

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."

Our policy excluding outpatient observation and swing-bed days is consistent with this regulatory interpretation of days to be counted under § 412.106(a)(1)(ii). That is, the services provided in these beds are not payable under the IPPS (unless the patient is admitted, in the case of observation bed days).

As outlined previously, our consistent and longstanding policy, which has been reviewed and upheld previously by several courts, including the United States District Court for the District of Columbia, is based on the principle of counting beds in the same manner as the patient days and costs are treated. Our policy to exclude observation and swing-bed days under the regulations at § 412.105(b) and § 412.106(a)(1)(ii) stems from this policy.

However, we are proposing to amend our policy with respect to observation bed days of patients who ultimately are admitted. As noted previously, our current policy is that these bed days are excluded from the available bed day and the patient day counts. This policy was communicated in a memorandum to all CMS Regional Offices on February 27, 1997. Specifically, we are proposing that, if a patient is admitted as an acute inpatient subsequent to receiving outpatient observation services, because the charges of the observation ancillary services the patient receives are currently treated as inpatient charges on the cost report, in order to be consistent with our policy to treat the costs and patient days consistently, we will begin to include the patient bed days associated with the observation services in the inpatient bed day count.

In order to avoid any potential future misunderstandings about our policies regarding the exclusion of observation and swing-bed days under the regulations at § 412.105(b) and § 412.106(a)(1)(ii), we are proposing to revise our regulations to specify our policy that observation and swing-bed bed days are to be excluded from the counts of both available beds and patient days, unless a patient treated in an observation bed is ultimately admitted, in which case the beds and days would be included in those counts.

5. Labor, Delivery, Recovery, and Postpartum Beds and Days

Prior to December 1991, Medicare's policy on counting days for maternity patients required an inpatient day to be counted for an admitted maternity patient in the labor/delivery room at the census taking hour. This is consistent with Medicare policy for counting days for admitted patients in any other ancillary department at the census-taking hour. However, based on decisions adverse to the government regarding this policy in a number of Federal courts of appeal, including the United States Court of Appeals for the District of Columbia Circuit, the policy regarding the counting of inpatient days for maternity patients was revised.

Therefore, our current policy regarding the treatment of labor and delivery bed days was initially described in Section 2205.2 of the PRM. Section 2205.2. of the PRM states that a maternity inpatient in the labor/delivery room at midnight is not included in the census of inpatient routine care if the patient has not occupied an inpatient routine bed at some time since admission. For example, if a Medicaid patient is in the labor room at the census and has not yet occupied a routine bed, the bed day is not counted as a routine bed day of care in Medicaid or total days and, therefore, is not included in the counts under existing §§ 412.105(b) and 412.106(a)(1)(ii). If the patient is in the labor room at the census but had first occupied a routine bed, a routine bed day is counted, in Medicaid and total days, for DSH purposes and for apportioning the cost of routine care on the cost report (consistent with our longstanding policy to treat days, costs, and beds similarly).

Increasingly, hospitals are redesigning their maternity areas from separate labor and delivery rooms apart from the postpartum rooms, to single labor, delivery room, and postpartum (LDRP) rooms. In order to appropriately track the days and costs of LDRP rooms, it is necessary to apportion them between the labor and delivery ancillary cost center and the routine adults and pediatrics cost center. This is done by determining the proportion of the patient's stay in the LDRP room that the patient was receiving ancillary services (labor and delivery) as opposed to routine adult and pediatric services (recovery and postpartum).

An example of this would be if 25 percent of the patient's time in the LDRP room was for labor/delivery services and 75 percent for routine care, over the course of a 4-day stay in the LDRP room. In that case, 75 percent of

the time the patient spent in the LDRP room is applied to the total bed days and costs (resulting in 3 routine adults and pediatrics bed days for this patient, 75 percent of 4 total days). The resulting days (or portion of days) are included in total days and in Medicaid days for all purposes. For purposes of determining hospital bed count, the time when the beds are unoccupied should be counted as available bed days using an average percentage (for example, 75 percent adults and pediatrics and 25 percent ancillary) based on all patients. In other words, 75 percent of the days the bed is unoccupied would be counted in the available bed count.

We realize that it may be burdensome for a hospital to determine for each patient in this type of room the amount of time spent in labor/delivery and the amount of time spent receiving routine care. Alternatively, the hospital could calculate an average percentage of time patients receive ancillary services, as opposed to routine inpatient care during a typical month, to apply the rest of the year.

6. Days Associated with Demonstration Projects Under Section 1115 of the Act

Some States extend medical benefits to a given population that could not have been made eligible for Medicaid under a State plan amendment under section 1902(r)(2) or section 1931(b) of the Act, under a demonstration under a section 1115(a)(2) demonstration project (also referred to as a section 1115 waiver). These populations are specific, finite populations identifiable in the award letters and special terms and conditions for the demonstrations.

On January 20, 2000, we issued an interim final rule with comment period (65 FR 3136), followed by a final rule issued on August 1, 2000 (65 FR 47086 through 47087), to allow hospitals to include the patient days of all populations that receive benefits under a section 1115 demonstration project in calculating the Medicare DSH adjustment. Previously, hospitals were to include only those days for populations under the section 1115 demonstration project who were, or could have been made, eligible under a State plan. Patient days of those expansion waiver groups who could not be made eligible for medical assistance under the State plan were not to be included for determining Medicaid patient days in calculating the Medicare DSH patient percentage. Under the January 20, 2000 interim final rule with comment period (65 FR 3137), hospitals could include in the numerator of the Medicaid fraction those patient days for individuals who receive benefits under