

beds. That is, only the days an acute inpatient care unit or ward bed is used to provide outpatient observation services are to be deducted from the available bed count under § 412.105(b). Otherwise, the bed is considered available for acute care services (as long as it otherwise meets the criteria to be considered available). This same policy applies for swing-beds. The policies to exclude observation bed days and swing-bed days as described above stem from the fact that these days are not payable under the IPPS.

Some hospitals have contested our policy excluding swing-beds and patient days and observation beds and patient days under existing §§ 412.105(b) and 412.106(a)(1)(ii). 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. The hospitals involved in this decision wanted to include observation and swing-bed days in their bed count calculation in order to qualify for higher DSH payments as available to hospitals with more than 100 beds. The Court found that "the listing of beds to be excluded from the count restricts the class of excluded beds only to those specifically listed." Because observation beds and swing-beds are not currently specifically mentioned in § 412.105(b) as being excluded from the bed count, the Court ruled that these beds must be included in the count.

The list of the types of beds excluded from the count under existing § 412.105(b) was never intended to be an exhaustive list of all of the types of beds to be excluded from the bed count under this provision. In fact, over the years, specific bed types have been added to the list as clarifications of the types of beds to be excluded, not as new exclusions (see the September 1, 1994 **Federal Register** (59 FR 45373) and September 1, 1995 **Federal Register** (60 FR 45810), where we clarified exclusions under our policy that were not previously separately identified in the regulation text).

Although the Court in *Clark* found that Congress had not explicitly "addressed the question of whether swing and observation beds should be included in the count of beds in determining whether a hospital qualifies for the DSH adjustment," *Clark*, 314 F.3d at 245, the Court found that observation and swing-bed days were included under the "plain meaning" of

the regulation text at § 412.106(a)(1)(ii), which reads: "The number of patient days includes only those days attributable to areas of the hospital that are subject to the prospective payment system and excludes all others." However, the preamble language of the rule that promulgated the regulatory provision at § 412.106(a)(1)(ii) clarified its meaning (53 FR 38480, September 30, 1988):

"Although previously the Medicare regulations did not specifically define the inpatient days for use in the computation of a hospital's disproportionate share patient percentage, we believe 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."

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 in *Amisub v. Shalala*, is based on the principle of counting beds in generally the same manner as the patient days and costs are counted. Our policy to exclude observation and swing-bed days under the regulations at § 412.105(b) and § 412.106(a)(1) stems from this policy.

In the May 19, 2003 proposed rule, although we reiterated our longstanding policy that observation beds and swing bed days generally are excluded, we proposed to amend our policy with respect to observation bed days of patients who ultimately are admitted. We are still in the process of reviewing the comments and defer action until a later rule with respect this issue—for example, patients in observation beds who are ultimately admitted to the hospital.

Comment: Some commenters objected to the exclusion of observation bed days from the available bed days count on the grounds that it is a flawed premise that the size of a hospital's bed complement should be impacted by the payment policy classification of the services provided to the patient. That is, a bed

should not be excluded from the available bed day count because it is used to provide services not payable under the IPPS on a particular day.

Response: When the application of IPPS payment policy is dependent on a determination of a hospital's number of beds, it seems reasonable to base that determination on the portion of the hospital that generates the costs that relate to those IPPS payments. As stated above, our bed counting policies start with the premise that the treatment of beds should be consistent with the treatment of the patient days and the costs of those days on the Medicare cost report. Therefore, we continue to believe it is appropriate to exclude outpatient observation bed days, even when the beds used to provide that service is located in a routine inpatient care unit or ward.

5. Labor, Delivery, and Postpartum Beds and Days

Prior to December 1991, Medicare's policy on counting days for maternity patients was to count an inpatient day 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 to reflect our current policy.

Our current policy regarding the treatment of labor and delivery bed days is described in Section 2205.2 of the PRM, which 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 inpatient 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 inpatient 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).