

Table III B—Wage Index for Rural Areas

State	Index
Alabama.....	1.1085
Alaska.....	2.0477
Arizona.....	.9757
Arkansas.....	.8965
California.....	1.0310
Colorado.....	.9443
Connecticut.....	1.0736
Delaware.....	1.0483
Florida.....	1.0226
Georgia.....	1.0082
Hawaii.....	.9781
Idaho.....	1.1509
Illinois.....	.8257
Indiana.....	.9112
Iowa.....	.9583
Kansas.....	.9309
Kentucky.....	.9683
Louisiana.....	1.0592
Maine.....	.9476
Maryland.....	.9856
Massachusetts.....	.9704
Michigan.....	1.1298
Minnesota.....	.7740
Mississippi.....	.9904
Missouri.....	.8754
Montana.....	1.0581
Nebraska.....	.8087
Nevada.....	1.2869
New Hampshire.....	.9531
New Jersey.....	1.0024
New Mexico.....	1.0318
New York.....	1.0244
North Carolina.....	.9599
North Dakota.....	.9332
Ohio.....	1.0486
Oklahoma.....	.8933
Oregon.....	1.1500
Pennsylvania.....	1.1025
Rhode Island.....	.9183
South Carolina.....	.9116
South Dakota.....	.8907
Tennessee.....	.9736
Texas.....	.8416
Utah.....	.8675
Vermont.....	.9717
Virginia.....	1.0337
Washington.....	1.0900
West Virginia.....	1.0825
Wisconsin.....	1.0362
Wyoming.....	1.0136

(Sections 1102, 1814(b), 1861(v)(1), 1866(a), and 1871 of the Social Security Act; 42 U.S.C. 1302, 1395f(b), 1395x(v)(1), 1395cc(a) and 1395hh.)

(Catalog of Federal Domestic Assistance Program No. 13.773, Medicare—Hospital Insurance.)

Dated: April 23, 1979.

Leonard D. Schaeffer,

Administrator, Health Care Financing Administration.

Approved: May 10, 1979.

Hale Champion,

Acting Secretary.

[FR Doc. 79-15449 Filed 5-17-79; 8:45 am]

BILLING CODE 4110-35-M

test report federal

Friday
May 18, 1979

Part VII

General Services Administration

Improving Government Regulations;
Semiannual Agenda

GENERAL SERVICES ADMINISTRATION

[32A CFR Chapter 1]

[41 CFR Chapter 101]

Agenda of Significant Regulatory Activity

AGENCY: General Services
Administration.

ACTION: Semiannual agenda.

SUMMARY: This agenda announces the significant regulatory actions that GSA plans for the 6-month period from mid-May 1979 to mid-November 1979. This agenda was developed under the guidelines in Executive Order 12044, Improving Government Regulations (43 FR 12661, Mar. 24, 1978). GSA's purpose in publishing this agenda is to allow interested persons an opportunity to participate in the early stages of the rulemaking process.

FOR FURTHER INFORMATION CONTACT: John T. Gilmartin, Director, Paperwork Management Division (202-566-0857).

SUPPLEMENTARY INFORMATION: On December 4, 1978, GSA published its final report on implementation plans for Executive Order 12044 at 43 FR 56728. As explained in the report, GSA will publish a semiannual agenda of significant regulatory activity during May and November of each year. The agenda lists, for each of GSA's services and staff offices, new significant regulations that are being considered, changes that are planned to existing significant regulations, significant regulations that will be reviewed during the upcoming 6-month period, and the status of items from the previous agenda.

Dated: May 11, 1979.

Clarence A. Lee, Jr.,

Acting Administrator of General Services.

Federal Preparedness Agency

A. New Regulations

No new significant regulations are being considered.

B. Changes to Existing Regulations

1. Procurement in high-unemployment areas (32A CFR Part 134). A proposed rule was published in the *Federal Register* on April 2, 1979 (43 FR 19207).

a. *Need for change:* Being revised in accordance with Executive Order 12073 and to preserve the mobilization aspects of the labor surplus area program.

b. *Legal basis:* Public Law 95-89 and Executive Orders 10480, 11051, 11725, and 12073.

c. *Contact point:* James J. Delaney, Planning Officer (202-566-0760).

d. *Regulatory analysis:* Will not be prepared.

2. Health Manpower Occupations (32A CFR Part 106).

a. *Need for change:* Update list of health manpower occupations and simplify the language.

b. *Legal basis:* Defense Production Act of 1950 and Executive Orders 11490 and 11921.

c. *Contact point:* Frederick J. Haase, Resources Management Division (202-566-0760).

d. *Regulatory analysis:* Will not be prepared.

C. Regulations Scheduled for Review

Since the November 17, 1978, agenda report, no additional significant regulations are scheduled for review.

D. Status of Agenda Items Published on November 17, 1978 (43 FR 53821).

1. Changes to existing regulations.

a. Stabilization Regulations for Prices, Rents, Wages, and Salaries (32A CFR Part 151).

(1) Deletion of Part 151 was published in the *Federal Register* on December 20, 1978 (43 FR 59378).

(2) *Contact point:* Dorinda L. Lowery, Management Services Division (202-566-1975).

2. Regulations scheduled for review.

(a) Dispersion and Protective Construction; Policy, Criteria, and Responsibilities (32A CFR Part 101).

(1) *Expected completion date for review* postponed from November 30, 1978, to November 1979.

(2) *Contact point:* Edward K. Zabrowski, Acting Assistant Director for National Resources Preparedness (202-566-0800).

b. Maintenance of the Mobilization Base (32A CFR Part 102).

(1) *Estimated completion date for review* postponed from November 30, 1978, to November 1979.

(2) *Contact point:* Edward K. Zabrowski, Acting Assistant Director for National Resources Preparedness (202-566-0800).

c. Emergency Action for Maintenance of the Mobilization Base (32A CFR Part 102a).

(1) *Expected completion date for review* postponed from November 30, 1978, to November 1979.

(2) *Contact point:* Edward K. Zabrowski, Acting Assistant Director for National Resources Preparedness (202-566-0800).

d. Defense Production; Priorities and Allocations Authority (32A CFR Part 103).

(1) *Expected completion date for review* postponed from November 30, 1978, to November 1979.

(2) *Contact point:* Edward K. Zabrowski, Acting Assistant Director for National Resources Preparedness (202-566-0800).

e. Guidance on Priority Use of Resources in Immediate Postattack Period (32A CFR Part 104).

(1) *Expected completion date for review* postponed from November 30, 1978, to November 1979.

(2) *Contact point:* Edward K. Zabrowski, Acting Assistant Director for National Resources Preparedness (202-566-0800).

f. National Security Policy Governing Scientific and Engineering Manpower (32A CFR Part 105).

(1) *Expected completion date for review* postponed from November 30, 1978, to November 1979.

(2) *Contact point:* Edward K. Zabrowski, Acting Assistant Director for National Resources Preparedness (202-566-0800).

g. Health Manpower Occupations (32A CFR Part 106).

(1) *Expected completion date for review:* Review was completed. A proposed rule was published in the *Federal Register* on February 28, 1979 (44 FR 11241). (See item B2, above.)

(2) *Contact point:* Nina Winkler, Office of the Director (202-566-1627).

h. Policy Guidance for a National Emergency Blood Program (32A CFR Part 107).

(1) *Expected completion date for review* postponed from November 30, 1978, to November 1979.

(2) *Contact point:* Edward K. Zabrowski, Acting Assistant Director for National Resources Preparedness (202-566-0800).

i. Program for Expansion of Supplies of Materials Needed for Defense Purposes in the Event of a Major Disaster (32A CFR Part 108).

(1) *Expected completion date for review* postponed from November 30, 1978, to November 1979.

(2) *Contact point:* Edward K. Zabrowski, Acting Assistant Director for National Resources Preparedness (202-566-0800).

j. Provision of Materials Under Government Control as Needed to Supplement Supplies Commercially Available in the Event of a Major Disaster (32A CFR Part 109).

(1) *Expected completion date for review* postponed from November 30, 1978, to November 1979.

(2) *Contact point:* Edward K. Zabrowski, Acting Assistant Director for National Resources Preparedness (202-566-0800).

k. Policy on Use of Government-Owned Industrial Plant Equipment by Private Industry (32A CFR Part 110).

(1) *Expected completion date for review* postponed from November 30, 1978, to November 1979.

(2) *Contact point:* Edward K. Zabrowski, Acting Assistant Director for National Resources Preparedness (202-566-0800).

l. General Policies for Strategic and Critical Materials Stockpiling Policy (32A CFR Part 111).

(1) *Expected completion date for review* postponed from November 30, 1978, to November 1979.

(2) *Contact point:* Edward K. Zabrowski, Acting Assistant Director for National Resources Preparedness (202-566-0800).

m. Use of Priorities and Allocation Authority for Federal Supply Classification (FSC) Common Use Items (32A CFR Part 112).

(1) *Expected completion date for review* postponed from November 30, 1978, to November 1979.

(2) *Contact point:* Edward K. Zabrowski, Acting Assistant Director for National Resources Preparedness (202-566-0800).

n. Policy Guidance and Delegation of Authorities for Use of Priorities and Allocations to Maximize Domestic Energy Supplies (32A CFR Part 113).

(1) *Expected completion date for review* postponed from November 30, 1978, to November 1979.

(2) *Contact point:* Edward K. Zabrowski, Acting Assistant Director for National Resources Preparedness (202-566-0800).

National Archives and Records Service

A. New Regulations

No new significant regulations are being considered.

B. Changes To Existing Regulations

1. Public Use of Archives and FRC Records (41 CFR 105-61.1)—in which only § 105-61.104, Access to National Security Information, has been defined as significant—is being revised to reflect new procedures on declassification of security classified documents.

a. *Need for change:* Executive Order 12065, National Security Information, mandated new declassification procedures.

b. *Legal basis:* Federal Property and Administrative Services Act of 1949, as

amended (Sec. 205(c), 63 Stat. 390; 40 U.S.C. 486(c)).

c. *Contact point:* Adrienne C. Thomas, Director, Planning and Analysis Division (202-523-3214).

d. *Regulatory analysis:* Will not be prepared.

