

hospitals' ratios of residents to beds. The determination of the number of beds, based on available bed days, is specified at § 412.105(b). This determination of the number of available beds is also applicable for other purposes, including the level of the disproportionate share hospital (DSH) adjustment payments under § 412.106(a)(1)(i).

Section 1886(d)(5)(F) of the Act specifies two methods for a hospital to qualify for the Medicare DSH adjustment. The primary method, which is the subject of a provision in this proposed rule, is for a hospital to qualify based on a complex statutory formula under which payment adjustments are based on the level of the DSH patient percentage. The first computation includes the number of patient days that are furnished to patients who were entitled to both Medicare Part A and Supplemental Security Income (SSI) benefits. This number is divided by the total number of patient days that are associated with patients entitled to benefits under Medicare Part A. The second computation includes hospital patient days that are furnished to patients who, for those days, were eligible for Medicaid but were not entitled to benefits under Medicare Part A. This number is divided by the number of total hospital inpatient days in the same period.

Hospitals whose DSH patient percentage exceeds 15 percent are eligible for a DSH payment adjustment (prior to April 1, 2001, the qualifying DSH patient percentage varied, in part, by the number of beds (66 FR 39882)). The DSH payment adjustment may vary based on the DSH patient percentage and the type of hospital: the statute provides for different adjustments for urban hospitals with 100 or more beds and rural hospitals with 500 or more beds, hospitals that qualify as rural referral centers or SCHs, and other hospitals.

We are combining our discussion of proposed changes to the policies for counting beds and patient days, in relation to the calculations at §§ 412.105(b) and 412.106(a)(1)(ii) because the underlying concepts are similar, and we believe they should generally be interpreted in a consistent manner for both purposes. Specifically, we are proposing to clarify that beds and patient days that are counted for these purposes should be limited to beds or patient days in hospital units or wards that would be directly included in determining the allowable costs of inpatient hospital care payable under the IPPS on the Medicare cost report.

As a preliminary matter, beds and patient days associated with these beds that are located in units or wards that are excluded from the IPPS (for example, psychiatric or rehabilitation units), and thus from the determination of allowable costs of inpatient hospital care under the IPPS on the Medicare cost report, are not to be counted for purposes of §§ 412.105(b) and 412.106(a)(1)(ii). The remainder of this discussion pertains to beds and patient days associated with these beds that are located in units or wards that are not excluded from the IPPS and for which costs are included in determining the allowable costs of inpatient hospital care under the IPPS on the Medicare cost report. For example, neonatal intensive care unit beds are included in the determination of available beds because the costs and patient days associated with these beds are directly included in the determination of the allowable costs of inpatient hospital care under the IPPS. In contrast, beds and patient days associated with these beds that are located in excluded distinct-part psychiatric or rehabilitation units would not be counted for purposes of §§ 412.105(b) and 412.106(a)(1)(ii) under any circumstances, because the costs associated with those units or wards are excluded from the determination of the costs of allowable inpatient care under IPPS.

This policy has been upheld in the past by various courts. (See, for example, *Little Co. of Mary Hospital and Health Care Centers v. Shalala*, 165 F.3d 1162 (7th Cir. 1999; *Grant Medical Center v. Shalala*, 905 F. Supp. 460 (S.D. Ohio 1995); *Sioux Valley Hospital v. Shalala*, No. 93-3741SD, 1994 U.S. App. LEXIS 17759 (8th Cir. July 20, 1996) (unpublished table decision); *Amisub v. Shalala*, No. 94-1883 (TFH) (D.D.C. December 4, 1995) (mem.)). In these cases, the courts agreed with the Secretary's position distinguishing between the treatment of neonatal intensive care unit beds and well-baby nursery beds based on the longstanding policy of CMS that neonatal intensive care unit days are considered intensive care days (part of inpatient routine care) rather than nursery days.

Our policies on counting beds are applied consistently for both IME and DSH although the incentives for hospitals can be different for IME and DSH. For purposes of IME, teaching hospitals have an incentive to minimize their number of available beds in order to increase the resident-to-bed ratio and maximize the IME adjustment. On the other hand, for DSH purposes, urban hospitals with under 100 beds and rural

hospitals with under 500 beds may have an incentive to increase their bed count in order to qualify for the higher DSH payments for urban hospitals with over 100 beds (or rural hospitals with over 500 beds).

However, some courts have applied our current rules in a manner that is inconsistent with our current policy and that would result in inconsistent treatment of beds, patient days, and costs. For example, in *Clark Regional Medical Center v. United States Department of Health & Human Services*, 314 F.3d 241 (6th Cir. 2002), the court upheld the district court's ruling that all bed types not specifically excluded from the definition of available bed days in the regulations must be included in the count of available bed days. Similarly, in a recent decision in the Ninth Circuit Court of Appeals *Alhambra v. Thompson*, 259 F.3d 1071 (Ninth Cir. 2001), the court ruled that days attributable to groups of beds that are not separately certified as distinct part beds (that is, nonacute care beds in which care provided is at a level below the level of routine inpatient acute care) but are adjacent to or in an acute care "area" are included in the "areas of the hospital that are subject to the prospective payment system" and should be counted in calculating the Medicare DSH patient percentage.

These courts considered subregulatory guidance (program instructions) in formulating their decisions. Although this proposed rule would clarify the underlying principles for our bed and patient days counting policies and would amend the relevant regulations to be consistent with these clarifications, we recognize the need to revise some of our program instructions to make them fully consistent with these clarifications and will act to do so as soon as possible.

While some of the topics discussed below pertain only to counting available beds (unoccupied beds) and some only to counting patient days (section 1115 waiver days, dual-eligible days, and Medicare+Choice days), several important topics are applicable to both bed-counting and day-counting policies (nonacute care beds and days, observation beds and days, and swing-beds and days). Therefore, for ease of discussion, we have combined all topics pertaining to counting available beds and patient days together in the following discussion.

2. Unoccupied Beds

The current policy for counting hospital beds for IME and DSH is specified at § 412.105(b). That count is based on total available bed days during