SECTION 6

Acute inpatient services

General short-term hospitals
Inpatient psychiatric facilities

Chart 6-1. Number of short-term acute care hospitals and inpatient stays, 2020

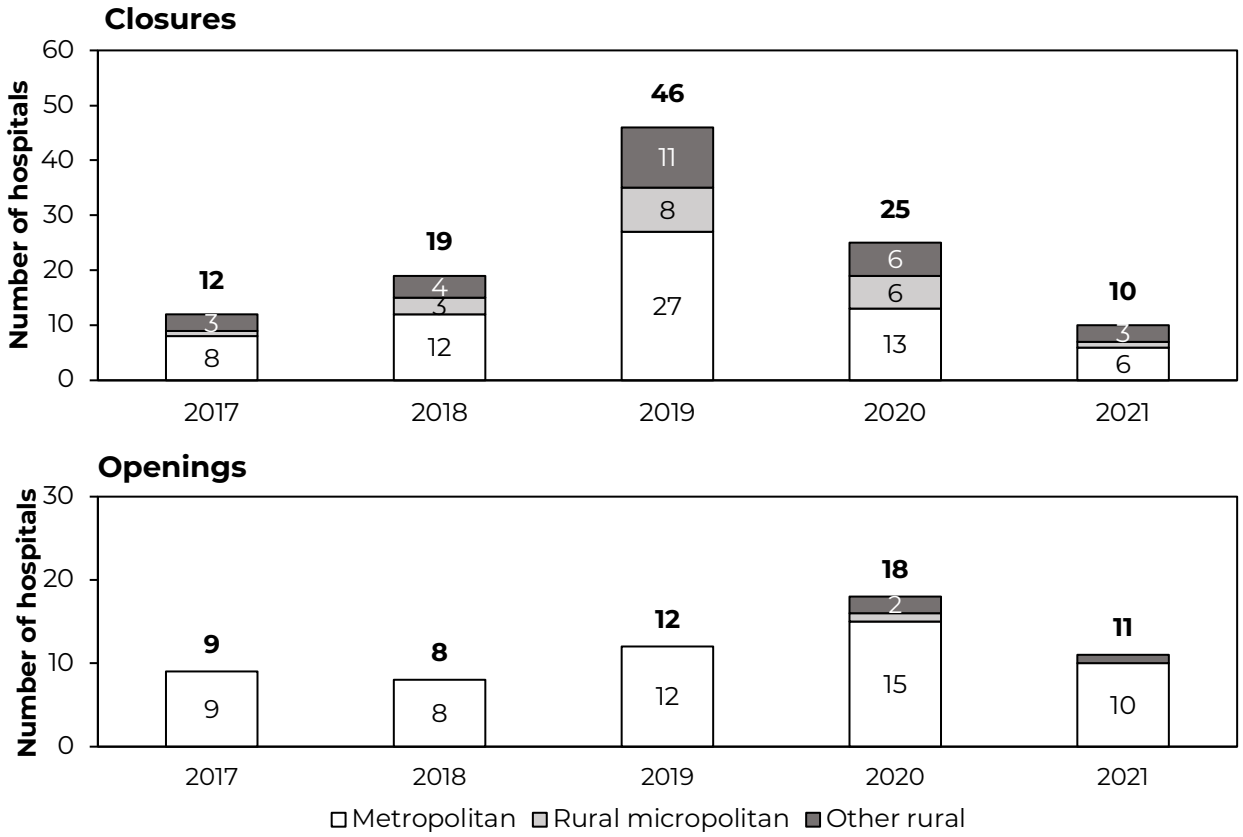
Hospital group	Hospitals		Inpatient stays			
			All payer		Medicare FFS	
	Number (in thousands)	Share of total	Number (in millions)	Share of total	Number (in millions)	Share of total
All short-term acute	**4.3**	**100**	**28.0**	**100**	**7.6**	**100**
IPPS	2.9	67	26.4	94	7.2	94
Metropolitan (urban)	2.2	51	24.5	88	6.5	85
Rural micropolitan	0.5	11	1.6	6	0.6	8
Other rural	0.2	5	0.3	1	0.1	1
For profit	0.7	16	4.4	16	1.2	15
Nonprofit	1.8	41	18.5	66	5.1	67
Government	0.4	10	3.6	13	0.9	12
DSH and teaching	1.0	24	16.9	60	4.3	56
DSH only	1.4	33	7.7	28	2.3	30
Teaching only	0.1	2	0.8	3	0.2	3
Neither	0.3	8	1.0	3	0.4	5
Sole community	0.3	8	1.0	4	0.4	5
Medicare dependent	0.1	3	0.2	1	0.1	1
Neither	2.4	56	25.2	90	6.7	88
Critical access	1.3	30	0.5	2	0.2	3
Maryland	<0.1	1	0.5	2	0.2	2

Note: FFS (fee-for-service), IPPS (inpatient prospective payment systems), 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 2020 and were complete as of our analysis. "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 and because children's and cancer hospitals are not listed separately.

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

- Due to cost report filing extensions during the coronavirus public health emergency, the number of hospitals in this chart is lower than in prior years. We include it here because it reflects the cost reports used to calculate margins and other metrics in subsequent charts in this chapter.

Chart 6-2. Fewer general short-term acute care hospitals closed in 2021



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 period. Data are for general short-term acute care hospitals in the U.S. paid under the inpatient prospective payment systems, 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, such as removing hospitals previously counted as closures but that have since reopened. The figures pertain to fiscal years.

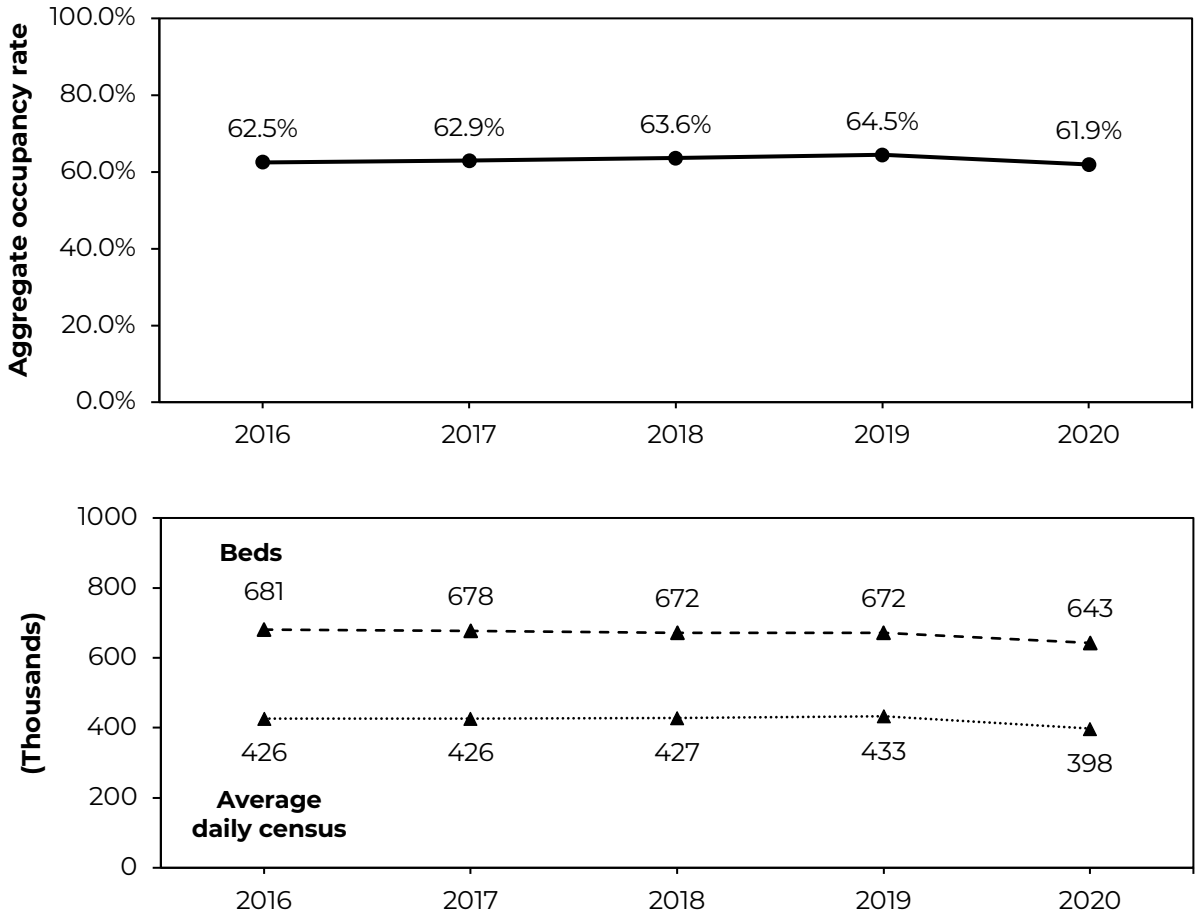
Source: MedPAC analysis of the CMS Provider of Services file, census data on metropolitan and micropolitan areas, internet searches, and personal communication with the Department of Health and Human Services Office of Rural Health Policy.

- In fiscal year 2021, 10 general short-term acute care hospitals participating in the Medicare program closed, and 11 hospitals opened. The number of closures decreased from the peak in 2019, while the number of openings stayed relatively consistent with historical trends. The decline in closures was likely a result of the substantial financial support provided by the federal government to hospitals during the coronavirus public health emergency.

- Among the 10 hospital closures in 2021, 6 were in metropolitan counties, 1 was in a rural micropolitan county, and 3 were in other rural counties.

- Nearly all of the hospital openings from 2017 to 2021 were in metropolitan counties.