2. Public Use of Donated Historical Materials (41 CFR 105-61.2) is being revised to correct certain citations.

a. *Need for change:* Executive Order 12065, National Security Information, mandated new declassification procedures that must be cited.

b. *Legal basis:* Federal Property and Administrative Services Act of 1949, as amended (Sec. 205(c), 63 Stat. 390; 40 U.S.C. 486(c)).

c. *Contact point:* Richard A. Jacobs, Deputy Assistant Archivist, Office of Presidential Libraries (202-523-3073).

d. *Regulatory analysis:* Will not be prepared.

C. Regulations Scheduled For Review

No significant regulations are presently being reviewed.

D. *Status of Agenda Items Published on November 17, 1978 (43 FR 53821)*

See items B1 and B2, above.

Office of Controller—Administration

A. New Regulations

1. Procedures for implementation of section 504 of the Rehabilitation Act of 1973.

a. *Need for regulations:* The Rehabilitation Act of 1973 requires each Federal agency administering programs or activities that resulted in awarding Federal financial assistance to develop regulations designed to implement section 504 of the act.

b. *Legal basis:* Rehabilitation Act of 1973; Public Law 93-112, as amended by the Rehabilitation Act Amendments of 1974, Public Law 93-516, 29 U.S.C. 794.

c. *Contact point:* Linda Goodwin, Equal Opportunity Staff (202-566-0488).

d. *Regulatory analysis:* Will not be prepared.

B. Changes To Existing Regulations

No significant regulations are scheduled to be changed.

C. Regulations Scheduled for Review

No significant regulations are scheduled for review.

D. *Status of Agenda Items Published on November 17, 1978 (43 FR 53821)*

No items were listed on the previous agenda.

Automated Data and Telecommunications Service

No significant regulatory actions are planned.

Federal Property Resources Service

No significant regulatory actions are planned.

Federal Supply Service

No significant regulatory actions are planned.

Office of Acquisition Policy

No significant regulatory actions are planned.

Office of General Counsel

No significant regulatory actions are planned.

Public Buildings Service

No significant regulatory actions are planned.

Transportation and Public Utilities Service

No significant regulatory actions are planned.

[FR Doc. 79-15419 Filed 5-17-79; 8:45 am]

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Test Report

Friday
May 18, 1979

Part VIII

Department of Health, Education, and Welfare

Public Health Service

**Medical Facility Construction and
Modernization; Requirements for
Provision of Services to Persons Unable
to Pay and Community Service by
Assisted Health Facilities**

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Public Health Service

42 CFR Part 124

Medical Facility Construction and Modernization; Requirements for Provision of Services to Persons Unable To Pay and Community Service by Assisted Health Facilities

AGENCY: Public Health Service, HEW.

ACTION: Final rules.

SUMMARY: The Secretary of Health, Education, and Welfare is issuing new rules establishing requirements for health care facilities assisted by the Department under Titles VI and XVI of the Public Health Service Act to fulfill assurances required to be given in their applications for assistance that they would make their services available to all persons in the community and that they would make available a reasonable volume of services to persons unable to pay. Public comment received on the proposed rules and the Department's own experience in monitoring compliance with the current rules, has indicated the need for revision of the current rules applying to those assurances. Therefore, the Secretary is issuing the rules below to carry out his duty under section 1602(6) of the Act and to establish standards of compliance that will promote better delivery of services under the assurances and more effective monitoring of compliance with the assurances.

EFFECTIVE DATES: For Subpart F ("Uncompensated Services"): (a) For facilities whose next fiscal year begins on or after September 1, 1979, these rules are effective at the beginning of that fiscal year.

(b) For facilities whose next fiscal year begins after May 18, 1979, but before September 1, 1979, these rules are effective no later than September 1, 1979. At facility option, these rules may be implemented as early as the beginning of the facilities' next fiscal year. For facilities covered by this paragraph, the annual compliance standard, and excess and deficit provisions, in § 124.503 are effective at the beginning of the facilities' next fiscal year. Credit for uncompensated services provided by a facility before it implements these new rules, or before September 1, 1979 if later, will be given towards the new compliance standard to the extent that those services are provided in accordance with the procedures under the current rules at 42 CFR 53.111.

For Subpart G ("Community Services"): September 1, 1979 for all facilities.

FOR FURTHER INFORMATION CONTACT: Ms. Florence B. Fiori, Director, Bureau of Health Facilities Financing, Compliance, and Conversion, Room 6-50, Center Building No. 1, 3700 East-West Highway, Hayattsville, Maryland 20782, 800-638-0742 (Md. Res. call: 800-492-0359).

SUPPLEMENTARY INFORMATION: On October 25, 1978, the Secretary proposed new rules to implement the requirement of section 1602(6) of the Public Health Service Act (42 U.S.C. 300a-1(6)). 43 FR 49954. That section requires the Secretary to prescribe:

The general manner in which each entity which receives financial assistance under this title [XVI] or title VI shall be required to comply with the assurances required to be made at the time such assistance was received and the means by which such entity shall be required to demonstrate compliance with such assurances.

The proposed rules proposed requirements concerning the assurances given by assisted facilities that they would provide a reasonable volume of services to persons unable to pay and a community service. Title VI assisted facilities gave assurances that—

(1) The facility or portion thereof to be constructed or modernized will be made available to all persons residing in the territorial area of the applicant; and (2) there will be made available in the facility or portion thereof to be constructed or modernized a reasonable volume of services to persons unable to pay therefor, but an exception shall be made if such a requirement is not feasible from a financial viewpoint. Section 603(e), PHS Act; 42 U.S.C. 291c(e)(3).

The assurances required of Title XVI assisted facilities are that—

At all times after such application is approved (i) the facility or portion thereof to be constructed, or modernized, or converted will be made available to all persons residing or employed in the area served by the facility, and (ii) there will be made available in the facility or portion thereof to be constructed, modernized, or converted a reasonable volume of services to persons unable to pay therefor and the Secretary, in determining the reasonableness of the volume of services provided, shall take into consideration the extent to which compliance is feasible from a financial viewpoint. Section 1604(b)(1)(J), PHS Act; 42 U.S.C. 300a-3(b)(1)(J).

In addition to inviting comments on the proposed rules, the Department held public hearings in Washington, D.C. on December 5 and 6, 1978. A summary of comments received, both through the hearings and the approximately 1,000

written comments submitted, appears in Appendix I.

The Department found the public participation very helpful in developing these final rules. A wide range of interests was represented at the hearing and in the written comments. Individual consumers related their personal experiences and difficulties in attempting to get health services from assisted facilities; consumer organizations and consumer legal representatives from different parts of the country described member or client problems with the administration of the program by state and federal officials, and by facilities; hospital administrators, financial management experts, and national and state hospital associations contributed their views of the effectiveness of the current program and the impact of the proposed rules on facilities' financial positions and ability to deliver services efficiently; and state and local governments, health systems agencies and other major health organizations contributed their expertise and perspectives. Although it was not possible to accept all of the suggestions made at the hearing or in written comments, the final rules reflect the Department's attempt to be responsive to as many of the concerns expressed as was consistent with its responsibilities to assure effective enforcement of the assurances and the financial and administrative integrity of the assisted facilities.

Summary of Objectives and Policies of the Final Rules

The basic objective of these rules is to assure that recipients of Titles VI and XVI who give the uncompensated services and the community service assurances provide those services within the context of sound planning for and management of the delivery of health care services. Based on public comments, as well as his own experience in monitoring the existing assurances program, the Secretary believes that changes in the regulations are necessary to assure effective provision of those services consistent with the statutory requirements.

In making changes to the regulation the Secretary has sought to minimize the burdens imposed on facilities to the extent possible, in keeping with the President's policy of imposing on recipients of the Federal funds only those burdens necessary for proper and efficient program implementation. He has also sought to preserve the flexibility of facilities to provide those services consistent with their own and local needs, without sacrificing the

interests of the intended beneficiaries in a fair and effective delivery of those services. To minimize misunderstanding of what facilities are required to do and to facilitate monitoring and enforcement, the rules articulate clear-cut compliance standards wherever possible.

Finally, these rules provide for Federal enforcement and administration of the assurances program in recognition of Congress demonstrated concern over past lax enforcement and its imposition of specific monitoring responsibilities on the Department. However, States able to assist the Secretary will be given and opportunity to do so. Moreover, the final rules clearly disclaim any intention to interfere with enforcement programs established by States under State law so long as the State programs do not prevent the Secretary from enforcing minimum Federal standards for assisted facilities.

Uncompensated Services

The specific objectives of the uncompensated services rules are to prescribe a minimum level of uncompensated services to be provided and to interfere as little as possible in the method by which they are provided. This is clear in the compliance standards of the rules.

The rules eliminate the present choice of compliance standards, and substitute a single, dollar-volume compliance level, so that both facilities and recipients will know how much uncompensated care will be available. The dollar-volume standard is the one included in the proposed rules—the lesser of three percent of operating costs or ten percent of the federal assistance under Title VI, XVI and supplementary programs. In order to keep the volume of uncompensated services provided from further declining each year, the compliance level for years after the effective date of the regulations is adjusted using the percentage change in the national Consumer Price Index for medical care.

The standard of performance required under these rules will be measured over the full 20 year period during which assisted facilities under Title VI are obligated to provide uncompensated services. However, facilities may meet the "20 year" standard in more than 20 years, if lack of community need or financial limitations preclude speedier compliance (so long as they comply with all of the requirements in the regulations). Thus, if a Title VI facility provides less than the annual standard for any reason it will be required to make up the deficit (adjusted by the

inflation factor) even if that means the 20 year period will be extended.

Similarly, facilities that provide more than the minimum standard in any year may obtain credit for these additional services against their total obligation, thus permitting them to fulfill their assurances in less than the 20 years. This excess credit provision should encourage facilities to provide early and adequate provision of services when the need for them exists in the community and permit facilities to adapt their uncompensated services obligation to other institutional or governmental requirements for providing services to poor persons.

