0.5 percent per year. Similarly, between 2014 and 2017, the supply of IPFs increased slightly, growing, on average, 0.2 percent per year. However, in 2018, the number of IPFs fell by 1.6 percent.
- A growing share of Medicare IPF users receive care in for-profit facilities. Between 2011 and 2014, the number of for-profit IPFs grew 5.4 percent per year, on average. Over the same period, the number of nonprofit IPFs fell more than 1 percent per year, on average. The number of for-profit IPFs continued to grow through 2017, while the number of nonprofit IPFs slightly declined. From 2017 to 2018, the number of for-profit IPFs remained relatively stable, while the number of nonprofit facilities decreased by 2.4 percent.

**Chart 6-24. Almost three-quarters of Medicare FFS beneficiaries' stays at IPFs were for psychosis, 2018**

MS-DRG	Diagnosis	Share
885	Psychosis	72.3%
884	Organic disturbances and mental retardation	7.0
057	Degenerative nervous system disorders without MCC	5.8
897	Alcohol/drug abuse or dependency, no rehabilitation, without MCC	4.5
881	Depressive neurosis	3.5
895	Alcohol/drug abuse or dependency with rehabilitation, without MCC	1.7
882	Neurosis except depressive	1.3
880	Acute adjustment reaction and psychosocial dysfunction	0.9
883	Disorders of personality and impulse control	0.7
056	Degenerative nervous system disorders with MCC	0.6
894	Alcohol/drug use—left AMA	0.4
886	Behavioral and developmental disorders	0.2
896	Alcohol/drug abuse or dependency without rehabilitation, with MCC	0.2
876	OR procedure with principal diagnosis of mental illness	0.1
887	Other mental disorders	0.1
081	Nontraumatic stupor and coma without MCC	<0.1
080	Nontraumatic stupor and coma with MCC	<0.1
	Nonpsychiatric MS-DRGs	0.8
	Total	100.0

Note: FFS (fee-for-service), IPF (inpatient psychiatric facility), MS-DRG (Medicare severity–diagnosis related group), MCC (major comorbidity or complication), AMA (against medical advice), OR (operating room). Total may not sum to 100 percent due to rounding.

Source: MedPAC analysis of MedPAR data.

- Medicare patients in IPFs are generally assigned 1 of 17 psychiatric MS-DRGs.
- The most frequently occurring IPF diagnosis—accounting for about 72 percent of IPF discharges in 2018—was psychosis. This broad category includes patients with principal diagnoses of schizophrenia, bipolar disorder, and major depression.
- In 2018, the next most common discharge diagnosis, accounting for 7 percent of IPF cases, was organic disturbances and mental retardation.

## Chart 6-25. The majority of Medicare FFS beneficiaries who received IPF services were under the age of 65, 2018

Characteristic	Share of all IPF users	Share of IPF users with more than one IPF stay
Current eligibility status		
Aged	42.6%	30.0%
Disabled	57.4	69.9
ESRD only	0.1	0.1
Age		
<45	23.1	31.0
45–64	33.6	38.3
65–79	28.8	22.9
80+	14.4	7.9
All	100.0	27.6

Note: FFS (fee-for-service). IPF (inpatient psychiatric facility), ESRD (end-stage renal disease). The “aged” category includes beneficiaries ages 65 and older without ESRD. The “disabled” category includes beneficiaries under age 65 without ESRD. The “ESRD only” category includes beneficiaries with ESRD, regardless of age. Components may not sum to totals due to rounding.

Source: MedPAC analysis of MedPAR data.

- Of Medicare beneficiaries who had at least one IPF stay in 2018, 57.4 percent qualified for Medicare because of a disability. These beneficiaries tend to be younger and poorer than the typical fee-for-service beneficiary.
- Approximately 28 percent of Medicare beneficiaries who used an IPF in 2018 had more than one IPF stay during the year. These beneficiaries were much more likely than all IPF users to be disabled, often because of a psychiatric diagnosis.