Chart 6-3. Short-term acute care hospitals' occupancy rate declined slightly in 2020

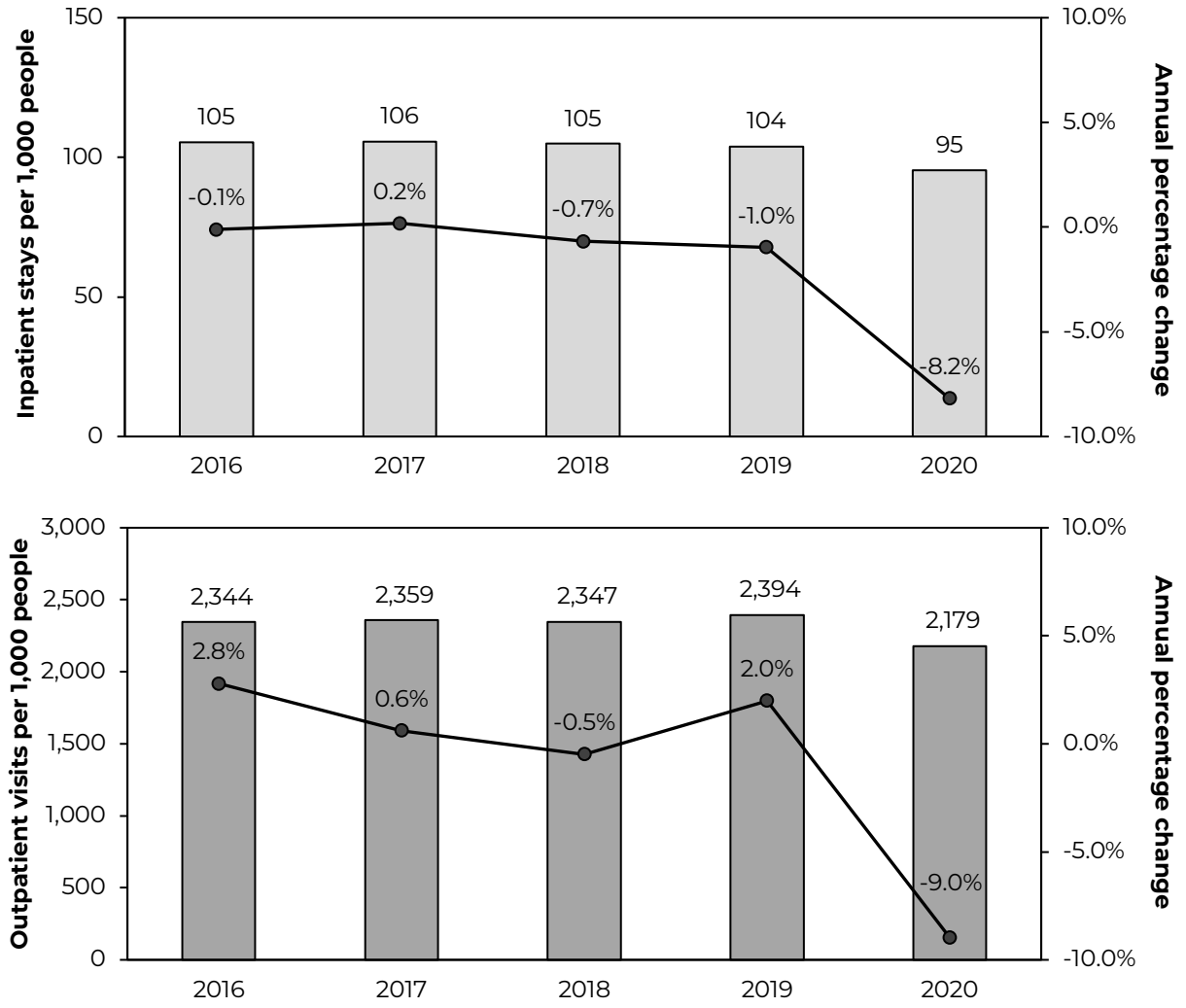


Note: "Aggregate occupancy rate" is calculated as total used bed days (including inpatient, swing, and observation bed days but excluding nursery bed days) divided by total bed days available. "Average daily census" is calculated as total used bed days divided by 365; "beds" refers to total bed days available divided by 365. 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 2020 and were complete as of our analysis. Occupancy rates may vary slightly from calculations of components due to rounding.

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

- Due to cost report filing extensions during the public health emergency, the number of hospitals in this chart is lower than in prior years.
- With that caveat, the short-term acute care hospitals' occupancy rate declined slightly in 2020, reversing the prior trend of slight increases in the aggregate occupancy rate from 2016 through 2019.
- While the second chart indicates a decline in both inpatient beds and average daily census in 2020, the decline is driven by the decline in the number of included hospitals.
- Hospital occupancy rates varied by month and state, with more states having higher occupancy rates as the coronavirus pandemic continued into 2021 (data not shown).

Chart 6-4. All-payer inpatient stays per capita and outpatient visits per capita declined in 2020



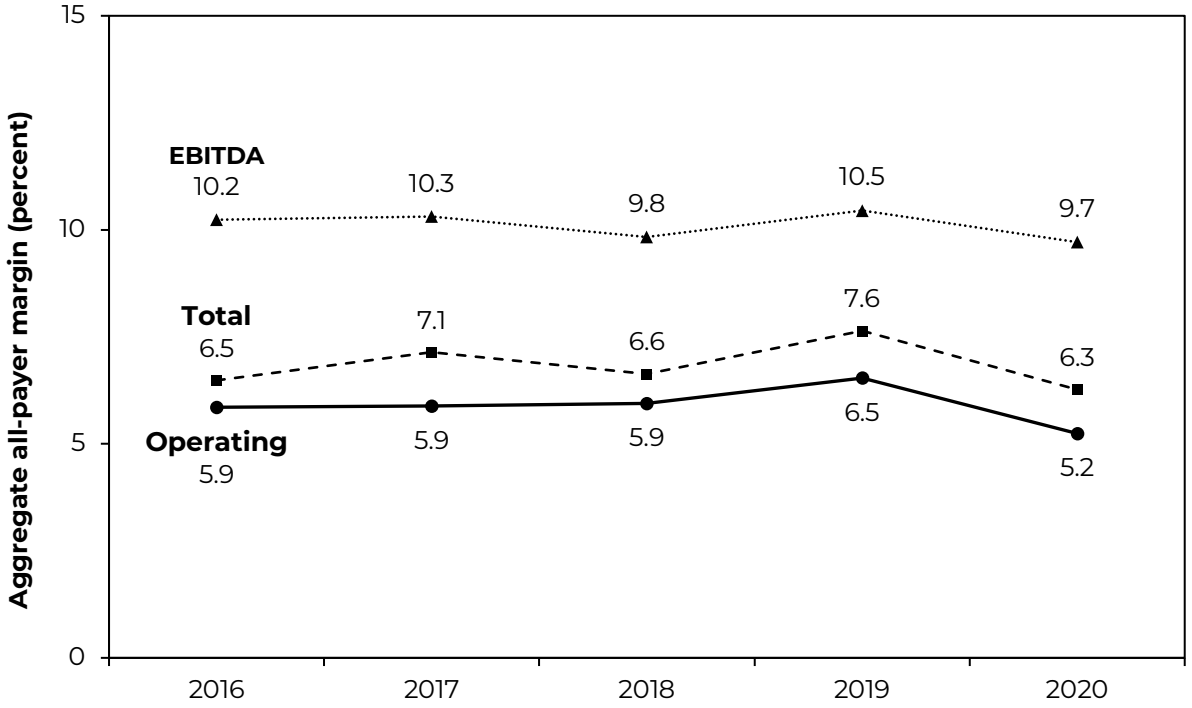
Note: "Outpatient visits" includes all clinic visits, referred visits, observation services, outpatient surgeries, and emergency department visits, regardless of the number of diagnostic and/or therapeutic treatments the patient received during the visit. Data are for community hospitals (nonfederal short-term general and specialty hospitals), estimated from those who responded to the American Hospital Association survey and reflect each hospital's own fiscal year. Given that not all hospitals are reporting the same 12-month period, the 2020 data reflect varying numbers of months of COVID-19 impacts.

Source: MedPAC analysis of Hospital Statistics data from the American Hospital Association and U.S. population estimates from National Health Expenditure data.

- In 2020, all-payer inpatient stays and hospital outpatient visits per capita declined, reflecting delayed and forgone care during the COVID-19 public health emergency. The exact numbers in 2020 should be interpreted with caution because hospitals reported data based on their own fiscal year, reflecting varying numbers of months of pandemic impacts.

- In contrast, from 2016 to 2019, there were divergent trends in all-payer inpatient stays and hospital outpatient visits per capita, with a cumulative 1.5 percent decline in inpatient stays but a 2.1 percent growth in outpatient visits.

Chart 6-5. IPPS hospitals' all-payer margin remained strong in 2020 with the support of federal relief funds



Note: IPPS (inpatient prospective payment systems), EBITDA (earnings before interest, taxes, depreciation, and amortization). Hospitals' margin is calculated as aggregate payments minus aggregate allowable costs, divided by aggregate payments. "All-payer" margin includes payments from all payers and, in 2020, reported federal relief funds. "Total margin" includes investments; "operating" margin is limited to patient care revenue; and EBITDA margin is a measure of cash flow. Data are for IPPS hospitals in the U.S. (excluding territories) that had a cost report with a midpoint in fiscal year 2020 and were complete as of our analysis.

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

- Hospitals' aggregate all-payer margin reflects the relationship between hospitals' payments and costs across all payers (Medicare, Medicaid, other government payers, and private payers). The all-payer total margin includes investment income, while the operating margin is limited to patient care revenue, and the EBITDA margin measures cash flow. In 2020, these measures include reported federal relief funds to support hospitals during the COVID-19 public health emergency.

- IPPS hospitals' all-payer total, operating, and EBITDA margins remained strong in 2020 with the support of over $32 billion in reported federal relief funds.

- The exact 2020 all-payer margins presented in this chart should be interpreted with caution. In particular, hospitals reported data based on their own fiscal year, reflecting varying numbers of months of pandemic impacts and differences in the extent to which they include federal relief funds. In addition, the final amount of federal relief funds that hospitals will end up retaining is still not known.