In summary, under the new procedures facilities will in essence determine the dollar balance of their 20 years' obligation, and credit towards that balance the amount provided in any year. The remaining balance will be adjusted using the CPI. Uncompensated services will be provided until the balance is exhausted. This new approach has permitted the Department to eliminate the burdensome and speculative process that was originally proposed for advance applications and approvals of lower levels of compliance when financial problems at the facility or demand for uncompensated services in a particular community is not great enough to meet the annual compliance standard. Review of facility performance will, in most cases, be after-the-fact, when hard facts are available. If community demand appears to be lower than the annual standard, an affirmative action program will be required to assure that those needing the services are alerted to its availability, and services provided after implementation of a satisfactory plan will be assumed to meet community need. When a deficit is incurred because of claimed financial problems, the facility will be permitted to make up those deficits in future years when it is able to, but a swifter pace will be required when the financial infeasibility claim proves unjustified.

The Secretary believes this approach is the best way to assure that a "reasonable volume" of services is actually made available during the period of obligation. This new system will apply only to years of the 20 year obligation remaining for Title VI facilities after the rules become effective. (Since facilities assisted under Title XVI do not have a time-limited obligation, those facilities will be required to make up deficits only if due to noncompliance with the regulations.)

The emphasis on the amount of care provided, rather than the method by

which it is provided, has resulted in procedural requirements that leave facilities maximum discretion in devising their uncompensated services programs. The regulations include those procedures that the Secretary believes will promote public awareness of the uncompensated services requirement, equitable eligibility determinations, and self-enforcement by beneficiaries, and that will minimize the burden on limited HEW and State resources.

Facilities are required to publish plans for allocating uncompensated services that describe the types of services available, when during the year they will be available, and whether reduced cost care will be given in addition to free care. Consistent with the objectives of local option and facility flexibility, facilities may tailor those plans according to their best judgment, so long as community need is considered by the facility in the plan's development. We have provided an opportunity for advisory participation by the HSA for the area and by others in the community to assure that community preferences can be heard, but final decisions are up to the facility. The final regulation increases the scope of facility discretion as to the contents of an allocation plan and permits revisions to the plans whenever the facility deems it advisable.

In order to ensure that persons who qualify for uncompensated services know about them, the rules require published, posted and individual notices. Prompt eligibility determinations on request are also required. To minimize the administrative burdens of these requirements, though, the individual notice requirement does not apply when uncompensated services are not available in the facility; the posted notices will be supplied by the Secretary in English and Spanish; and the prior determination requirement for crediting uncompensated services has been eliminated as proposed. Under the new procedures, persons unable to pay may request and can obtain a determination of eligibility before services are provided or after collection action has begun.

Eligibility for uncompensated services will be determined using national income-based criteria, so that both facilities and recipients may readily determine who is eligible. Two tiers of eligibility are established using the CSA poverty guidelines. Facilities must provide services without charge to persons with incomes in the lower tier (below the poverty level), but have the option of providing services at no, partial or full charge to persons with

incomes in the upper tier. This will permit facilities to target their limited uncompensated services to the neediest.

Reporting, recordkeeping and investigation provisions have been designed with the intention of minimizing both the Department's and the facilities' burdens of proving compliance, maximizing the Department's and the public's ability to ascertain compliance, and making most effective use of limited enforcement resources. All of the details of required reports are not established in these rules, but will be set in connection with the development and clearance of an assurances monitoring reporting form. However, these reports, needed to assist the Department in conducting periodic investigations, will only be required every three years (instead of every year) for facilities meeting their annual compliance standard, and in any year that the annual level is not reached or the Secretary determines a report is needed for sound administration. Clear recordkeeping requirements are also established to avoid the current problem of distinguishing between uncompensated services qualifying for credit and "bad debts," "courtesy allowances" and other write-offs that do not qualify.

The final rules also recognize that because of expected volume, all complaints cannot possibly be resolved promptly by the Secretary. Therefore, complainants will be given the opportunity to request early dismissal to permit them to file a court action if desired. In addition, in order to permit concentration of resources on serious program implementation problems, the final rules permit the Secretary, on his own initiative, to dismiss complaints that cannot be reached on a timely basis and to focus his investigation resources on far reaching compliance issues. To avoid unnecessary and premature litigation, however, facilities will be given prompt notice of the filing of a complaint, and a minimum 45 day period in which to try to obtain voluntary settlement if they wish.

Community Services

With one important exception, the final rules are not significantly changed from the proposed rule. Under the final rules, assisted facilities must make their services available on a nondiscriminatory basis; they must participate, if qualified, in major governmental and third party reimbursement programs (medicaid, medicare, Blue Cross, etc.) and they must not rely on admissions policies that have the effect of excluding persons

in the community who need services on grounds other than availability of the service in the facility, or inability to pay or qualify for uncompensated services. As requested by providers, consumers and governmental agencies, the regulation includes specific illustrations of the admissions practices that may have the prohibited exclusionary effects, and possible alternatives available to facilities to remedy the problem.

The Secretary has determined that one new provision is needed to correct a problem that has arisen under the current rules. Facilities that provide emergency services will not be in compliance with their assurance to make their services available to residents of the community if they deny needed emergency services to any such person. Uncompensated services credit may be claimed for such services if the individual served is eligible and the facility's obligation has not been satisfied, or the facility may, if it does not include emergency services in its uncompensated services allocation plan, bill and institute collection procedures to obtain payment for these cases. In either event, however, emergency treatment cannot be withheld, whether or not the individual can demonstrate in advance of treatment the ability to pay for the services.

The reporting, recordkeeping, and enforcement provisions parallel those in the uncompensated services regulations.

Analysis of Comments and Rules

Appendix I to the rules below is a more complete statement of the basis and purpose of the provisions of the final rules. It includes a summary of the significant comments received and the Department's response to those comments, and an explanation of the basis for significant changes from the proposed rules.

Effective Date

The community service rules are effective for all facilities on September 1, 1979. In establishing the effective date for the uncompensated services rules the Secretary took account of two competing needs, namely the facilities' and Department's need for orderly and efficient implementation of the new procedural requirements, and beneficiaries' needs for prompt and effective provision of health services by assisted facilities. To avoid unnecessary disruption of facilities' accounting and bookkeeping practices that would occur if the rules took effect in the middle of a fiscal year, the new rules will be effective at the beginning of a facility's next fiscal year beginning on or after

September 1, 1979. This should also give facilities enough time to conform their practices to the new procedural requirements and to develop the necessary allocation plan with community comment.

Many facilities begin their next fiscal year during June, July, or August, and many of those facilities may not be able to fully implement the new procedural requirements at the beginning of the next fiscal year given the short time remaining. Therefore, for these facilities the new procedures are also effective on September 1, 1979. For this first year, publication of proposed allocation plans is required 60 days before September 1, 1979, rather than 60 days prior to the beginning of the fiscal year. Any facility able to implement the new procedures earlier in their next fiscal year may, and is encouraged, to do so.

The additional time into the fiscal year given to these facilities to implement the new rules is not a basis for reducing their total uncompensated services obligation in their next fiscal year. The Department will measure compliance for these facilities' next fiscal year using the annual compliance standard in these new rules, and will apply the deficit make up provisions for the entire fiscal year. Credit will be given for uncompensated services provided before the revised rules are required to be implemented in accordance with the rules that are currently in effect. Any deficit incurred in the next fiscal year will be required to be made up. This procedure therefore gives facilities with fiscal years beginning too soon to implement the new rules sufficient time to do so, while at the same time this extra lead time does not excuse facilities from their uncompensated services obligation for the period beginning with the next fiscal year and ending on September 1, 1979.

Regulatory Analysis

In accordance with the requirements of Executive Order No. 12044, the Department has prepared a Regulatory Analysis of the final rules. This analysis is published as Appendix II.

Reevaluation

The Secretary recognizes the need for monitoring the impact of these rules and reassessing their effectiveness on a continuing basis. Therefore, the Department will develop an evaluation plan that will provide it with the information required, and will obtain public comment on that plan and on the impact of the regulations. The Department's intention is to begin its review of these rules, particularly the

inflation factor and the various administrative compliance costs, in 1981, and complete it by the end of 1982. Should the evaluation results demonstrate that costs unexpectedly and significantly exceed current estimates, the Department will reconsider the applicable provisions earlier than 1982.

Accordingly, 42 C.F.R. Part 124 is amended as set forth below.

Dated: May 10, 1979.

Charles Miller II,

Acting Assistant Secretary for Health.

Approved: May 10, 1979.

Hale Champion,

Acting Secretary.

Part 124 of Title 42, *Code of Federal Regulations*, is amended by adding a new Subpart F and a new Subpart G, to read as follows:

Subpart F—Reasonable Volume of Uncompensated Services to Persons Unable To Pay

Sec.

124.501 Applicability.

124.502 Definitions.

124.503 Compliance level.

124.504 Affirmative action requirement.

124.505 Notice of availability of uncompensated services.

124.506 Financial eligibility criteria for identifying persons unable to pay.

124.507 Allocation of services: plan requirement.

124.508 Determinations of eligibility.

124.509 Exclusions from uncompensated services.

124.510 Reporting and record maintenance requirements.

124.511 Investigation and enforcement.

124.512 Agreements with State agencies.

Authority: Sec. 215, 1525, 1602(6), Public Health Service Act as amended; 58 Stat. 690, 88 Stat. 2249, 88 Stat. 2259; (42 U.S.C. 216, 300m-4, 300o-1(6)).

Subpart F—Reasonably Volume of Uncompensated Services to Persons Unable To Pay

§ 124.501 Applicability.

(a) The provisions of this subpart apply to any recipient of Federal assistance under Title VI or XVI of the Public Health Service Act that gave an assurance that it would make available, in the facility or portion of the facility constructed, modernized or converted with that assistance, a reasonable volume of services to persons unable to pay for the services.

(b) The provisions of this subpart apply to facilities for the following periods:

(1) *Facilities assisted under Title VI.* Except where the deficit and excess compliance provisions provide for a

longer or shorter period, a facility assisted under Title VI of the Act shall provide uncompensated services at the annual compliance level required by § 124.503(a) for:

(i) Twenty years after the completion of construction, in the case of a facility for which the Secretary provided grant assistance under section 606 of the Act; or

(ii) The period from completion of construction until the amount of a direct loan under sections 610 or 623 of the Act, or the amount of a loan with respect to which the Secretary provided a guarantee and interest subsidy under section 623 of the Act, is repaid, in the case of a facility for which such a loan was made.

