

reflect our longstanding interpretation of the statutory intent, especially relating to the calculation of the Medicare DSH patient percentage.

Comment: Several commenters objected to our proposal and indicated that we were attempting to codify the Secretary's litigation position in *Alhambra* and administratively overrule the Ninth Circuit's decision in that case. Commenters asserted that the flaw in the proposal is that it is inconsistent with the Act to base the Medicaid days calculation of the DSH patient percentage on whether or not Medicare pays for the services that are generally provided within a unit. Specifically, commenters believed the proposal would restrict the definition of patient days in a way that is not authorized by the Act.

Response: We disagree that our proposed clarification is inconsistent with the statute. First, the clarification is merely a codification of the Secretary's longstanding policy. In addition, we believe that interpreting the statute as we have historically done is reasonable and permissible. Section 1886(d)(5)(F)(vi)(II) of the Act governs the portion of the disproportionate share percentage made up of the percentage of patient days used by patients eligible for medical assistance under a title XIX State plan. Specifically, section 1886(d)(5)(F)(vi)(II) of the Act states that the numerator of such fraction equals the "number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under title XIX, but who were not entitled to benefits under part A of this title." The statute does not define the term "hospital's patient days." Thus, the statute is ambiguous, and the Secretary has the authority to reasonably interpret that term.

We note that although the calculation performed under section 1886(d)(5)(F)(vi)(II) of the Act includes a count of patient days used by Medicaid-eligible individuals, the calculation actually is used to determine how much additional payment the hospital should receive under Medicare for the higher Medicare costs associated with treating a disproportionate share of low-income individuals. This point is demonstrated in the rationale for establishing the DSH adjustment as described in the Committee Report accompanying Pub. L. 99-272: "Hospitals that serve a disproportionate share of low-income patients have higher Medicare costs per case" (H. Rept. No. 99-242(I), 99th Cong., 2d Sess., (1985), p. 16).

Furthermore, we view section 1886(d)(5)(F)(vi)(II) of the Act as purely a Medicare, inpatient hospital provision, given that there already exists a distinct formula for computing DSH payments under title XIX—the Medicaid title. Because the DSH formula in title XVIII of the Act is intended to provide an add-on payment to inpatient hospitals for additional amounts they incur in treating low-income, Medicare patients, we believe it is reasonable to count only those days spent in wards or units that would generally provide an acute level of care.

We believe it is reasonable to interpret the phrase, "hospital's patient days," to mean only the hospital's inpatient days at a level of care that would be covered under the IPPS as a means to determine an IPPS payment adjustment. Further, we believe that it is administratively inefficient and impracticable to calculate a hospital's inpatient days based on a determination, on a day-by-day basis, of whether a particular patient in a particular inpatient bed is receiving a level of care that would be covered under the IPPS. Therefore, we proposed to use, as a proxy, the level of care that is generally provided in particular units or wards, and to exclude patient days attributable to units or wards in which care delivered is not generally of a type that would be covered under the IPPS.

We also do not believe that by placing our longstanding interpretation of our rules in regulations we are unlawfully overruling or nullifying the decision by the Ninth Circuit in *Alhambra Hospital v. Thompson*, 259 F.3d 1071 (9th Cir. 2001). The Ninth Circuit decision focused on an interpretation of CMS' previous regulation at § 412.106(a)(1)(ii)—not on an interpretation of the statute. (For example, when the court stated the "Standard of Review" it would use to decide the case, it referred only to "[o]ur review of an agency's interpretation of its own regulations." *Alhambra* at 1074). Although we respectfully disagree with the Ninth Circuit's interpretation of the existing regulations, we are nonetheless amending them, through notice and comment rulemaking to ensure that going forward the regulations clearly reflect our longstanding position. Therefore, we do not agree with the commenter's assertion that our proposed policy is an illegal attempt to administratively overrule the Ninth Circuit's decision in *Alhambra*. Therefore, going forward, we plan to apply the clarified regulation to hospitals in all U.S. jurisdictions, including hospitals in the Ninth Circuit.

4. Observation Beds and Swing-Beds

Observation services are those services furnished by a hospital on the hospital's premises that include use of a bed and periodic monitoring by a hospital's nursing or other staff in order to evaluate an outpatient's condition or to determine the need for a possible admission to the hospital as an inpatient. When a hospital places a patient under observation but has not formally admitted him or her as an inpatient, the patient initially is treated as an outpatient. Consequently, the observation bed days are not recognized under the IPPS as part of the inpatient operating costs of the hospital.

Observation services may be provided in a distinct observation bed area, but they may also be provided in a routine inpatient care unit or ward. In either case, our policy is the bed days attributable to beds used for observation services are excluded from the counts of available bed days and patient days at §§ 412.105(b) and 412.106(a)(1)(ii). This policy was clarified in a memorandum that was sent to all CMS Regional Offices (for distribution to fiscal intermediaries) dated February 27, 1997, which stated that if a hospital provides observation services in beds that are generally used to provide hospital inpatient services, the days that those beds are used for observation services should be excluded from the available bed day count (even if the patient is ultimately admitted as an acute inpatient).

A swing-bed is a bed that is otherwise available for use to provide acute inpatient care and is also occasionally used to provide SNF-level care. The criteria for a hospital to meet the requirements to be granted an approval from CMS to provide posthospital extended care services are located under § 482.66, and for a swing-bed CAH under § 485.645. Under § 413.114(a)(1), payment for posthospital SNF care furnished in swing-beds is in accordance with the provisions of the prospective payment system for SNF care (effective for services furnished in cost reporting periods beginning on and after July 1, 2002). Similar to observation beds and patient days, swing-beds and patient days are excluded from the counts of available bed days and patient days at §§ 412.105(b) and 412.106(a)(1)(ii) when the swing-bed is used to furnish SNF care.⁷

Observation beds and swing-beds are both special, frequently temporary, alternative uses of acute inpatient care

⁷ Ibid.