Chart 6-6. IPPS hospitals' all-payer total margin continued to vary across hospital groups in 2020, including differences in targeted federal relief funds

Hospital group	All-payer total margin					
	2016	2017	2018	2019	2020 without relief funds	2020 with relief funds
All IPPS	6.5%	7.1%	6.6%	7.6%	3.0%	6.3%
Metropolitan (urban)	6.6	7.2	6.8	7.8	3.1	6.2
Micropolitan	5.3	6.3	5.1	6.6	3.1	7.0
Other rural	1.9	2.7	0.7	1.4	–0.8	3.9
For profit	10.8	10.5	11.3	12.4	10.3	12.3
Nonprofit	6.2	7.3	6.3	7.3	2.5	5.9
DSH and teaching	6.3	7.0	6.4	7.4	2.3	5.6
DSH only	6.5	6.9	6.7	7.6	4.3	7.6
Teaching only	7.8	9.9	9.7	8.8	4.7	6.6
Neither	8.8	9.6	9.1	10.6	6.7	9.1
CAHs	3.7	3.6	2.8	3.6	2.1	6.4

Note: IPPS (inpatient prospective payment systems), DSH (disproportionate share hospital), CAH (critical access hospital). "Relief funds" refers to Provider Relief Fund payments and Paycheck Protection Program forgiven loans recorded on hospitals' cost reports. Hospitals' margin is calculated as aggregate payments minus aggregate allowable costs, divided by aggregate payments. "All-payer total margin" includes payments from all payers and from investments and, for 2020, is reported with and without reported federal relief funds. Metropolitan (urban) counties contain an urban cluster of 50,000 or more people; rural micropolitan counties contain a cluster of 10,000 to 50,000 people; all other counties are classified as "other rural." Data are for IPPS hospitals in the U.S. (excluding territories) that had a cost report with a midpoint in fiscal year 2020 and were complete as of our analysis.

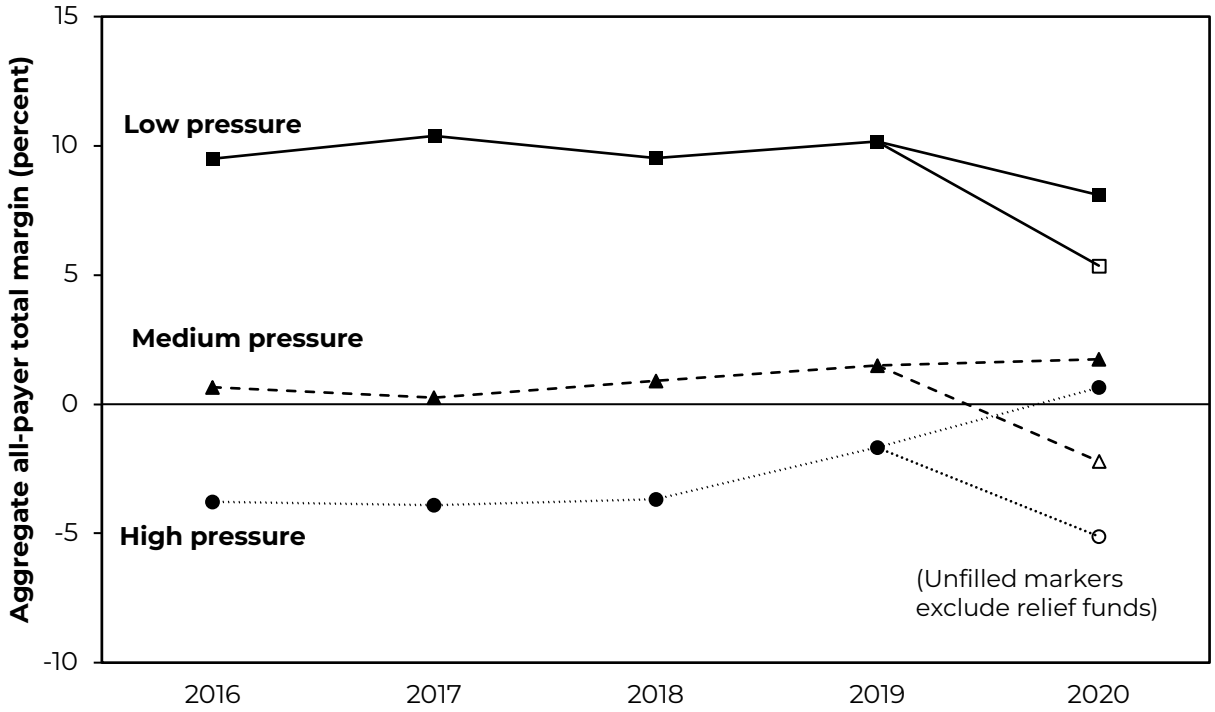
Source: MedPAC analysis of hospital cost report data from CMS.

- In 2020, there continued to be substantial variation in the all-payer total margin across hospital groups, and the variation increased relative to 2019. The exact 2020 all-payer margins presented in this chart should be interpreted with caution. In particular, hospitals reported data based on their own fiscal year, reflecting varying numbers of months of pandemic impacts and differences in the extent to which they include federal relief funds.

- Given those caveats, rural hospitals' all-payer total margin reached a near record high in 2020 (3.9 percent) due to the targeted relief funds these hospitals received.

- Disproportionate share hospitals' all-payer total margin declined in 2020 among those that were also teaching hospitals and held steady among those that were not also teaching hospitals. However, this difference in part reflects that teaching hospitals are more likely to have cost reporting years ending in June, before the 90-day period that DSH hospitals had to attest to the targeted relief funds.

Chart 6-7. IPPS hospitals' all-payer total margin continued to be higher for those under low fiscal pressure, 2016–2020



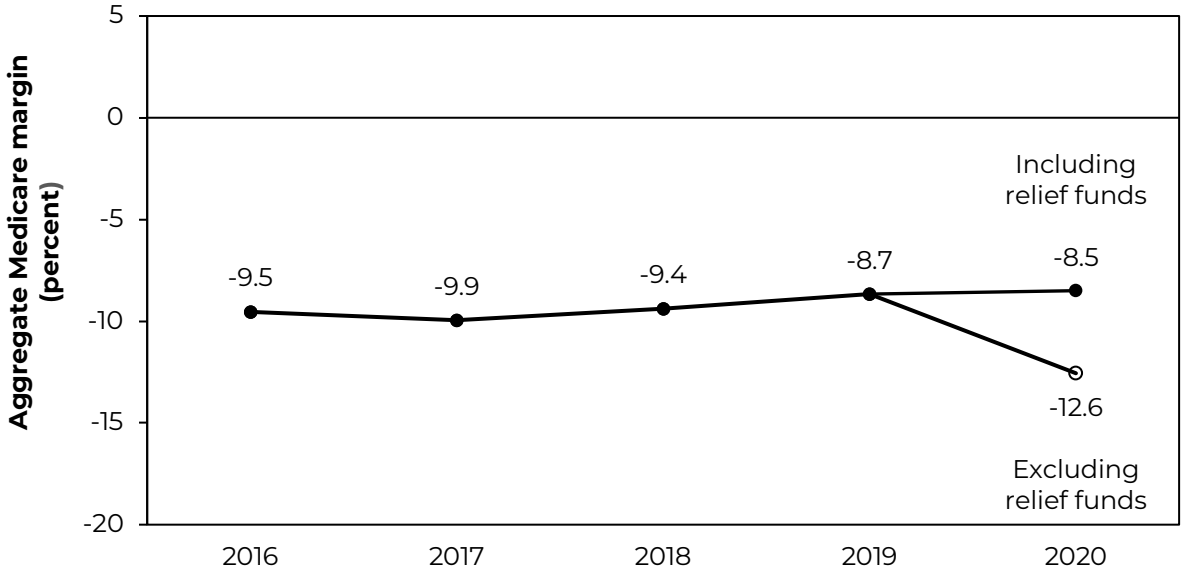
Note: IPPS (inpatient prospective payment systems). "Relief funds" refers to Provider Relief Fund payments and Paycheck Protection Program forgiven loans recorded on hospitals' cost reports. Hospitals' margin is calculated as aggregate payments minus aggregate allowable costs, divided by aggregate payments. "All-payer total margin" includes payments from all payers, from investments, and, in 2020, with and without reported federal relief funds. "Low-pressure" hospitals are defined as those with a median non-Medicare profit margin greater than 5 percent over five years and a net worth that would have grown by more than 1 percent per year over that period if the hospital's Medicare profits had been zero. "High-pressure" hospitals are defined as those with a median non-Medicare profit margin of 1 percent or less over five years and a net worth (assets minus liabilities) that would have grown by less than 1 percent per year over that period if the hospital's Medicare profits had been zero. "Medium-pressure" hospitals are those that fit into neither the high- nor the low-pressure categories. Data are for IPPS hospitals in the U.S. (excluding territories) that had a cost report with a midpoint in fiscal year 2020 and were complete as of our analysis.

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

- The all-payer total margin continued to vary depending on IPPS hospitals' level of fiscal pressure. IPPS hospitals under low fiscal pressure—defined as those with a median non-Medicare profit margin of greater than 5 percent and growth in net worth—continued to have a higher aggregate all-payer total margin than hospitals under more fiscal pressure. (In contrast, the aggregate Medicare margin is lower among IPPS hospitals under low fiscal pressure; see Chart 6-10.)

- While this variation held in 2020, IPPS hospitals under high fiscal pressure disproportionately benefited from federal relief funds, such that their 2020 all-payer total margin including relief funds became positive. The exact 2020 all-payer margins presented in this chart should be interpreted with caution. In particular, hospitals reported data based on their own fiscal year, reflecting varying numbers of months of pandemic impacts and differences in the extent to which they include federal relief funds.