(iii) "Completion of construction" means:

(A) The date on which the Secretary determines the facility was opened for service;

(B) If the opening date is not available, it means the date on which the Secretary approved the final part of the facility's application for assistance under Title VI of the Act;

(C) If the date of final approval is not available, it means whatever date the Secretary determines most reasonably approximates the date of final approval.

(2) *Facilities assisted under Title XVI.* The provisions of this subpart apply to a facility assisted under Title XVI of the Act at all times following the Secretary's approval of the facility's application for assistance under Title XVI, except that if the facility does not at the time of that approval provide health services, the assurance applies at all times following the facility's initial provision of health services to patients, as determined by the Secretary.

§ 124.502 Definitions.

As used in this subpart—

"Act" means the Public Health Service Act, as amended.

"Allowable credit" for services provided to a specific patient means the lesser of the facility's usual charge for those services, or the usual charge multiplied by the percentage which the total allowable cost as reported by the facility in the facility's preceding fiscal year under Title XVIII of the Social Security Act (42 U.S.C. 1395) and Subpart D of the implementing regulations (42 CFR 405.401 *et seq.*) bears to the facility's total patient revenues for the year.

"Applicant" means a person who requests uncompensated services or on whose behalf uncompensated services are requested.

"Facility" means an entity that received assistance under Title VI or XVI of the Act and provided an assurance that it would provide a reasonable volume of services to persons unable to pay for the services.

"Federal assistance" means assistance received by the facility under Title VI or Title XVI of the Act and any assistance supplementary to that Title VI or Title XVI assistance received by the facility under any of the following acts: the District of Columbia Medical Facilities Construction Act of 1968, 82 Stat. 631 (Pub. L. 90-457); the Public Works Acceleration Act of 1962 (42 U.S.C. 2641, *et seq.*); the Public Works and Economic Development Act of 1965 (42 U.S.C. 3121, *et seq.*); the Appalachian Regional Development Act of 1965, as amended (40 U.S.C. App.); the Local Public Works Capital Development and Investment Act of 1976 (Pub. L. 94-369). In the case of a loan guarantee with interest subsidy, or a direct loan sold and guaranteed by the Secretary with an interest subsidy, the amount of Federal assistance under Title VI or Title XVI for a fiscal year is the total amount of the interest subsidy that the Secretary will have paid by the close of that fiscal year, as well as any other payments which the Secretary has made as of the beginning of the fiscal year on behalf of the facility in connection with the loan guarantee or the direct loan which has been sold.

"Fiscal year" means the facility's fiscal year.

"Health Systems Agency" or "HSA" means an agency fully or conditionally designated by the Secretary under section 1515 of the Act.

"Operating costs" for any fiscal year means the total operating expenses of a facility as set forth in an audited financial statement, minus the amount of reimbursement, if any, received (or if not received, claimed) in that year under Titles XVIII and XIX of the Social Security Act.

"Persons unable to pay" means persons who meet the income criteria set out in § 124.506 of this subpart.

"Request for uncompensated services" means any indication by or on behalf of an individual seeking services of the facility of the individual's inability to pay for services. A request for uncompensated services may be made at any time, including following institution of a collection action against the individual.

"Secretary" means the Secretary of Health, Education, and Welfare or his delegatee.

"State agency" means the agency of a State fully or conditionally designated

by the Secretary as the State health planning and development agency under section 1521 of the Act.

"Uncompensated services" means services that are made available to persons unable to pay for them without charge or at a charge which is less than the allowable credit for those services. The amount of uncompensated services provided in a fiscal year is the total allowable credit for services less the amount charged for the services following an eligibility determination. In determining the amount of uncompensated services, the Secretary includes only those services provided to individuals with respect to whom the facility has made a written determination of eligibility.

§ 124.503 Compliance level.

(a) *Annual compliance level.* (1) A facility is in compliance with its assurance to provide a reasonable volume of services to persons unable to pay if it provides for the fiscal year uncompensated services at a level not less than the lesser of—

(i) Three percent of its operating costs for the most recent fiscal year for which an audited financial statement is available; or

(ii) Ten percent of all Federal assistance provided to or on behalf of the facility, adjusted by a percentage equal to the percentage change in the national Consumer Price Index for medical care between the year in which the facility received assistance or 1979, whichever is later, and the most recent year for which a published Index is available. For purposes of this paragraph, the Federal assistance in the case of a loan which is guaranteed or made and sold by the Secretary will be deemed to have been provided in the year in which the Secretary made the loan.

(b) *Deficit in compliance.* (1) *Facilities assisted under Title VI.*—If in any fiscal year a facility assisted under Title VI of the Act fails to meet its annual compliance level, it shall provide uncompensated services in an amount sufficient to make up that deficit (as adjusted under paragraph (d)). The facility may make up a deficit at any time during its period of obligation or in the year or years (if necessary) immediately following, except where the facility failed to provide uncompensated services at the required level although financially able to do so, or where the facility did not comply with the requirements of this subpart.

(2) *Facilities assisted under Title XVI.* If in any fiscal year a facility assisted under Title XVI of the Act fails to meet

its annual compliance level but has otherwise complied with the requirements of this subpart, the amount of uncompensated services provided in that year constitutes compliance with this subpart.

(c) *Excess compliance.* (1) Whenever a facility provides in a fiscal year uncompensated services in an amount exceeding its annual compliance level, it may apply the amount of excess (as adjusted under paragraph (d)) to reduce its annual compliance level in any subsequent fiscal year. The facility may use any excess amount to reduce its annual compliance level only if the services in excess of the annual compliance level are provided in accordance with the requirements of this subpart.

(2) A facility assisted under Title VI may in any fiscal year apply the amount of excess credited under this paragraph to satisfy the remainder of its obligation to provide uncompensated services. In any fiscal year, the amount of uncompensated services required to satisfy the remainder of the facility's obligation is its annual compliance level for that fiscal year provided multiplied by the number of years remaining in its period of obligation, plus any deficits required to be made up under this section.

(d) *Calculation and adjustment of deficit and excess.* (1) The amount of a deficit or excess in uncompensated services in any fiscal year is the difference between the facility's annual compliance level for that year and the amount of uncompensated services the facility provided in that year.

(2) The amount of any deficit the facility makes up, and the amount of any excess compliance applied to reduce a facility's annual compliance level, must be adjusted by a percentage equal to the percentage change in the National Consumer Price Index for medical care between the fiscal year in which the facility had a deficit or provided the excess, and the fiscal year in which the facility makes up the deficit or applies the excess to reduce its annual compliance level or satisfy its remaining obligations.

§ 124.504 Affirmative action requirement.

(a) A facility that fails to meet its annual compliance level in any fiscal year shall adopt and implement an affirmative action plan, except where it claims and reports to the Secretary that it was financially unable to provide uncompensated services at the annual compliance level.

(b) The affirmative action plan must include provisions that reasonably can

be expected to enable the facility to meet its annual compliance level. An affirmative action plan may include, among other approaches devised by the facility:

(1) Wide notice of the availability of uncompensated services at the facility. Notice under this paragraph may include:

(i) publication of notices in newspapers of general circulation in the area;

(ii) announcement of the availability of uncompensated services in other communication media in the area (such as radio and television stations); and

(iii) notification of the availability of uncompensated services to organizations in the area that would be likely to refer persons in need of uncompensated services to the facility (such as legal services organizations, community action agencies, and other public and private social services agencies).

(2) If the facility's allocation plan restricts the types of services that will be provided as uncompensated services, or restricts uncompensated services to persons in Category A, expansion of the allocation plan to include other types of services or persons in Category B.

(3) Expansion of the area served by the facility for the purpose of providing uncompensated services; and

(4) Establishment of arrangements with other providers of health care under which those providers (if willing and able to do so) will refer to the facility persons requesting uncompensated services.

(c) The facility shall implement its affirmative action plan when it submits it to the Secretary under § 124.510(a), and shall provide uncompensated services in accordance with the plan, incorporating any changes the Secretary may require, until the annual compliance level is reached in a fiscal year.

§ 124.505 Notice of availability of uncompensated services.

(a) *Published notice.* A facility shall, no later than 60 days before the beginning of its fiscal year, publish in a newspaper of general circulation in its area notice of its uncompensated services obligation. The notice shall include, at a minimum:

(1) The plan of allocation the facility proposes to adopt;

(2) The amount of uncompensated services the facility intends to make available in the fiscal year or a statement that the facility will provide uncompensated services to all persons

unable to pay who request uncompensated services; and

(3) An explanation if the amount of uncompensated services the facility intends to make available in a fiscal year is less than the annual compliance level, either because it is not financially able to meet this level or because it has credited excess compliance from another fiscal year. If a facility has satisfied its remaining uncompensated services obligation since the last published notice under this paragraph, or will satisfy the remaining obligation during the fiscal year, the explanation must include this information.

(b) *Notice to HSA.* (1) The facility shall simultaneously provide a copy of the notice under paragraph (a) to the HSA for the area. The HSA may seek public comment, comment to the facility on the extent to which the allocation plan will or will not meet community needs, or take any other appropriate action.

(2) The facility may revise the plan published under paragraph (a) based on comments received from the HSA or the public. The facility shall send a copy of the plan as adopted to the HSA at the beginning of the fiscal year.

(3) A facility may change its allocation plan during a fiscal year after providing notice to the HSA of the revised plan.

(c) *Posted notice.* (1)(i) The facility shall post notices, which the Secretary supplies in English and Spanish, in appropriate areas in the facility, including but not limited to the admissions area, the business office and the emergency room.

(ii) If in the service area of the facility the "usual language of households" of ten percent or more of the population, according to the most recent figures published by the Bureau of the Census, is other than English or Spanish, the facility shall translate the notice into that language and post the translated notice on signs substantially similar in size and legibility to, and posted with, those supplied under paragraph (c)(1)(i) of this section.

(iii) The facility shall make reasonable efforts to communicate the contents of the posted notice to persons who it has reason to believe cannot read the notice.

(2) If a facility determines that it has provided uncompensated services in an amount sufficient to meet its annual compliance level for the fiscal year or its allocation for any period specified in its allocation plan, and that it will not continue to provide uncompensated services during the fiscal year of the appropriate period, it may post an additional notice stating that it has

satisfied its obligation for the fiscal year or appropriate period, and when additional uncompensated services will be available.

