

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 reports. 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).

The remainder of this discussion pertains to beds and patient days 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 the 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) 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 LEXIS 17759 (8th Cir. July 20, 1996) (unpublished table decision); *Amisub v. Shalala*, No. 94-1883 (TFH) (D.D.C. December 4, 1995) (mem.).)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 final rule clarifies the underlying principles for our bed and patient days counting policies and amends 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.

Comment: One commenter expressed concern about our policy to use the same definition of beds for IME and DSH. The commenter argued that Congress used different terminology to define the types of beds that should be used for these two payment adjustments. Section 1886(d)(5)(B)(vi)(I) of the Act indicates the IME adjustment is to be based on "the hospital's available beds (as defined by the Secretary)." For purposes of the DSH adjustment, section 1886(d)(5)(F)(v) of the Act simply refers to the number of "beds" in the hospital. The commenter believed that, because the Act does not narrow the bed count for DSH purposes to those that are available, it is unlawful and inappropriate for CMS to use the available bed definition for DSH purposes.

Response: We believe both statutory references cited by the commenter provide the Secretary with administrative discretion to define beds, one explicitly and one implicitly. In light of this discretion, we strongly believe it is important to apply a consistent definition for purposes of both IME and DSH adjustments, particularly because many hospitals receive both types of adjustments. We note that we have used available beds for purposes of determining whether hospitals qualify for DSH payments Congress directed us to make this adjustment in 1988. Since that time, Congress has amended the DSH provisions in the Act on numerous occasions, and certainly could have made clear its intention that we not use available beds for DSH purposes if that was its intent. Therefore, we disagree with this comment.

2. Unoccupied Beds

We are still reviewing the large number of comments on our proposal on unoccupied beds in the May 19, 2003 proposed rule. Due to the number and nature of the comments we received on our proposed policy, we are addressing the public comments in a separate document. We refer individuals who are interested in reviewing the background information and discussion of the proposed policy to the May 19, 2003 proposed rule (68 FR 37202 through 37204).

3. Nonacute Care Beds and Days

As noted above, our policies for counting beds are generally consistent with the method of reporting patient days for the purpose of calculating 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