Chart 6-8. IPPS hospitals' Medicare margin remained negative in 2020, but increased slightly when including Medicare's share of federal relief funds



Note: IPPS (inpatient prospective payment systems). "Relief funds" refers to Provider Relief Fund payments and Paycheck Protection Program forgiven loans recorded on hospitals' cost reports, with the Medicare share calculated using fee-for-service Medicare's share of 2019 all-payer operating revenue. Hospitals' "Medicare margin" is calculated as aggregate Medicare payments minus aggregate allowable Medicare costs, divided by aggregate payments. Payments and costs include multiple hospital service lines (including inpatient, outpatient, swing bed, skilled nursing, rehabilitation, psychiatric, and home health services) as well as direct graduate medical education and uncompensated care payments. Data are for IPPS hospitals in the U.S. (excluding territories) that had a cost report with a midpoint in fiscal year 2020 and were complete as of our analysis.

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

- Hospitals' Medicare margin reflects the relationship between hospitals' Medicare fee-for-service (FFS) payments and Medicare-allowable costs across inpatient, outpatient, and other services, as well as supplemental Medicare payments not tied to the provision of services (such as uncompensated care and direct graduate medical education payments).

- From 2019 to 2020, IPPS hospitals' Medicare margin fell when excluding federal relief funds. However, because federal relief funds were intended to help cover lost revenue and payroll costs—including lost revenue from Medicare patients and the cost of staff who help treat these patients—we include a portion of these relief funds (based on FFS Medicare's share of 2019 all-payer operating revenue) in our Medicare margins. Using this method, we allocated $6.4 billion of the over $32 billion in federal funds that hospitals reported on their cost reports toward hospitals' care of FFS Medicare beneficiaries. With these relief funds, IPPS hospitals' 2020 Medicare margin increased slightly from 2019.

- The exact 2020 Medicare margins presented in this chart should be interpreted with caution. In particular, hospitals reported data based on their own fiscal year, reflecting varying numbers of months of pandemic impacts and differences in the extent to which they include federal relief funds.

Chart 6-9. IPPS hospitals' Medicare margin continued to vary across hospital groups in 2020, including differences in targeted federal relief funds

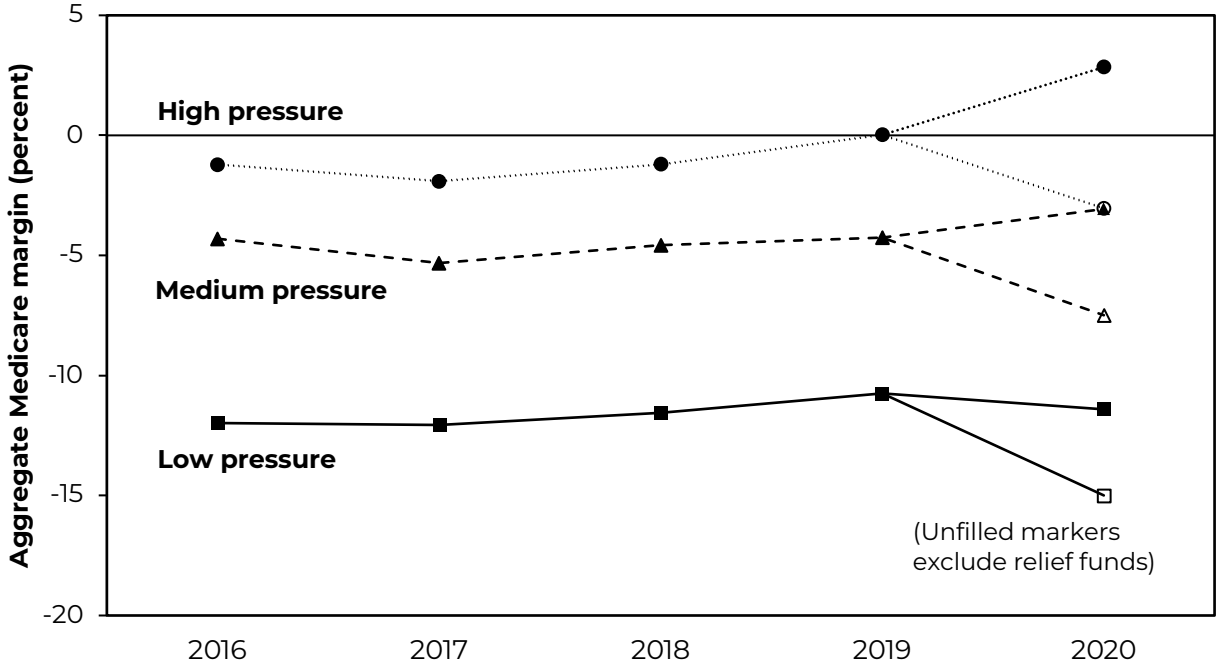
Hospital group	Medicare total margin					
	2016	2017	2018	2019	2020 without relief funds	2020 with relief funds
All IPPS	–9.5%	–9.9%	–9.4%	–8.7%	–12.6%	–8.5%
Metropolitan (urban)	–9.7	–10.1	–9.6	–9.0	–13.0	–9.1
Micropolitan	–8.0	–8.3	–6.9	–6.1	–8.4	–3.8
Other rural	–4.1	–5.6	–5.3	–2.6	–4.2	1.3
For profit	–2.3	–2.8	–1.0	0.5	0.5	3.1
Nonprofit	–10.8	–11.0	–10.6	–10.1	–14.8	–10.5
DSH and teaching	–8.3	–8.6	–8.3	–7.8	–12.1	–8.0
DSH only	–10.6	–11.1	–10.4	–9.1	–12.2	–8.1
Teaching only	–14.1	–15.0	–13.2	–12.7	–17.3	–14.8
Neither	–16.7	–17.9	–15.7	–15.2	–18.4	–15.2
CAHs	–1.7	–1.8	–1.9	–1.8	–1.2	3.6

Note: IPPS (inpatient prospective payment systems), DSH (disproportionate share hospital), CAH (critical access hospital). "Relief funds" refers to Provider Relief Fund payments and Paycheck Protection Program forgiven loans recorded on hospitals' cost reports, with the Medicare share calculated using fee-for-service Medicare's share of 2019 all-payer operating revenue. Hospitals' "Medicare margin" is calculated as aggregate Medicare payments minus aggregate allowable Medicare costs, divided by aggregate payments. Payments and costs include multiple hospital service lines (including inpatient, outpatient, swing bed, skilled nursing, rehabilitation, psychiatric, and home health services) as well as direct graduate medical education and uncompensated care payments. Metropolitan (urban) counties contain an urban cluster of 50,000 or more people; rural micropolitan counties contain a cluster of 10,000 to 50,000 people; all other counties are classified as "other rural." Data are for IPPS hospitals in the U.S. (excluding territories) or CAHs that had a cost report with a midpoint in fiscal year 2020 and were complete as of our analysis.

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

- In 2020, there continued to be substantial variation in hospitals' Medicare margins, and the variation increased relative to 2019. The exact 2020 all-payer margins presented in this chart should be interpreted with caution. In particular, hospitals reported data based on their own fiscal year, reflecting varying numbers of months of pandemic impacts and the extent to which they include federal relief funds.
- Given those caveats, rural hospitals continued to have a higher Medicare margin than urban hospitals and had a larger increase when including federal relief funds.
- Disproportionate share hospitals continued to have a higher Medicare margin than other hospitals and had a larger increase after allocating federal relief funds.
- For-profit hospitals continued to have a higher Medicare margin than nonprofits and maintained a positive Medicare margin even prior to federal relief fund allocation.

Chart 6-10. IPPS hospitals' Medicare margin continued to be higher for those under high fiscal pressure, 2016–2020



Note: IPPS (inpatient prospective payment systems). "Relief funds" refers to Provider Relief Fund payments and Paycheck Protection Program forgiven loans recorded on hospitals' cost reports. Hospitals' "Medicare margin" is calculated as aggregate Medicare payments minus aggregate allowable Medicare costs, divided by aggregate payments. Payments and costs include multiple hospital service lines (including inpatient, outpatient, swing bed, skilled nursing, rehabilitation, psychiatric, and home health services) as well as direct graduate medical education and uncompensated care payments. "High-pressure" hospitals are defined as those with a median non-Medicare profit margin of 1 percent or less over five years and a net worth (assets minus liabilities) that would have grown by less than 1 percent per year over that period if the hospital's Medicare profits had been zero. "Low-pressure" hospitals are defined as those with a median non-Medicare profit margin greater than 5 percent over five years and a net worth that would have grown by more than 1 percent per year over that period if the hospital's Medicare profits had been zero. "Medium-pressure" hospitals are those that fit into neither the high- nor the low-pressure categories. Data are for IPPS hospitals in the U.S. (excluding territories) that had a cost report with a midpoint in fiscal year 2020 and were complete as of our analysis.

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

- IPPS hospitals' Medicare margin continued to vary depending on their level of fiscal pressure. IPPS hospitals under the highest fiscal pressure—defined as those with a median non-Medicare profit margin of 1 percent or less and a lack of material growth in worth—continued to have a higher aggregate Medicare margin than hospitals under less fiscal pressure. (In contrast, IPPS hospitals under fiscal pressure have a lower all-payer total margin; see Chart 6-7.)

- While this variation held in 2020, IPPS hospitals under high fiscal pressure disproportionately benefited from federal relief funds, causing their 2020 Medicare margin including relief funds to become positive. The exact 2020 Medicare margins presented in this chart should be interpreted with caution. In particular, hospitals reported data based on their own fiscal year, reflecting varying numbers of months of pandemic impacts and differences in whether they include federal relief funds.