(d) *Individual notice.* (1) In any period during a fiscal year in which uncompensated services are available in the facility, the facility shall provide individual written notice of the availability of uncompensated services to each person who seeks services in the facility on behalf of himself or another. The individual written notice must:

(i) State that the facility is required by law to provide a reasonable amount of care without or below charge to people who cannot afford care;

(ii) Set forth the criteria the facility uses for determining eligibility for uncompensated services (in accordance with the financial eligibility criteria and the allocation plan);

(iii) State the location in the facility where anyone seeking uncompensated services may request them; and

(iv) State that the facility will make a written determination of whether the person will receive uncompensated services, within two working days of a request for uncompensated services.

(2) The facility shall provide the individual written notice before providing services, except where the emergency nature of the services provided makes prior notice impractical. If this exception applies, the facility shall provide the written notice to next of kin or to the patient as soon as practical, but not later than when first presenting a bill for services.

(3) The facility shall make reasonable efforts to communicate the contents of the individual written notice to persons who it has reason to believe cannot read the notice.

§ 124.506 Financial eligibility criteria for identifying persons unable to pay.

(a) A person unable to pay for health services is a person who falls into either of the following categories:

(1) *Category A*—A person whose individual or family income, as applicable, for the 12 months preceding the determination of eligibility is not more than the current poverty income guideline of the Community Services Administration (as set forth in 45 CFR 1060.2-1 *et seq.*) that applies to the individual or family. The facility shall provide uncompensated services to persons in this category without charge.

(2) *Category B*—A person whose individual or family income, as applicable, for the 12 months preceding the determination of eligibility is greater than the current poverty income guideline of the Community Services

Administration (as set forth in 45 CFR 1060.2-1 *et seq.*) that applies to the individual or family but not more than twice that guideline. If persons in Category B are included in the allocation plan, the facility shall provide uncompensated services to these persons without charge, or in accordance with a schedule of charges, as specified in the allocation plan.

(b) A person is eligible for uncompensated services if his annual income is at or below the level established under paragraph (a) when calculated by either of the following methods:

(1) Multiplying by four the person's income for the three months preceding the determination of eligibility; or

(2) Using the person's actual income for the 12 months preceding the determination of eligibility.

§ 124.507 Allocation of services: plan requirement.

(a) A facility shall provide its uncompensated services in accordance with a plan that sets out a method by which the facility will distribute its uncompensated services among persons unable to pay. In developing its plan the facility shall take into consideration comments it receives from the HSA or others with respect to community need. The plan must:

(1) Include the type of services that will be made available;

(2) Specify the method, if any, for distributing those services in different periods of the year;

(3) State whether persons eligible under Category B criteria will be provided uncompensated services, and if so, whether the services will be available without charge or at a reduced charge;

(4) If services will be made available to Category B persons at a reduced charge, specify the method used for reducing charges, and provide that this method is applicable to all persons in Category B; and

(5) Provide that the facility provides uncompensated services to all persons eligible under the plan who request uncompensated services.

(b) A facility may adopt any allocation plan that meets the requirements of paragraph (a). If the facility fails to adopt and publish a plan as required by § 124.505 it will be presumed to have adopted a plan under which it provides all services of the facility without charge to all persons unable to pay who first request such services, until its annual compliance level has been met for the fiscal year.

§ 124.508 Determinations of eligibility.

(a) *Determinations.* In any period or periods in a fiscal year in which uncompensated services are available, the facility shall make a determination of eligibility for uncompensated services within two working days following the request for uncompensated services. The facility shall give the applicant a copy of the determination promptly.

(b) *Content of favorable determinations.* A determination that an applicant is eligible must indicate:

(1) That the facility will provide uncompensated services at no charge or at a specified charge less than the allowable credit for the services;

(2) The date on which services were requested;

(3) The date on which the determination was made;

(4) The income of the applicant; and
(5) The date on which services were or will be first provided to the applicant.

(c) *Reasons for denial.* The facility shall provide each applicant who requests uncompensated services and is denied them, in whole or in part, a written and dated statement of the reasons for the denial when the denial is made. This requirement applies throughout the facility's fiscal year.

(d) *Verification.* A facility may, as a condition to providing uncompensated services to any applicant, require the applicant to furnish any information that is reasonably necessary to substantiate the applicant's income.

§ 124.509 Exclusions from uncompensated services.

A facility may not include the following in computing the uncompensated services it provides:

(a) Any amount that the facility has received, or is entitled to receive, from a third party insurer or under a governmental program, except where the person to whom the facility provides services refused to take reasonable actions necessary to obtain the entitlement.

(b) Any amount in excess of the payment that the facility has received, or is entitled to receive, from a third party insurer or under a governmental program where the facility has agreed or is otherwise required to accept this payment as payment in full for the services;

(c) Any amount for services provided 96 hours or more following notification to the facility by a professional standards review organization (PSRO) that the PSRO disapproved the services under section 1155(a)(1) of the Social Security Act; and

(d) Any amount for which reimbursement would be available under a governmental program (such as medicare or medicaid) in which the facility, although eligible to do so, and required by § 124.603(c)(1) to do so, does not participate.

§ 124.510 Reporting and record maintenance requirements.

(a) *Reporting requirements.* (1) *Timing of reports.*—(i) A facility shall submit to the Secretary a report to assist the Secretary in determining compliance with this subpart once every three fiscal years, on a schedule to be prescribed by the Secretary.

(ii) A facility shall submit the required report more frequently than once every three years under the following circumstances:

(A) If the facility determines that in the preceding fiscal year it did not provide uncompensated services at the annual compliance level, it shall submit a report in the fiscal year in which the deficit is determined.

(B) If the Secretary determines, and notifies the facility in writing, that a report is needed for proper administration of the program, the facility shall submit a report within 90 days after receiving notice from the Secretary, or within 90 days after the close of the fiscal year, whichever is later.

(iii) Except as specified in paragraph (a)(ii)(B) of this section, the reports required by this section shall be submitted within 90 days after the close of the fiscal year, unless a longer period is approved by the Secretary for good cause.

(2) *Content of report.* The report must include the following information, in a form prescribed by the Secretary:

(i) Information that the Secretary prescribes to permit a determination of whether a facility has met the annual compliance level for the fiscal years covered by the report;

(ii) The date on which the notice required by § 124.505(a) was published and sent to the HSA for the area, and the name of the newspaper that printed the notice;

(iii) If the amount of uncompensated services provided by the applicant in the preceding fiscal year was lower than the annual compliance level, an explanation of why the facility did not meet the required level. If the facility claims that it failed to meet the required compliance level because it was financially unable to do so, it shall explain and document its claim;

(iv) If the facility is required to submit an affirmative action plan, a copy of the

plan. If an affirmative action plan was in effect during the preceding fiscal year, documentation of actions taken to implement the plan; and

(v) Other information that the Secretary prescribes.

(3) A facility shall provide a copy of any report to the HSA for the area when submitting it to the Secretary.

(4) *Institution of suit.* Not later than 10 days after being served with a summons or complaint, the facility shall notify the Regional Health Administrator for the Region of HEW in which it is located of any legal action brought against it alleging that it has failed to comply with the requirements of this subpart.¹

(b) *Record maintenance requirements.*

(1) A facility shall maintain, make available for public inspection consistent with personal privacy, and provide to the Secretary on request, any records necessary to document its compliance with the requirements of this subpart in any fiscal year, including:

(i) any documents from which the information required to be reported under paragraph (a) of this section was obtained;

(ii) accounts which clearly segregate uncompensated services from other accounts; and

(iii) copies of the determinations of eligibility under § 124.508(b).

A facility shall maintain these records until 180 days following the close of the Secretary's investigation under § 124.511(a).

(2) In any fiscal year a facility may stop providing individual written notice, and may stop making eligibility determinations, only if it maintains records that document on a current basis that it has met its annual compliance level for the fiscal year or appropriate period specified in its allocation plan.

(3) A facility shall, within 60 days of the end of each fiscal year, ascertain the amount of uncompensated services it provided in that fiscal year. Documents that support the facility's determination shall be made available to the public or the HSA for the area on request. If a report is or will be filed under § 124.510 a facility may respond to a request by providing a copy of the report to the requester.

§ 124.511 Investigation and enforcement.

(a) *Investigations.* (1) The Secretary periodically investigates the compliance of facilities with the requirements of this subpart, and investigates complaints.

(2)(i) A complaint is considered to be filed with the Secretary on the date the

¹ The addresses of the Regional Offices of HEW are set out in 45 CFR 5.31.

following information is received in the Office of the Regional Health Administrator for the Region of HEW in which the facility is located:

(A) The name and address of the person making the complaint or on whose behalf the complaint is made;

(B) The name and location of the facility;

(C) The date or approximate date on which the event complained of occurred; and

(D) A statement of what actions the complainant considers to violate the requirements of this subpart.

(ii) The Secretary promptly provides a copy of the complaint to the facility named in the complaint.

(3) When the Secretary investigates a facility, the facility shall provide to the Secretary on request any documents, records and other information concerning its operations that relate to the requirements of this subpart.

(4) Section 1612(c) of the Act provides that if the Secretary dismisses a complaint or the Attorney General has not brought an action for compliance within six months from the date on which the complaint is filed, the person filing it may bring a private action to effectuate compliance with the assurance. If the Secretary determines that he will be unable to issue a decision on a complaint or otherwise take appropriate action within the six month period, he may, based on priorities for the disposition of complaints that are established to promote the most effective use of enforcement resources, or on the request of the applicant, dismiss the complaint without a finding as to compliance prior to the end of the six month period, but no earlier than 45 days after the complaint is filed.

(b) Enforcement.

(1) If the Secretary finds, based on his investigation under paragraph (a) of this section, that a facility did not comply with the requirements of this subpart, he may take any action authorized by law to secure compliance, including but not limited to voluntary agreement or a request to the Attorney General to bring an action against the facility for specific performance.

(2) A facility that has denied uncompensated services to any person because it failed to comply with the requirements of this subpart will not be in compliance with its assurance until it takes whatever steps are necessary to remedy fully the noncompliance.

