

purposes may be intermingled with acute care inpatient beds.

Beds being used to provide specific categories of nonacute services, such as outpatient services in an observation bed or skilled nursing services in a swing-bed, are excluded from the count. As discussed later, this flows from our policy that the bed days are treated consistently with the assignment of the costs on the Medicare cost report of the services provided in the bed.

In the case of individual rooms in an otherwise occupied unit that are altered to be used for other uses besides inpatient care, we are proposing the bed(s) should be counted if a patient could be admitted to the room within 24 hours (proposed § 412.105(b)(3)). This would apply even if the bed(s) were not currently located in the room, as long as a bed could be physically placed in the room and made available within 24 hours. We are proposing that it would no longer be necessary for the hospital to determine whether a bed could be staffed within 24 to 48 hours. For example, in the case of a room that has been altered for use as a staff lounge, if the room could be made available to house a patient merely by replacing the lounge furniture with a patient bed, the bed should be counted as available.

Under this proposal, other than when an inpatient room is used to provide observation services, labor/delivery room services, or skilled nursing services in a swing-bed (all discussed later in this proposed rule), the alternative purpose of the room is only relevant if it impacts whether the room could be made available for patient occupancy within 24 hours. If the hospital was fully occupied (no other room was available), and the room still was not put into service when needed, that would provide evidence that the room could not be made available and beds in the room should be excluded from the bed count.

Therefore, we are proposing to amend § 412.105(b) to indicate that the bed days in a unit that is unoccupied by patients receiving IPPS-level care for the 3 preceding months are to be excluded from the available bed day count for the current month. We are further proposing the beds in a unit that was occupied for IPPS-level care during the 3 preceding months should be counted unless they could not be made available for patient occupancy within 24 hours, or they are used to provide outpatient observation services or swing-bed skilled nursing care.

3. Nonacute Care Beds and Days

As noted above, these policies are consistent with the reporting of the

days, costs, and beds that are used to calculate the costs of hospital inpatient care in individual cost centers on the Medicare cost report. Furthermore, since the IME and DSH adjustments are part of the IPPS, we read the statute to apply only to inpatient beds and days.

Under the existing provisions of § 412.105(b), the regulations specifically exclude beds or bassinets in the healthy newborn nursery, custodial care beds, or beds in excluded distinct part hospital units as types of beds excluded from the count of available beds.

Existing regulations at § 412.106(a)(1)(ii) state that the number of patient days used in the DSH percentage calculation includes only those days attributable to areas of the hospital that are subject to the IPPS and excludes all others. This regulation was added after being proposed in the March 22, 1988 *Federal Register* (53 FR 9339), and made final in the September 30, 1988 *Federal Register* (53 FR 38479). At that time, we indicated that, "based on a reading of the language in section 1886(d)(5)(F) of the Act, which implements the disproportionate share provision, we are in fact required to consider only those inpatient days to which the prospective payment system applies in determining a prospective payment hospital's eligibility for a disproportionate share adjustment." Using this reasoning, we stated that the DSH patient percentage calculation should only include patient days associated with the types of services paid under the IPPS.

As noted previously, a recent decision in the Ninth Circuit Court of Appeals (*Alhambra v. Thompson*) 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.

In light of the Ninth Circuit decision that our rules were not sufficiently clear to permit exclusion of bed days based on the area where the care is provided, we are proposing to revise our regulations to be more specific. Therefore, in this proposed rule, we are proposing to clarify that beds and patient days are excluded from the calculations at § 412.105(b) and § 412.106(a)(1)(ii) if the nature of the care provided in the unit or ward is inconsistent with what is typically furnished to acute care patients, regardless of whether these units or

wards are separately certified or are located in the same general area of the hospital as a unit or ward used to provide an acute level of care. Although the intensity of care may vary within a particular unit, such that some patients may be acute patients while others are nonacute, we understand that a patient-by-patient review of whether the care received would be paid under the IPPS would be unduly burdensome. Therefore, we believe it is more practical to permit the application of this principle based upon the location at which the services were furnished.

In particular, we are proposing to revise our regulations to clarify that the beds and patient days attributable to a nonacute care unit or ward should not be included in the calculations at § 412.105(b) and § 412.106(a)(1)(ii), even if the unit is not separately certified by Medicare as a distinct-part unit and even if the unit or ward is within the same general location of the hospital as areas that are subject to the IPPS.

Exceptions to this policy are outpatient observation and swing-bed days, which are excluded from the count of available bed days even if the care is provided in an acute care unit. Our policies pertaining to these beds are discussed further below. Another exception is healthy newborn nursery days. The costs, days, and beds of a healthy newborn nursery are excluded from inpatient calculations for Medicare purposes. Meanwhile, for the purpose of computing the Medicaid patient share computation of the DSH patient percentages, these days are included both as Medicaid patient days and as total patient days. Nursery costs are not directly included in calculating Medicare hospital inpatient care costs because Medicare does not generally cover services for infants. However, Medicaid does offer extensive coverage to infants, and nursery costs would be directly included in calculating Medicaid hospital inpatient care costs. Therefore, these costs, days, and beds are excluded for Medicare purposes, but included for determining the Medicaid DSH percentage. (This policy was previously communicated through a memorandum to CMS Regional Offices on February 27, 1997.)

Generally, as discussed previously, if the nature of the care provided in the unit or ward is consistent with what is typically furnished to acute care patients, and, therefore, would be characteristic of services paid under the IPPS, the patient days, beds, and costs of that unit or ward would be classified as inpatient acute care (except for observation bed days and swing bed days, as discussed later in this