Chart 6-11. Financial pressure led to lower hospital costs per discharge in 2020

	Level of financial pressure, 2015–2019		
	High pressure (non-Medicare margin ≤ 1%)	Medium pressure	Low pressure (non-Medicare margin > 5%)
Number of hospitals	590	314	1,618
Financial characteristics, 2020 (medians)			
Non-Medicare margin (private, Medicaid, uninsured)	–3%	5%	13%
Standardized cost per Medicare discharge (as a share of the national median)			
For-profit and nonprofit hospitals	0.93	0.97	1.03
Nonprofit hospitals	0.97	1.00	1.05
For-profit hospitals	0.85	0.87	0.93
Annual growth in cost per discharge, 2017–2020	5%	5%	5%
Medicare margin (Before federal relief funds)	–2%	–6%	–12%
Patient characteristics (medians)			
Total hospital discharges in 2020	3,345	5,651	7,823
Medicare share of inpatient days*	58%	59%	59%
Medicaid share of inpatient days*	24%	24%	21%
Medicare case-mix index	1.46	1.56	1.69

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 systems with over 500 discharges that had complete cost reports as of the time of our analysis. "High-pressure" hospitals are defined as those with a median non-Medicare profit margin of 1 percent or less over five years and a net worth (assets minus liabilities) that would have grown by less than 1 percent per year over that period if the hospital's Medicare profits had been zero. "Low-pressure" hospitals are defined as those with a median non-Medicare profit margin greater than 5 percent over five years and a net worth that would have grown by more than 1 percent per year over that period if the hospital's Medicare profits had been zero. "Medium-pressure" hospitals are those that fit into neither the high- nor the low-pressure categories.
* Unlike data books in prior years that focused on Medicare fee-for-service (FFS) days, the number of Medicare and Medicaid inpatient days in this chart includes FFS days and managed care days. Most inpatient days are now either Medicaid or Medicare.

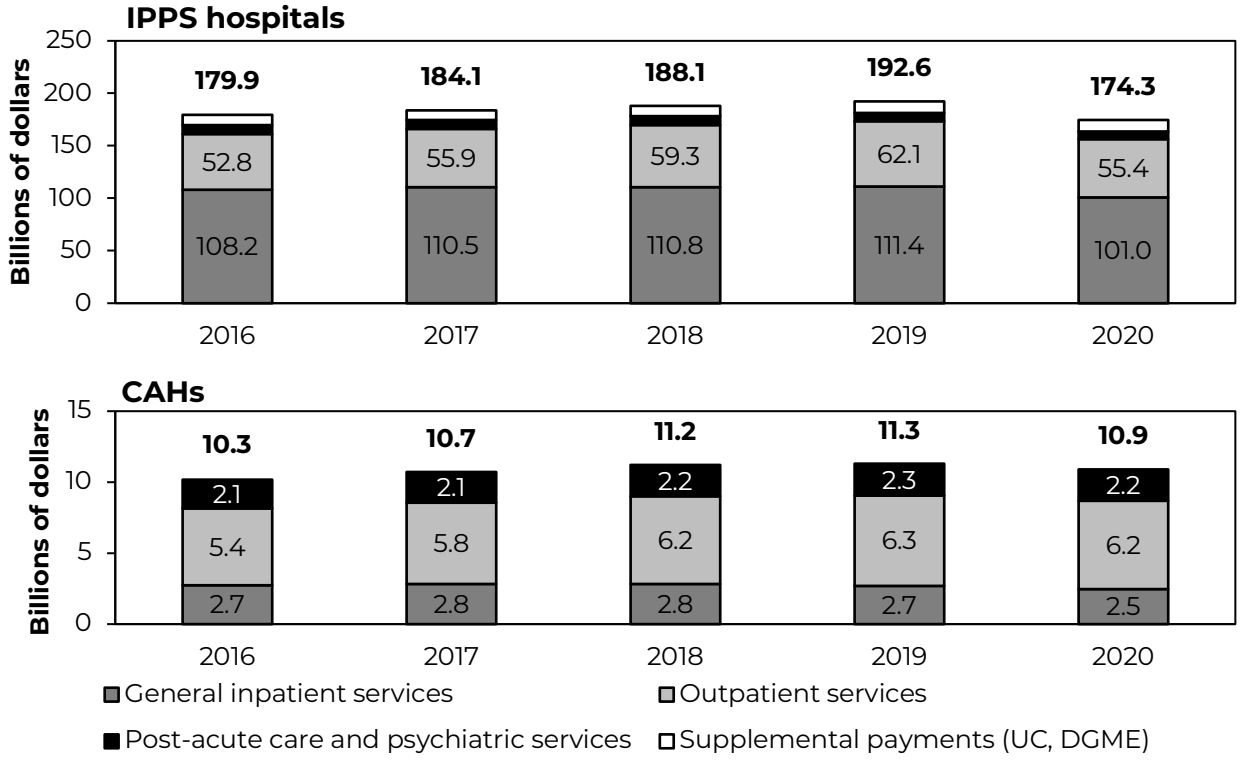
Source: MedPAC analysis of hospital cost report data and claims files from CMS.

- Hospitals under high financial pressure had 7 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 7 percent below the median even when they were not under financial pressure.

- Hospitals with lower volume and lower case mix are more likely to be under financial pressure.

- Cost per case grew rapidly in 2020 due to the pandemic's effect on costs, volume, and case mix. One limitation of this analysis is that it measures only hospital inpatient costs.

Chart 6-12. Medicare FFS payments for inpatient services continued to be the largest component of payments to IPPS hospitals but not to CAHs, 2016–2020



Note: FFS (fee-for-service), IPPS (inpatient prospective payment systems), CAH (critical access hospital), UC (uncompensated care), DGME (direct graduate medical education). Medicare-designated CAHs are limited to 25 beds and primarily operate in rural areas; Medicare pays these hospitals based on their reported costs. Data are for IPPS hospitals in the U.S. (excluding territories) or CAHs with complete cost report data as of the time of our analysis. Components may not sum to totals due to rounding and components with values not shown. The 2020 payment amounts do not include Medicare's share of Provider Relief Fund payments or Paycheck Protection Program forgiven loans provided as part of the public health emergency.

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

- In 2020, Medicare FFS payments for general inpatient services continued to be the largest component of payments to IPPS hospitals, while payments for outpatient services continued to be the largest component of payments to CAHs.
- For both IPPS hospitals and CAHs, the share of total Medicare FFS payments for inpatient services has been slowly declining while the share for outpatient services has been increasing.
- The exact 2020 payments should be interpreted with caution. The decrease in Medicare FFS payments reflects both the decrease in services during the COVID-19 public health emergency and a lower number of hospitals due to cost report filing extensions during the public health emergency.

Chart 6-13. About 15 percent of IPPS payments in 2020 were from adjustments and additional payments

Hospital group	Share of IPPS payments					
	Base PPS	Low income (DSH)	Teaching (IME)	Outliers	Rural and/or isolated	Quality
All IPPS	84.5%	3.2%	6.9%	4.7%	1.3%	–0.8%
Metropolitan (urban)	84.6	3.3	7.2	4.9	0.6	–0.8
Micropolitan	84.2	2.4	2.4	2.3	9.1	–0.5
Other rural	79.9	2.4	0.6	1.3	16.4	–0.6
For profit	89.7	3.4	4.1	2.9	0.9	–1.2
Nonprofit	84.8	3.0	6.8	4.6	1.2	–0.7
Government	77.4	4.1	10.1	7.0	2.1	–0.9
DSH and teaching	81.1	3.6	10.0	5.4	0.6	–0.9
DSH only	91.2	3.1	0.0	3.2	3.1	–0.8
Teaching only	89.1	0.1*	6.0	4.3	0.6	–0.3
Neither	94.1	0.1*	0.0	2.9	3.2	–0.5
Sole community	79.6	2.3	2.6	2.4	13.4	–0.4
Medicare dependent	82.8	2.0	0.5	1.2	14.2	–0.5
Low volume	78.8	2.1	0.7	1.5	17.1	–0.2

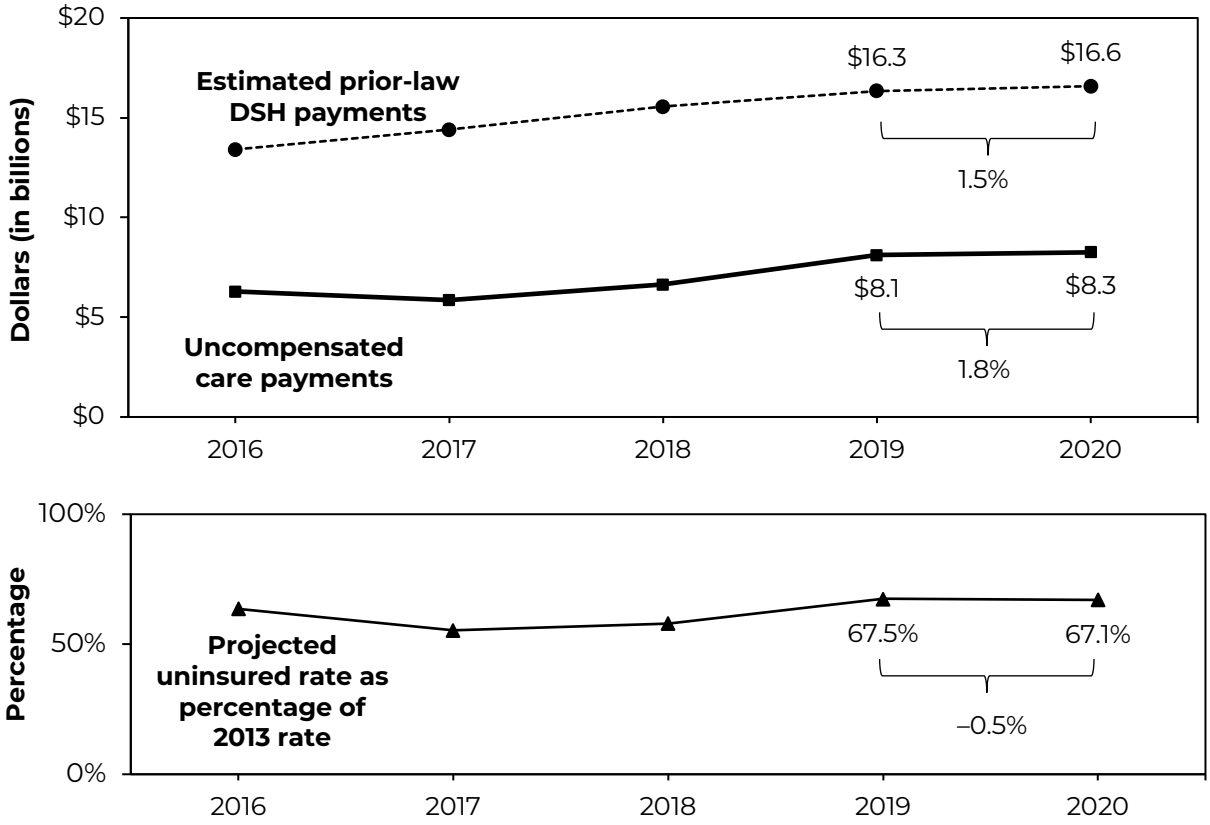
Note: IPPS (inpatient prospective payment systems), DSH (disproportionate share hospital), IME (indirect medical education). Payments are shares of total inpatient operating and capital PPS payments and exclude uncompensated care, direct graduate medical education, Medicare Advantage IME, and other pass-through payments outside of the IPPS. "Rural and/or isolated" includes additional payments to sole community hospitals, Medicare-dependent hospitals, and low-volume hospitals. While sole community and Medicare-dependent hospitals that are paid on their hospital-specific rate do not technically receive any base PPS payments or adjustments, the "Rural and/or isolated" column includes only the amount by which their rate exceeds the otherwise applicable IPPS payments. "Quality" includes payments and penalties from the Value-Based Purchasing Program, Hospital Readmissions Reduction Program, and Hospital-Acquired Conditions Reduction Program. Metropolitan (urban) counties contain an urban cluster of 50,000 or more people; rural micropolitan counties contain a cluster of 10,000 to 50,000 people; all other counties are classified as "other rural." Components may not sum to totals due to rounding and because other types of payments, such as new technology payments, are not included in the table. Data are for IPPS hospitals in the U.S. (excluding territories) with complete cost report data as of the time of our analysis.
* DSH group is defined by receiving inpatient operating DSH payments, while the DSH payments column includes both inpatient operating and capital DSH payments. All urban hospitals with more than 100 beds are eligible for inpatient capital DSH payments.