(3)(i) If in a fiscal year a facility fails to provide uncompensated services in an amount sufficient to meet its compliance level, and the Secretary determines—

(A) that, contrary to the report filed under § 124.510, the facility was financially able to provide some or all of the deficit amount in the fiscal year in question; or

(B) that the deficit was due to the facility's failure to comply with a requirement of this subpart—the facility shall provide uncompensated services in an amount sufficient to make up the deficit in the fiscal year following the finding, unless the Secretary determines that it is financially unable to do so. If the Secretary determines that the facility is not financially able to provide all of the deficit in the fiscal year following the finding, the Secretary sets a compliance level for that year and subsequent years that permits the deficit to be made up in as short a period of time as he determines is consistent with the financial stability of the facility. Any deficit is calculated and adjusted in accordance with § 124.503(d).

(ii) Where a facility indicates in its published notice that it will provide uncompensated services in an amount below the annual compliance level because of a financial inability to meet the annual compliance level, and the Secretary determines during the fiscal year that the facility is financially able to provide additional uncompensated services, he may require the facility to provide additional appropriate amounts of uncompensated services during the fiscal year.

(iii) In determining whether a facility was or is financially able to meet its annual compliance level, the Secretary will consider factors such as:

(A) the ratio of revenues to expenses;

(B) the occupancy rate;

(C) the ratio of current assets to current liabilities;

(D) the average cost per patient day;

(E) the number of days of operating expenses in accounts payable;

(F) the number of days of revenues in accounts receivable;

(G) the sinking fund (or depreciation fund) balance;

(H) the debt coverage ratio; and

(I) the availability of restricted or unrestricted funds (such as an endowment) available for charitable use. In making this determination the Secretary will consider any comments submitted by the HSA for the area or by other persons.

(4)(i) Where a facility submits an affirmative action plan, the Secretary reviews the plan. If the Secretary determines that the plan is inadequate, he notifies the facility of additional actions it shall incorporate into the plan, including but not limited to, any of the

illustrative approaches listed in § 124.504(b).

(ii) In determining whether an affirmative action plan is acceptable, the Secretary will consider any comments submitted by the HSA for the area or by other persons.

§ 124.512 Agreements with State agencies.

(a) Where the Secretary finds that it will promote the purposes of this subpart, and the State agency is able and willing to do so, he may enter into an agreement with the State agency for the State agency to assist him in administering this subpart in the State. An agreement may be terminated by the Secretary or the State agency on 60 days' notice.

(b) Under an agreement, the State agency will provide the Secretary with any assistance he requests in any one or more of the following areas, as set out in the agreement:

(1) Investigation of complaints regarding noncompliance;

(2) Monitoring of the compliance of facilities with the requirements of this subpart;

(3) Review of affirmative action plans submitted under § 124.504;

(4) Review of reports submitted under § 124.510;

(5) Making initial decisions for the Secretary with respect to compliance, subject to appeal by any party to the Secretary or review by the Secretary on his own initiative; and

(6) Application of any sanctions available to it under State law (such as license revocation or termination of State assistance) against facilities determined to be out of compliance with the requirements of this subpart.

(c) A State agency may use funds received under section 1525 of the Act to pay for expenses incurred in the course of carrying out this agreement.

(d) Nothing in this subpart precludes any State from taking any action authorized by State law regarding the provision of uncompensated services by facilities in the State as long as the action taken does not prevent the Secretary from enforcing the requirements of this subpart.

Subpart G—Community Service

Sec.

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124.602 Definitions.

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Authority: Sec. 215, 1525, 1602(6), Public Health Service Act as amended; 58 Stat 690, 88 Stat. 2249, 88 Stat. 2259; 42 U.S.C. 216, 300m-4, 300o-1(6).

Subpart G—Community Service

§ 124.601 Applicability.

The provisions of this subpart apply to any recipient of Federal assistance under Title VI or XVI of the Public Health Service Act that has given an assurance that it would make the facility or portion thereof assisted available to all persons residing (and, in the case of Title XVI assisted applicants, employed), in the territorial area it serves. This assurance is referred to in this subpart as the "community service assurance."

§ 124.602 Definitions.

As used in this subpart—

"Act" means the Public Health Service Act, as amended.

"Facility" means the an entity that received assistance under Title VI or Title XVI of the Act and provided a community service assurance.

"Fiscal year" means facility's fiscal year.

"Secretary" means the Secretary of Health, Education, and Welfare or his delegatee.

"Service area" means the geographic area designated as the area served by the facility in the most recent State plan approved by the Secretary under Title VI, except that, at the request of the facility, the Secretary may designate a different area proposed by the facility when he determines that a different area is appropriate based on the criteria in 42 CFR 53.1(d).

"State agency" means the agency of a state fully or conditionally designated by the Secretary as the State health planning and development agency of the State under section 1521 of the Act.

§ 124.603 Provision of services.

(a) General.

(1) In order to comply with its community service assurance, a facility shall make the services provided in the facility or portion thereof constructed, modernized, or converted with Federal assistance under Title VI or XVI of the Act available to all persons residing (and, in the case of facilities assisted under Title XVI of the Act, employed) in the facility's service area without discrimination on the ground of race, color, national origin, creed, or any other ground unrelated to an individual's need for the service or the availability of the needed service in the facility. Subject to paragraph (b) (concerning emergency services) a facility may deny services to

persons who are unable to pay for them unless those persons are required to be provided uncompensated services under the provisions of Subpart F.

(2) A person is residing in the facility's service area for purposes of this section if the person:

(i) is living in the service area with the intention to remain there permanently or for an indefinite period;

(ii) is living in the service area for purposes of employment; or

(iii) is living with a family member who resides in the service area.

(b) Emergency services.

(1) A facility may not deny emergency services to any person who resides (or, in the case of facilities assisted under Title XVI of the Act, is employed) in the facility's service area on the ground that the person is unable to pay for those services.

(2) A facility may discharge a person that has received emergency services, or may transfer the person to another facility able to provide necessary services, when the appropriate medical personnel determine that discharge or transfer will not subject the person to a substantial risk of deterioration in medical condition.

(c) Third party payor programs.

(1) The facility shall make arrangements, if eligible to do so, for reimbursement for services with:

(i) Those principal State and local governmental third-party payors that provide reimbursement for services that is not less than the actual costs, as determined in accordance with accepted cost accounting principles; and

(ii) Federal governmental third-party programs, such as medicare and medicaid.

(2) The facility shall take any necessary steps to insure that admission to and services of the facility are available to beneficiaries of the governmental programs specified in subparagraph (1) of this paragraph without discrimination or preference because they are beneficiaries of those programs.

(d) Exclusionary admissions policies.

A facility is out of compliance with its community service assurance if it uses an admission policy that has the effect of excluding persons on a ground other than those permitted under paragraph (a) of this section. Illustrative applications of this requirement are described in the following paragraphs:

(1) A facility has a policy or practice of admitting only those patients who are referred by physicians with staff privileges at the facility. If this policy or practice has the effect of excluding persons who reside (or for Title XVI

facilities, are employed) in the community from the facility because they do not have a private family doctor with staff privileges at the facility, the facility would not be in compliance with its assurance. The facility is not required to abolish its staff physician admissions policy as a usual method for admission. However, to be in compliance with its community service assurance it must make alternative arrangements to assist area residents who would otherwise be unable to gain admission to obtain services available in the facility. Examples of alternative arrangements a facility might use include:

(i) authorizing the individual's physician, if licensed and otherwise qualified, to treat the patient at the facility even though the physician does not have staff privileges at the facility;

(ii) for those patients who have no physician, obtaining the voluntary agreement of physicians with staff privileges at the facility to accept referrals of such patients, perhaps on a rotating basis;

(iii) if an insufficient number of physicians with staff privileges agree to participate in a referral arrangement, requiring acceptance of referrals as a condition to obtaining or renewing staff privileges;

(iv) establishing a hospital-based primary care clinic through which patients needing hospitalization may be admitted; or

(v) hiring or contracting with qualified physicians to treat patients who do not have private physicians.

(2) A facility, as required, is a qualified provider under the Title XIX medicaid program, but few or none of the physicians with staff privileges at the facility or in a particular department or sub-department of the facility will treat medicaid patients. If the effect is that some medicaid patients are excluded from the facility or from any service provided in the facility, the facility is not in compliance with its community service assurance. To be in compliance a facility does not have to require all of its staff physicians to accept medicaid. However, it must take steps to ensure that medicaid beneficiaries have full access to all of its available services. Examples of steps that may be taken include:

(i) obtaining the voluntary agreement of a reasonable number of physicians with staff privileges at the facility and in each department or sub-department to accept referral of medicaid patients, perhaps on a rotating basis;

(ii) if an insufficient number of physicians with staff privileges agree to participate in a referral arrangement,

requiring acceptance of referrals as a condition to obtaining or renewing staff privileges;

(iii) establishing a clinic through which Medicaid beneficiaries needing hospitalization may be admitted; or

(iv) hiring or contracting with physicians to treat Medicaid patients.

(3) A facility requires advance deposits (pre-admission or pre-service deposits) before admitting or serving patients. If the effect of this practice is that some persons are denied admission or service or face substantial delays in gaining admission or service solely because they do not have the necessary cash on hand, this would constitute a violation of the community service assurance. While the facility is not required to forego the use of a deposit policy in all situations, it is required to make alternative arrangements to ensure that persons who probably can pay for the services are not denied them simply because they do not have the available cash at the time services are requested. For example, many employed persons and persons with other collateral do not have savings, but can pay hospital bills on an installment basis, or can pay a small deposit. Such persons may not be excluded from admission or denied services because of their inability to pay a deposit.

§ 124.604 Posted notice.

(a) The facility shall post notices, which the Secretary supplies in English and Spanish, in appropriate areas of the facility, including but not limited to the admissions area, the business office and the emergency room.

(b) If in the service area of the facility the "usual language of households" of ten percent or more of the population, according to the most recent figures published by the Bureau of the Census, is other than English or Spanish, the facility shall translate the notice into that language and post the translated notice on signs substantially similar in size and legibility to, and posted with, those supplied under paragraph (a).

(c) The facility shall make reasonable efforts to communicate the contents of the posted notice to persons who it has reason to believe cannot read the notice.

§ 124.605 Reporting and record maintenance requirements.

