

the hospital's cost reporting period, divided by the number of days in the cost reporting period. The regulations specify certain types of beds to be excluded from this count (for example, beds or bassinets in the healthy newborn nursery, custodial care beds, and beds in excluded distinct part hospital units).

Further instructions for counting beds are detailed in section 2405.3, Part I, of the Medicare Provider Reimbursement Manual (PRM). That section states that a bed must be permanently maintained for lodging inpatients and it must be available for use and housed in patient rooms or wards. Thus, beds in a completely or partially closed wing of the facility are considered available only if the hospital can put the beds into use when they are needed.

Currently, if a bed can be staffed for inpatient care either by nurses on staff or from a nurse registry within 24 to 48 hours, the unoccupied bed is determined available.<sup>5</sup> In most cases, it is a straightforward matter to determine whether unoccupied beds can be staffed within this timeframe because they are located in a unit that is otherwise staffed and occupied (an unoccupied bed is available for patient care but it is not occupied by a patient on a particular day). The determination is not as simple in situations where a room in an otherwise occupied unit has been altered for other purposes, such as for a staff lounge or for storage.

Section 2405.3 of the PRM states that beds in unoccupied rooms or wards are to be excluded from the bed count if the associated costs are excluded from depreciable plant assets because the area is not available for patient use. However, issues continue to arise with regard to how to treat entire units or even entire floors that are unoccupied over a period of time. For example, in one recent Provider Reimbursement Review Board (PRRB) decision, the hospital acknowledged that an entire floor was temporarily unoccupied for approximately 2 years. Rooms on the floor were used for office space, storage and outpatient services. The PRRB ruled that current rules allowed these beds to be counted. Specifically, the PRRB found the beds could reasonably be made ready for inpatient use within 24 to 48 hours, the rooms were counted on the hospital's cost report as depreciable plant assets available for patient care, and the hospital could adequately provide patient care in the beds using

staff nurses or nurses from a nurse registry. Upon review, the Administrator also ultimately upheld this decision based on existing policies and instructions.

We do not believe that an accurate bed count should include beds that are essentially hypothetical in nature; for example, when the beds are on a floor that is not used for inpatient care throughout the entire cost reporting period (and, indeed, may have been used for other purposes). Followed to the extreme, a hospital could count every bed in its facility, even if it had no intention of ever using a bed for inpatient care, as long as it would be theoretically possible to place an inpatient in the bed. We do not believe such a result would accurately reflect a hospital's inpatient bed capacity. Even though some teaching hospitals have an incentive to minimize the bed count for payment purposes, some DSH hospitals have an incentive to maximize the bed count for the same reason. Our current policy is intended to reflect a hospital's bed count as accurately as possible, achieving a balance between capturing short-term shifts in occupancy and long-term changes in capacity. Therefore, we believe further clarification and refinement of our policies relating to counting available beds is necessary.

In the FY 2003 IPPS proposed rule published on May 9, 2002 (67 FR 31462), we proposed that, if a hospital's reported bed count results in an occupancy rate (average daily census of patients divided by the number of beds) below 35 percent, the applicable bed count, for purposes of establishing the number of available beds for that hospital would exclude beds that would result in an average annual occupancy rate below 35 percent. However, at the time the FY 2003 IPPS final rule was published on August 1, 2002 (67 FR 50060), we decided not to proceed with the proposed changes as final and to reconsider the issue as part of a future comprehensive analysis of our bed and patient day counting policies.

In this proposed rule, rather than establish a minimum standard occupancy rate, we are proposing to determine whether beds in a unit are available based upon whether the unit was used to provide patient care of a level generally payable under the IPPS ("IPPS level of care") at any time during the 3 preceding months. If any of the beds in the unit were used to provide an IPPS level of care at any time during the preceding 3 months, all of the beds in the unit are counted for purposes of determining available bed days during the current month. If no patient care of a type generally payable under the IPPS

was provided in that unit during the 3 preceding months, the beds in the unit are to be excluded from the determination of available bed days during the current month (proposed §§ 412.105(b)(2) and 412.106(a)(1)(ii)(C)).

For example, our policy as to how to count beds during minor renovations of units, wards, or individual rooms has been that unless the space costs are treated as nonallowable, the beds would be counted. Under the policy we are proposing, beds in an otherwise unoccupied unit that are occupied (for purposes of providing IPPS-level care) at any time during the 3 preceding months would be counted as available for the current month. This would apply even if the rooms were undergoing renovation during a portion of that 3-month period.

We believe a unit or ward can be defined as a group of rooms staffed by nurses assigned to a single nursing station. In most cases, the patients treated within a single unit or ward will receive a similar level of care (that is, acute, intensive, rehabilitation, psychiatric, or skilled nursing). However, we encourage comments on the most useful definition of a unit or ward.

We believe this proposed policy would provide a clear standard for both hospitals and fiscal intermediaries to use to determine whether otherwise unoccupied beds should be counted. We note that if the required time period for excluding the unoccupied beds were to be set too low, hospitals could potentially manipulate their available bed count by not admitting any patients to a unit during low occupancy periods, thereby distorting the measure of hospital size. We believe 3 months, one quarter of a hospital's fiscal year, represents a reasonable standard for determining that a unit is not being used to provide patient care and may be excluded from the hospital's available bed count.

It is also necessary to consider our policy with respect to individual beds within rooms located in an otherwise occupied unit when those beds are used for alternative purposes. For example, section 2405.3 of the PRM states that beds used for the following are excluded from the definition (of a bed): Postanesthesia or postoperative recovery rooms, outpatient areas, emergency rooms, ancillary departments nurses' and other staff residences, and other such areas as are regularly maintained and utilized for only a portion of the stay of patients or for purposes other than inpatient lodging. In some situations, beds used for these excluded

<sup>5</sup> This policy was first articulated in correspondence to the Blue Cross and Blue Shield Association (BCBSA) on November 2, 1988, and published in BCBSA's Administrative Bulletin #1841, 88.01, on November 18, 1988.