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

- In 2020, base payments accounted for about 85 percent of IPPS payments to hospitals for inpatient services provided to Medicare fee-for-service beneficiaries, while low-income and teaching adjustments, outlier payments, rural and/or isolated payments, and quality payments and penalties accounted for the remaining 15 percent.

- While the exact 2020 payments should be interpreted with caution due to the public health emergency, the share of IPPS payments for different adjustments was similar to those in 2019, which had more complete data.

Chart 6-14. Medicare's uncompensated care payments to IPPS hospitals increased nearly 2 percent in 2020

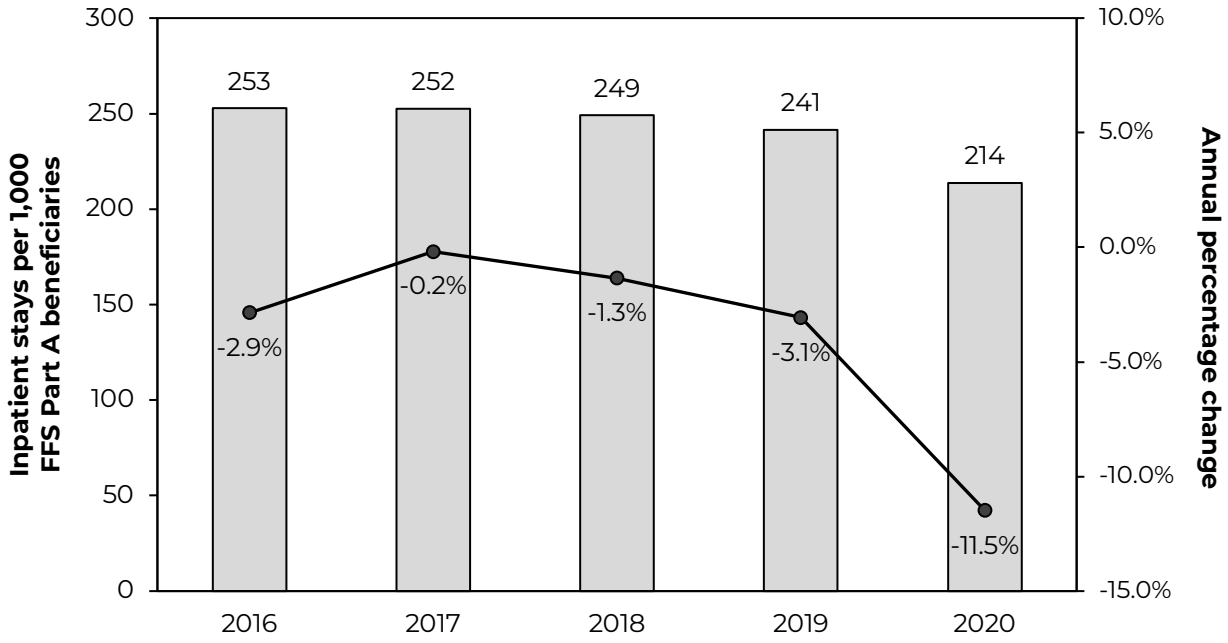


Note: IPPS (inpatient prospective payment systems), DSH (disproportionate share hospital). "Estimated prior-law DSH payments" refers to operating DSH payments only. "Uncompensated care payments" are postsequestration; the 2 percent sequestration of Medicare payments was suspended in May 2020. CMS estimated that from 2019 to 2020, the uninsured rate declined from 9.5 percent to 9.4 percent, equivalent to a change from 67.7 percent to 67.1 percent of the 2013 uninsured rate of 14 percent. There was also a 0.2 percentage point mandatory reduction in 2019, bringing the projected uninsured rate in 2019 down to 67.5 percent.

Source: MedPAC analysis of IPPS final rules.

- In addition to IPPS payments for fee-for-service Medicare beneficiaries' inpatient stays, the Medicare program makes uncompensated care payments to IPPS hospitals to help cover their costs of treating uninsured patients. When the rate of uninsured individuals increases and hospitals have greater losses on uncompensated care, the Medicare program makes higher uncompensated care payments to hospitals.
- In 2020, uncompensated care payments grew 1.8 percent to $8.3 billion. Under current law, the uncompensated care pool is the product of two factors: 75 percent of the estimated DSH payment under prior law and the uninsured rate as a percentage of the rate in 2013. This amount is subject to sequestration (when the sequester is in effect). Thus, the 1.8 percent growth in the 2020 uncompensated care pool was the result of (1) an estimated 1.5 percent increase in what DSH payments would have been under prior law; (2) a projected 0.5 percent decline in the national uninsured rate relative to 2013 (after taking into account the mandatory reduction through 2019); and (3) a 0.8 percent increase from the suspension of Medicare sequestration.

Chart 6-15. Medicare FFS inpatient stays per capita declined more than 11 percent in 2020



Note: FFS (fee-for-service). Data are for short-term acute care hospitals in the U.S. (exclusive of territories). The number of inpatient stays per 1,00 FFS Part A beneficiaries can change from what was previously published when CMS updates its estimates of FFS enrollment.

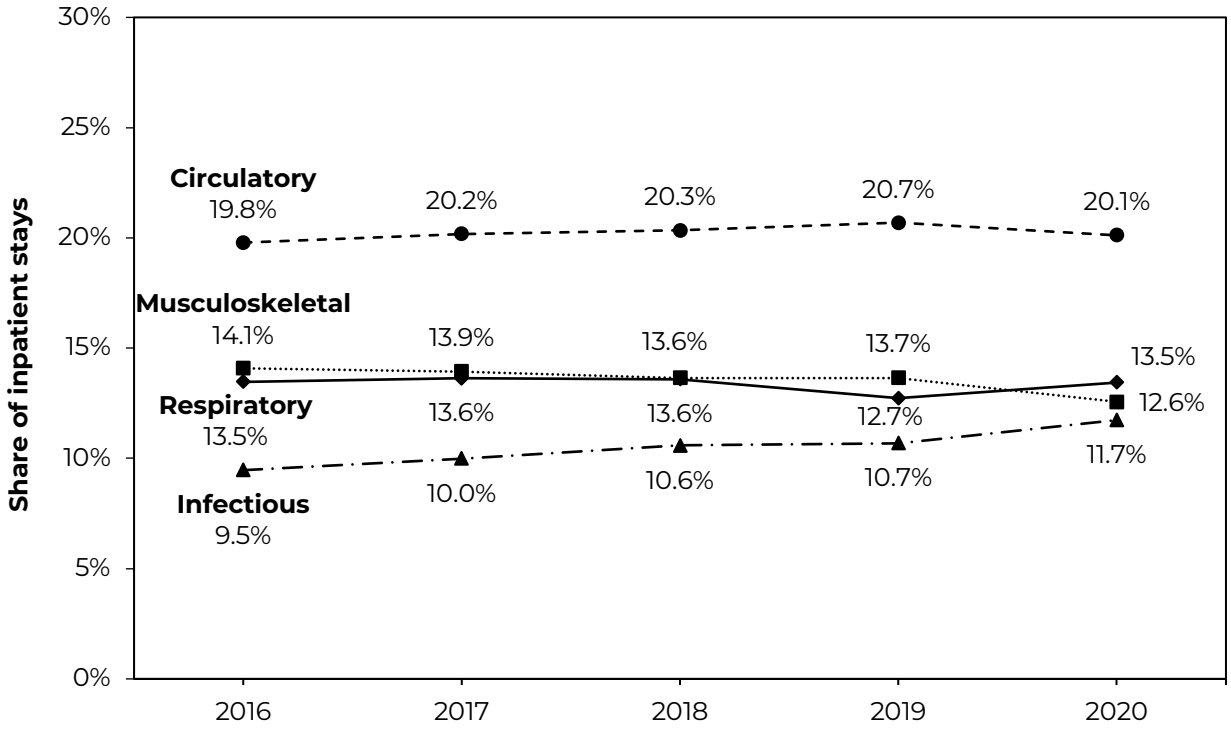
Source: MedPAC analysis of Medicare Provider Analysis and Review data and enrollment data from CMS.