(a) *Reporting requirements.*

(1) *Timing of reports.*

(i) A facility shall submit to the Secretary a report to assist the Secretary in determining compliance with this subpart once every three fiscal years, on a schedule to be prescribed by the Secretary. The report required by

this section shall be submitted not later than 90 days after the end of the fiscal year, unless a longer period is approved by the Secretary for good cause shown.

(ii) A facility shall also submit the required report whenever the Secretary determines, and so notifies the facility in writing, that a report is needed for proper administration of the program. In this situation the facility shall submit the report specified in this section for the filing of reports, within 90 days after receiving notice from the Secretary, or within 90 days after the close of the fiscal year, whichever is later.

(2) *Content of report.* The report must be submitted on a form prescribed by the Secretary and must include information that the Secretary prescribes to permit a determination of whether a facility has met its obligations under this subpart.

(3) The facility shall provide a copy of any report to the HSA for the area when submitting it to the Secretary.

(4) *Institution of suit.* Not later than 10 days after being served with a summons or complaint, the applicant shall notify the Regional Health Administrator for the Region of HEW in which it is located of any legal action brought against it alleging that it has failed to comply with the requirements of this subpart.¹

(b) *Record maintenance requirements.*

(1) A facility shall maintain, make available for public inspection consistent with personal privacy, and provide to the Secretary on request, any records necessary to document its compliance requirements of this subpart in any fiscal year, including documents from which information required to be reported under paragraph (a) of this section was obtained. A facility shall maintain these records until 180 days following the close of the Secretary's investigation under § 124.606(a).

§ 124.606 Investigation and enforcement.

(a) *Investigations.*

(1) The Secretary periodically investigates the compliance of facilities with the requirements of this subpart, and investigates complaints.

(2)(i) A complaint is filed with the Secretary on the date on which the following information is received in the Office of the Regional Health Administrator for the Region of HEW in which the facility is located:

(A) The name and address of the person making the complaint or on whose behalf the complaint is made;

(B) The name and location of the facility;

¹ The addresses of the Regional Office of HEW are set out in 45 C.F.R. 5.31.

(C) The date or approximate date on which the event complained of occurred, and

(D) A statement of what actions the complainant considers to violate the requirements of this subpart.

(ii) The Secretary promptly provides a copy of the complaint to each facility named in the complaint.

(3) When the Secretary investigates a facility, the facility shall provide to the Secretary on request any documents, records and other information concerning its operations that relate to the requirements of this subpart.

(4) The Act provides that if the Secretary dismisses a complaint or the Attorney General has not brought an action for compliance within six months from the date on which the complaint is filed, the person filing it may bring a private action to effectuate compliance with the assurance. If the Secretary determines that he will be unable to issue a decision on a complaint or otherwise take appropriate action within the six month period, he may, based on priorities for the disposition of complaints that are established to promote the most effective use of enforcement resources, or on the request of the complainant, dismiss the complaint without a finding as to compliance prior to the end of the six month period, but no earlier than 45 days after the complaint is filed.

(b) *Enforcement.*

(1) If the Secretary finds, based on his investigation under paragraph (a) of this section, that a facility did not comply with the requirements of this subpart, he may take any action authorized by law to secure compliance, including but not limited to voluntary agreement or a request to the Attorney General to bring an action against the facility for specific performance.

(2) If the Secretary finds, based on his investigation under paragraph (a) of this section, that a facility has limited the availability of its services in a manner proscribed by this subpart, he may, in addition to any other action that he is authorized to take in accordance with the Act, require the facility to establish an effective affirmative action plan that in his judgment is designed to insure that its services are made available in accordance with the requirements of this subpart.

§ 124.607 Agreements with State agencies.

(a) Where the Secretary finds that it will promote the purposes of this subpart, and the State agency is able and willing to do so, he may enter into an agreement with the State agency for

the State agency to assist him in administering this subpart in the State.

(b) Under an agreement, the State agency will provide the Secretary with any assistance he requests in any one or more of the following areas, as set out in the agreement:

- (1) Investigation of complaints of noncompliance;
- (2) Monitoring the compliance of facilities with the requirements of this subpart;
- (3) Review of affirmative action plans submitted under § 124.606(b);
- (4) Review of reports submitted under § 124.605;
- (5) Making initial decisions for the Secretary with respect to compliance, subject to appeal by any party to the Secretary or review by the Secretary on his own initiative; and
- (6) Application of any sanctions available to it under State law (such as license revocation or termination of State assistance) against facilities determined to be out of compliance with the requirements of this subpart.

(c) A State agency may use funds received under section 1525 of the Act to pay for expenses incurred in the course of carrying out this agreement.

(d) Nothing in this subpart precludes any State from taking any action authorized by State law regarding the provision of services by any facility in the State as long as the action taken does not prevent the Secretary from enforcing the requirements of this subpart.

Appendix I

SUMMARY OF PUBLIC COMMENTS AND DEPARTMENT'S ACTIONS ON THE UNCOMPENSATED SERVICES AND COMMUNITY SERVICE REGULATIONS

The public comments and the Department's actions on the proposed rules are summarized below. The discussion proceeds sequentially through the regulations. In order to ease understanding of the comments and the Department's response, a brief background statement of the existing and proposed rules precedes each section.

Uncompensated Services

I. Applicability of the rules.

A. Background.

The present rules, set out at 42 CFR 53.111, apply only to Title VI facilities. They apply to facilities assisted with grants for 20 years after completion of construction and to facilities assisted with loans or loan guarantees during the period in which the loan remains unpaid. 42 CFR 53.111(a).

The proposed rules retained the policies of the present rules for Title VI facilities, adding a definition of the term "completion of construction." For Title XVI assisted facilities, the rules applied "at all times" following approval of the Title XVI

application, except where the facility assisted did not provide health services when approved. In that case, the rules became applicable when the facility began to provide services. Proposed 42 CFR 124.501.

B. Public comment.

1. Consumers generally opposed the 20 year limit for Title VI facilities as proposed. A large number argued that it should be eliminated entirely, on grounds such as the following: substantial consumer need and hospitals' ability to provide services; the alleged failure of the Department and Title VI State agencies to enforce the obligations in the past; the lack of statutory support for the 20 year limit. Many consumers asserted that prior to 1972, when the 20 year limit was established, the duty to provide uncompensated care was essentially unrecognized and that since 1972 enforcement has been inadequate or inconsistent. Several consumers emphasized that the durational limitation is strictly regulatory. Thus, they argue that facilities which received aid before 1972 did not rely on the limitation. According to consumers, the cases cited in the proposed rules as upholding the 20 year limit merely endorse the Department's authority to apply a limitation but would not bar the removal or alteration by the Department of it.

Other consumers, however, acknowledged that 20 years of actually providing services might be "reasonable", as well as politically more acceptable than restoration of an unlimited duty. They therefore suggested various modifications of the durational limitation. The proposals most commonly made were having the 20 years run from (1) the effective date of the new regulations; (2) the date the facility can document its provision of uncompensated care or the completion of construction, whichever is later; or (3) 1972, when the existing regulations were issued, on the theory that there were no compliance standards (and hence no compliance) before that date. If the 20 year limitation were to run from the effective date of the new regulations, a few comments suggested that the regulations provide for a credit for years in which a facility met the "3%" or "10%" level of care under the present regulations. Consumer comments also urged that if the present 20 year limit is maintained, it be enforced retrospectively.

2. Another consumer suggestion was that the supplemental programs included in the Federal assistance base upon which the 10% compliance level is calculated should be added to § 124.501(a), thereby making these regulations applicable to those supplementary programs.

3. Provider comments consistently supported the proposed retention of the Title VI time limits on the uncompensated services obligation. It was argued that the durational limit is statutorily required, i.e., that the obligation to the government should last only as long as the government's right of recovery (section 609 of the Act) and that the term "reasonable volume" implies an absolute dollar amount of services that is inconsistent with an open-ended obligation. Numerous

providers also argued that eliminating or extending the durational limitation now would constitute "impairment of contract", particularly with respect to those facilities assisted after 1972. They argued that any extension of the obligation would impair their long-term financial solvency and divert funds from patient care, and that facilities that have undertaken long-term financial plans and commitments relying on their limited obligations under the present regulations would be significantly harmed.

4. Providers generally opposed the applicability of the uncompensated services assurance without a durational limitation for Title XVI assisted facilities. See proposed § 124.501(b)(2). Some asserted that the perpetual obligation was unauthorized, and that the period of obligation should be the same as for Title VI assisted facilities. Some argued that the Department has misinterpreted the statutory language "at all times," and that the phrase only meant "at all times" during the period in which the obligation applies (that is, 20 years). Providers also expressed the view that it would be prohibitively costly to assume an open-ended obligation and that the net effect of such a rule would be to discourage providers from seeking assistance under Title XVI, a result not intended by Congress. Others argued that the effect of the rule would be to perpetually penalize private-pay patients, who must bear the cost of the uncompensated services provided.

5. A few provider and government comments opposed the clarification of the term "completion of construction" in the proposed rules. They argued that this change would only cause confusion, since for most Title VI facilities the commencement of the obligation is already clearly established.

C. Department's Actions and Response

Although the Department has retained the 20 year period of obligation for Title VI assisted facilities it has made one change that is responsive to those comments that urged that the 20 year period should not be used to "forgive" non-compliance during the 20 year period. Section 124.501(b)(1) now permits lengthening or shortening of the durational limitations for Title VI facilities, to be consistent with the deficit make-up and excess compliance provisions of § 124.503 (b) and (c). The concept underlying those sections is that Title VI facilities undertook to provide a total "volume" of services. The size of that volume is a function of both the annual compliance level and the remaining period of obligation, but it is in essence a fixed amount of services. That being the case, facilities that fail to provide that volume before their 20 year period of obligation expires should not benefit from their failure, while facilities that more than meet their obligation in some years should be credited with the extra amount of services provided. These considerations dictated adjustment of the period of obligation. The discussion below of the compliance level and deficit and excess compliance provisions explains the Department's position more fully.