- The number of inpatient stays per 1,000 Medicare FFS beneficiaries decreased from 241 in 2019 to 214 in 2020, an 11.5 percent decline. This decline is slightly larger than the 8.2 percent decline in all-payer inpatient stays per capita, though that difference could reflect differences in reporting hospitals (see Chart 6-4).

- The decrease in Medicare FFS inpatient stays per capita in 2020 was driven by a large drop in spring 2020, followed by a partial rebound as beneficiaries and providers continued to postpone care because of the coronavirus pandemic. For the first five months of fiscal year 2020 (from October 2019 through February 2020), Medicare FFS inpatient stays per capita were slightly below 2019 levels, while average case mix was slightly higher—both consistent with historical trends. However, in March 2020, inpatient volume began to decline, and by April, inpatient stays per capita were 40 percent below the level in 2019. Inpatient volume partially rebounded by summer 2020 but remained about 15 percent below 2019 levels through the end of fiscal years 2020 and 2021, and case mix remained about 6 percent higher than 2019 levels (data not shown).

- The magnitude of the decrease in Medicare FFS inpatient stays per capita varied across types of hospitals. For example, from 2019 to 2020, the number of Medicare FFS inpatient stays per capita fell 11.2 percent at hospitals located in metropolitan (urban) areas, 13.1 percent at those in rural micropolitan areas, and 14.1 percent at those located in other rural areas (data not shown).

Chart 6-16. Four major diagnostic categories accounted for over half of all Medicare FFS inpatient stays at short-term acute care hospitals, 2016–2020



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 from CMS.

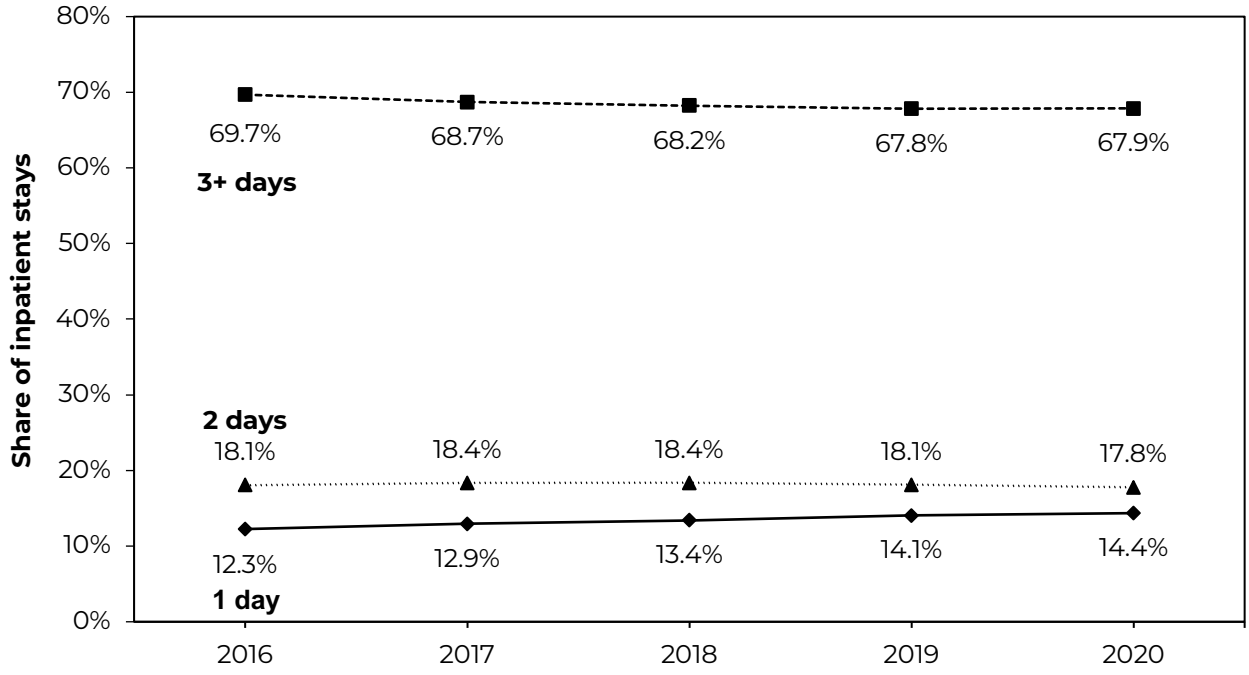
- Over half of all Medicare FFS inpatient stays at short-term acute care hospitals were for beneficiaries with a primary diagnosis in one of four major diagnostic categories: circulatory, musculoskeletal, respiratory, or infectious diseases.

- The most common major diagnostic category of Medicare FFS inpatient stays is diseases of the circulatory system, such as heart failure and cardiac arrhythmia. In each of 2016 through 2020, about 20 percent of Medicare FFS inpatient stays were for circulatory system diseases.

- Of the four most common major diagnostic categories, the one with the largest increase from 2016 to 2020, was infectious and parasitic diseases, such as septicemia. This rise continued a longer-term trend, with the share of Medicare FFS beneficiaries' inpatient stays for infectious diseases doubling since 2010 (data not shown).

- In 2020, the share of Medicare FFS inpatient stays for respiratory conditions increased while the share for musculoskeletal conditions declined, reflecting the increase in COVID-19 stays and delays in nonemergency stays, such as those for hip and knee replacements, during the public health emergency.

Chart 6-17. Share of one-day stays among Medicare FFS beneficiaries at short-term acute care hospitals continued to increase in 2020



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.

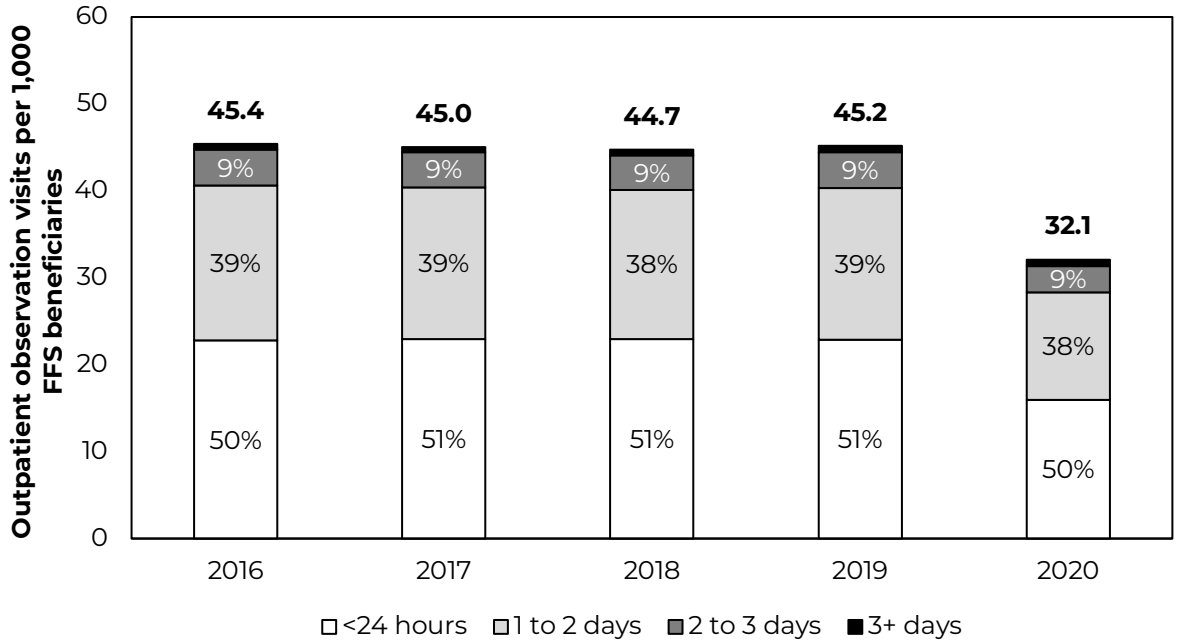
Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS.

- The share of Medicare FFS beneficiaries' inpatient stays at short-term acute care hospitals that were only one day long steadily increased from 2016 to 2020, up to 14.4 percent, reversing the prior trend of declining one-day stays from 2010 to 2014 (data not shown). 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 would deny payment for one-day stays.

- The share of Medicare FFS beneficiaries' inpatient stays that were three days or longer also slightly increased in 2020, reversing the declining trend from 2016 to 2019. The growth in 2020 was driven by an increase in the share of inpatient stays seven days or longer, which increased from 21.1 percent in 2019 to 22.7 percent in 2020 (data not shown). In contrast, the share of stays of exactly three days declined from 18.5 percent in 2019 to 17.2 percent in 2020, which likely in part reflects the waiver during the public health emergency of the three-day stay requirement for skilled nursing facilities.

- Driven by the increase in longer stays, in 2020 the average length of inpatient stay increased 3.9 percent, to 5.14 days per stay (data not shown).

Chart 6-18. Number of Medicare FFS outpatient observation visits per capita declined 30 percent in 2020



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 observation visits—that is, observation visits that did not result in an inpatient admission—per Medicare FFS Part B beneficiary. Years are calendar years. Components may not sum to 100 percent due to rounding and component values not shown.

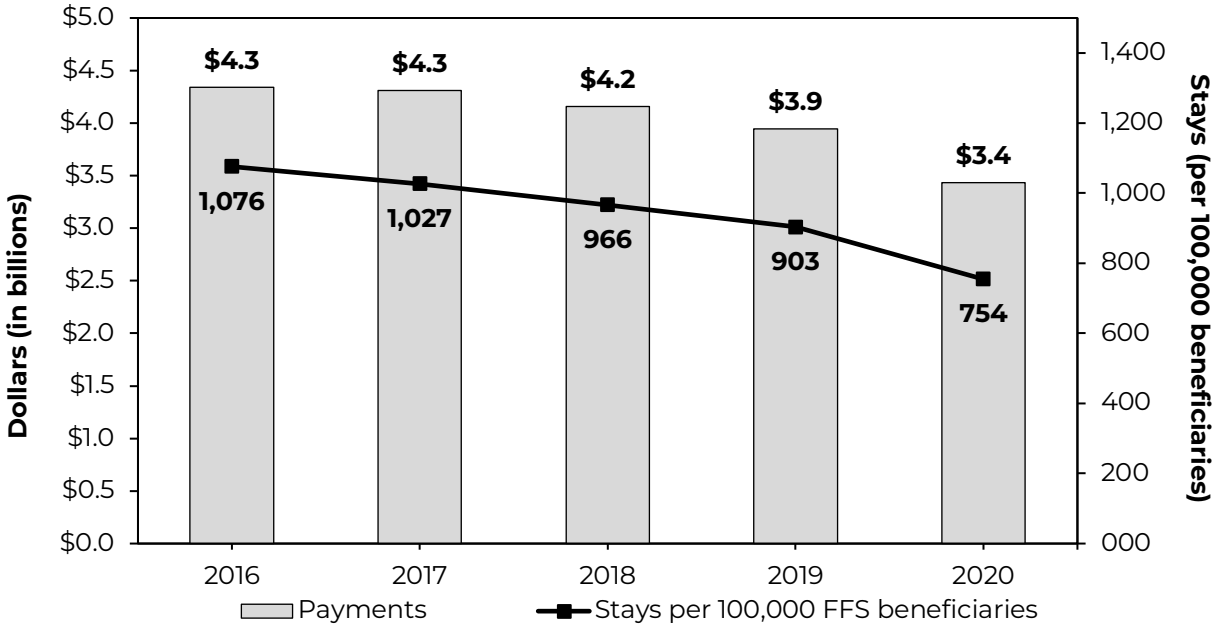
Source: MedPAC analysis of outpatient standard analytical file data from CMS.

- Hospitals sometimes use observation care to determine whether a patient should be hospitalized for inpatient care, transferred to an alternative treatment setting, or sent home.

- The number of Medicare FFS outpatient observation visits per capita remained relatively steady from 2016 to 2019, at about 45 visits per 1,000 beneficiaries. The distribution of observation visits by length of stay also remained steady, with about half longer than 24 hours, including 10 percent that spanned more than 2 days.

- In 2020, the number of Medicare FFS outpatient observation visits per capita declined 30 percent to about 32 visits per 1,000 beneficiaries, though the distribution by length of stay remained similar to prior years. The decline in observation visits in 2020 reflects the COVID-19 public health emergency and is similar to the decline in non-COVID emergency room visits (data not shown).

Chart 6-19. Inpatient psychiatric facility PPS payments and stays continued to decline, with largest decline in FY 2020



Note: PPS (prospective payment system), FY (fiscal year), FFS (fee-for-service). The 2020 payment amounts do not include Medicare's share of Provider Relief Fund payments or Paycheck Protection Program forgiven loans provided as part of the public health emergency.

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 PPS.
- From 2016 to 2019, total (Medicare FFS plus beneficiary) payments for IPF PPS services decreased from $4.3 billion to $3.9 billion—equivalent to a 3 percent annual decrease—and inpatient psychiatric stays decreased from 1,076 stays to 903 per 100,000 Medicare FFS beneficiaries—equivalent to a 6 percent annual decrease.
- From 2019 to 2020, the decrease in payments was 13 percent (from $3.9 billion to $3.4 billion) and the decline in stays was 17 percent (from 903 to 754 per 100,000 Medicare FFS beneficiaries). This substantial decrease is likely related to avoidance or deferral of stays due to the COVID-19 public health emergency.

Chart 6-20. The share of freestanding and for-profit Medicare-certified inpatient psychiatric facilities continued to increase, 2016–2020

Type of IPF	2016	2017	2018	2019	2020	Average annual change 2016–2019	Average annual change 2019–2020
All	1,600	1,610	1,590	1,540	1,530	–1.3%	–0.6%
Share of all							
Urban	78%	78%	78%	79%	79%	0.5	0.0
Rural	21	21	20	19	19	–2.4	–0.5
Freestanding	31	33	33	35	36	3.3	2.7
Hospital-based units	69	67	67	65	64	–1.6	–1.5
Nonprofit	46	46	46	45	44	–1.0	–1.8
For profit	32	33	33	34	34	1.8	1.0
Government	22	22	21	21	22	–0.5	2.1

Note: IPF (inpatient psychiatric facility). Data are from facilities that submitted valid Medicare cost reports and had at least one Medicare IPF prospective payment system stay in the given fiscal year. The number of cases presented differs from past reports due to a change in methodology. IPF counts are rounded to the 10s' place. 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 the Provider of Services data from CMS.

- From 2016 to 2020, the number of IPFs nationwide decreased about 1 percent each year, from about 1,600 to 1,530.
- Most IPFs are located in urban areas (nearly 80 percent). The share of IPFs in urban and rural areas remained mostly steady, with a slight shift in the share of IPFs toward urban areas since 2016.
- Most IPFs (64 percent in 2020) are hospital-based units; however, since 2016, the share of freestanding IPFs grew by approximately 3 percent annually while the share of hospital-based IPFs decreased.
- About a third of IPFs are for profit, and the share of for-profit IPFs has been increasing over time by more than 1 percent annually. The shares of freestanding and for-profit IPFs have steadily increased by nearly 5 percent annually in the past five years (data not shown).

Chart 6-21. Growing share of Medicare FFS beneficiaries' stays at IPFs were for schizophrenia, schizotypal, and other psychotic disorders, 2016–2020

MS–DRG/ ICD–10 block	Diagnosis	2016	2019	2020	Average annual change 2016–2019	Average annual change 2019–2020
885	Psychosis	70.9%	73.4%	74.4%	1%	1%
F30–F39	Mood [affective] disorders	38.7	38.6	37.5	0	–3
F20–F29	Schizophrenia, schizotypal, delusion, and other non-mood psychotic disorders	32.3	34.8	36.9	3	6
884	Organic disturbances and mental retardation	6.6	7.0	6.9	2	–2
057	Degenerative nervous system disorders without MCC	6.5	5.5	4.9	–6	–10
897	Alcohol/drug abuse or dependency, no rehabilitation, without MCC	4.6	4.4	4.2	–2	–3
881	Depressive neurosis	4.4	3.2	2.9	–10	–9
895	Alcohol/drug abuse or dependency with rehabilitation, without MCC	1.6	1.6	1.6	0	–2
882	Neurosis except depressive	1.3	1.3	1.3	1	–4
	Other psychiatric MS–DRGs*	3.1	2.8	3.0	–3	7
	Nonpsychiatric MS–DRGs	0.9	0.8	0.8	–5	4
	Total	100.0	100.0	100.0		

Note: FFS (fee-for-service), IPF (inpatient psychiatric facility), MS–DRG (Medicare severity diagnosis related group), ICD–10 (International Classification of Diseases, 10th Revision), MCC (major comorbidity or complication). Totals may not sum to 100 percent due to rounding.
*Other psychiatric MS–DRGs include 056 (degenerative nervous system disorders with MCC), 080 (nontraumatic stupor and coma with MCC), 081 (nontraumatic stupor and coma without MCC), 876 (operating room procedure with principal diagnosis of mental illness), 880 (acute adjustment reaction and psychosocial dysfunction), 883 (disorders of personality and impulse control), 886 (behavioral and developmental disorders), 887 (other mental disorders), 894 (alcohol/drug use—left against medical advice), 896 (alcohol/drug abuse or dependency without rehabilitation, with MCC)

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

- Medicare FFS patients in IPFs are generally assigned 1 of 17 psychiatric MS–DRGs. However, the MS–DRG system does not differentiate well among Medicare beneficiaries in IPFs; in 2020, 96 percent of cases were assigned to seven MS–DRGs and nearly 75 percent of cases were assigned to the psychosis MS–DRG.

- The psychosis MS–DRG is a broad category including patients with principal diagnoses of mood disorders (such as bipolar disorder and major depression) and non-mood psychotic disorders (such as schizophrenia). From 2016 to 2019, the share of patients with non-mood psychotic disorders increased by 3 percent annually. More recently, from 2019 to 2020, corresponding with the start of the COVID-19 public health emergency, this share increased by 6 percent. In contrast, the share of patients with mood disorders did not change prior to 2019 but decreased by 3 percent between 2019 and 2020. Given that the number of overall IPF stays decreased substantially (see Chart 6-19) during this time, it may be that patients with certain diagnoses (such as schizophrenia and psychotic disorders) were less able to avoid or defer IPF use.

Chart 6-22. Medicare FFS beneficiaries using IPFs tended to be disabled, under age 65, low income, and non-White, FY 2020

Characteristic	Share of all IPF users	Share of IPF users with more than one IPF stay in 2020	Share of all FFS beneficiaries
All	100%	27%	—
Current eligibility status and demographics			
Aged	45	31	87
Disabled	55	69	13
ESRD	0.1	0.0	0.2
Female	50	45	53
Male	50	55	47
<45	24	33	3
45–64	31	36	10
65–79	31	24	66
80+	14	7	21
Non-Hispanic White	73	68	78
Black	16	19	9
Asian/Pacific Islander	1	2	3
Hispanic	6	7	6
American Indian/Alaska native	1	1	1
Other or unknown	3	3	3
Urban	80	83	80
Rural	20	17	20
Dual eligible or LIS during year			
No	33	23	82
Yes	67	77	18

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 Medicare FFS beneficiaries who had at least one IPF stay in 2020, 55 percent qualified for Medicare because of a disability, compared with 13 percent across all FFS beneficiaries. Beneficiaries who used IPF care also tended to be younger and poorer.

- Twenty-seven percent of Medicare FFS beneficiaries who used an IPF in 2020 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 diagnosis), under age 65, low income, and non-White.

- The shares and patterns were similar for beneficiaries using IPFs in 2019.