With respect to those comments it has not accepted the Department responds as follows:

1. While the Department agrees with consumers that it did not have to interpret the uncompensated services assurance as being limited to 20 years, it does not agree that once having done so it can now "wipe the state clean" and completely eliminate or substantially modify that limitation. As pointed out in the preamble to the proposed rules, the courts have consistently upheld the validity of this interpretation of the statute, so it cannot seriously be contended that the limitation itself is contrary to law. The Department recognizes that any facilities that have avoided their obligations in the past will benefit from the limitation. Nevertheless, the proposal to eliminate or recalculate the limitation clearly raises significant legal and practical questions. Moreover, the Department has no grounds for making the factual assumption that would be implied if it eliminated or recalculated the limitation—namely, that all facilities have avoided their obligation and therefore should get no credit for past years of compliance. Moreover, it is persuaded that there has been provider reliance on the 20 year rule, certainly by those facilities funded after 1972 and, to some extent, in the long-term financial planning since that time by all assisted facilities.

The suggestion that facilities be credited with compliance for only those years since 1972 in which compliance is clearly established answers some of these problems, but has difficulties of its own. It would require the Department to audit thousands of facilities to establish which years could be credited. This effort would entail a diversion of Department resources that would significantly impair its ability to implement these rules. In addition, many facilities did not retain records sufficient to establish compliance for all those years, nor did the current regulations require that they do so. In many cases, therefore, past compliance will be impossible to establish administratively. The Department expresses no opinion as to the possible remedies available to a private litigant against a particular facility.

Finally, the Department notes that it has accepted—prospectively, to be sure—the theory behind most of the consumer suggestions. Unlike the policy of the present regulation, the durational limitation is no longer absolute; the passage of time will no longer avoid the obligation of a noncomplying facility. Although the Department does not believe it can rectify all the injustices of the past, it has taken steps to assure that they do not recur in the future.

2. The Department has not accepted the suggestion that these regulations apply to the supplemental programs. Those programs lie outside the scope of this regulation, which addresses Titles VI and XVI assistance only. Also, four of the five acts are not totally administered by the Secretary, and thus may lie outside his power to regulate unilaterally. The Department is presently looking into whether it may and should issue regulations to cover the assurances given under these Acts in connection with projects not funded in conjunction with Title VI projects. Finally,

to the extent that assistance under those programs is "supplemental" to Title VI or XVI assistance and not "freestanding," it is in effect covered by their inclusion in the term "Federal assistance" as defined in § 124.502.

3. As discussed above, the Department is persuaded by the reasons given by the providers in support of the retention of the durational limitation. Their comments are hence not discussed extensively here. However, the Department has not accepted the provider position completely, in that it has provided for extension of the period of obligation where there is a deficit in the amount of uncompensated services provided. The Department does not believe that any extension of the period of obligation constitutes "impairment of contract" as many providers urged. Assuming for discussion that the government-facility relationship is a contractual one, the obligation facilities assumed was to provide "a reasonable volume" of services. The extension of the period of obligation where a deficit occurs does not increase what facilities are required to provide but rather merely assures that the facilities live up to their end of the bargain.

4. The Department has not modified the unlimited period of obligation proposed for Title XVI assisted facilities. The "at all times" language is statutory. See section 1604(b)(1)(J), discussed in the preamble. The Department does not believe that the "at all times" language means "at all times" for a 20 year period, as argued by many providers. The change in language from that in the Title VI assurance would make no sense if this theory were correct, since that has always been the interpretation of the Title VI assurance. Moreover, when Congress intended a 20 year period to apply in Title XVI, it clearly said so. See section 1631(a).

5. In defining the term "completion of construction," the Department intended to codify and clarify longstanding administrative practice. Moreover, since the Department believes that its definition accords with the way the term has been administered in the past, it does not believe that the confusion anticipated by some comments will materialize.

II. Definitions

A. Background

The proposed rules carried forward several of the definitions of the current rules either unchanged or with only technical modifications. However, a few terms of the current regulations were modified, and two new terms introduced. The term "operating costs" (which is used as the base for the 3% compliance level) was changed to make clear that the costs to be considered are those of a previous, rather than the current, fiscal year. The term "Federal assistance" was expanded to include assistance under programs supplemental to Title VI. The term "uncompensated services" was modified to eliminate the reference to "reasonable cost" and reflect the new "allowable credit" approach. The term "allowable credit" was proposed, to provide a more precise means of calculating the extent to which services provided to a person unable to pay may be

credited toward a facility's uncompensated services quota.

B. Public comment

The public comment focused on the changed and new definitions described above, although one definition unchanged from the current regulations ("applicant") evoked criticism. The definitions below are discussed in the order they appear in the final rules.

1. "Allowable credit": This definition drew comment from a number of providers. Most objected to the use of the Medicare allowable cost factor and asserted that computation on a cost basis is unfair to charge-based payors and is unworkable. A common objection was that the allowable credit excludes Medicare nonallowable costs, while the base for computing the option of 3% of operating costs includes Medicare nonallowable costs. This, it was argued, results in a two-step inflation of the obligation (for 3% facilities) and an arbitrary application of Medicare cost principles, and the Department was urged to base the credit on the facility's operating expenses or customary charges. Arguing that the regulations should use the ratio of actual cost to charges in determining credit, providers urged that since uncompensated services patients benefit from upgraded services which may nevertheless be unallowable under Medicare (e.g., telephones), they should participate in their cost. Other specific suggestions were made for use of various ratios based on usual charges or operating expenses to determine allowable credit.

Providers also pointed out that if the definition of allowable credit requires use of post-audit figures then it would be impossible for a facility to tell during the year what the status of its obligation was. However, if the unaudited figures are used (as implied by the proposed rules), then the allowable credit will be based on inaccurate figures.

2. "Applicant": This term was generally characterized as difficult and ambiguous. Consumer comments suggested that "applicant" be replaced with "facility" or "federally-assisted facility" to reflect the fact that covered facilities have already received Federal funds.

3. "Federal assistance": Providers protested that, unless specifically provided for by the statutes governing the supplemental programs listed, any expansion of the Titles VI and XVI obligations to include such funds is unauthorized. Consumers, on the other hand, argued that the regulations must cover the listed supplemental construction programs, which "look like Hill-Burton, act like Hill-Burton, were filed on Hill-Burton forms and were accompanied by the same Hill-Burton promises."

Providers also objected that "Federal assistance" for loans and loan guarantees is inappropriately defined to include the total amount of interest subsidy that has been "or will be" provided over the life of the loan. Providers argued that the definition should cover only interest subsidies that have been made as of the year in which the obligation computation is made. Failure to do this

would, together with the inflation factor, make the cost of the loan money exceed usury rates.

4. *"Operating costs"*: Consumer comments proposed that the definition should not exclude payments received from Medicare and Medicaid, arguing that exclusion of such payments implied that they were "inappropriate or inadequate." Another consumer suggestion was that operating costs be defined not in terms of an audited financial statement for a prior year but rather in terms of a combination of actual and projected costs for the current year to avoid minimizing the obligation due to intervening inflation in costs.

5. *"Request for services"*: Several consumer comments urged that the terms "request for services" and "promptly" be defined carefully, so that the standard for compliance with the eligibility determination requirement would be clear. Time periods such as 2 and 5 working days were suggested.

6. *"Service area"*: Several consumer comments urged that the term "service area" be defined for these regulations. One suggested that it be whatever area the facility said it would serve in its Title VI or XVI application.

7. *"State agency"*: A governmental comment urged that the term State agency be expanded to include other agencies accredited by the Secretary.

8. *"Uncompensated services"*: Some providers interpreted the exclusion of amounts "actually charged" for services to prohibit determinations of eligibility after rendition of a bill, and urged a change in the definition to exclude "amounts actually collected from" rather than "amounts actually charged" such persons. Substantially similar points were made by a few consumers.

C. Department's Actions and Response

1. *"Allowable credit"*: The rules clarify that past allowable cost figures must be used, to eliminate the problems with using projected figures noted by providers. Otherwise, the definition remains unchanged. The Department believes that the ratio of allowable cost to revenues is a reasonable one for purposes of calculating what portion of charges should be credited towards fulfillment of the obligation. It believes that costs credited towards the obligation should not take into account costs not directly related to patient care; use of Medicare "allowable costs" accomplishes this. The consumer suggestion that only the allowable cost to revenues ratio be used has been rejected, however, because where care is subsidized the usual charge will be less than the ratio; in such cases the benefit to persons unable to pay is simply the amount not being charged.

2. *"Applicant"*: The Department agrees with those comments characterizing the term "applicant" as used in the proposed rules as confusing. That term now is used to denote persons who apply for uncompensated services; the term "facility" is now used to denote the assisted facility.

3. *"Federal assistance"*: The Department agrees with consumers that it should include

the programs of supplemental assistance in the base for calculation of the "10%" compliance level. As for the provider argument that it has no legal authority to include those programs, the Secretary is clearly authorized to define what is a "reasonable volume of services". Inclusion of the supplemental programs in the base of Federal assistance on which the 10% compliance level is calculated is reasonable, since funding under those programs was, by definition, provided for the Title VI project. The uncompensated services assurance, given for the Title VI project as a whole, can thus reasonably be said to have been given for the supplemental programs also.

The Department is persuaded by the provider comments that the inclusion of future assistance in the amount of "Federal assistance" for purposes of the loan and loan guarantee program is onerous. Accordingly, the definition has been changed to make clear that only accrued assistance is "Federal assistance" for purposes of the 10% compliance level.

4. *"Operating costs"*: The consumer suggestion that the definition of operating costs include Medicaid/Medicare reimbursements has been rejected. The exclusion mirrors that in the existing regulations. To eliminate it would change the 3% compliance level, which is not the Department's intent. Rather, except for the inflation factor, the Department believes that the present dollar-volume compliance levels are a reasonable measurement of "reasonable volume" and should therefore not be changed. The suggestion that operating costs be based on combined actual and projected costs has been rejected as unworkable. Because of accounting lags, current and projected numbers are inherently subjective, open to question and subject to revision. It is far more important that facilities, the public and the Secretary know currently and with certainty what a 3% facility's current compliance obligation is than that the method by which that obligation is calculated incorporate any cost increases of the most recent few months.

5. *"Request for uncompensated services"*: A definition of this term has been added in response to the many requests that it be defined. The definition is discussed fully in section XI below.

6. *"Service area"*: This term has not been defined for the uncompensated services regulations. It is not needed here, because the scope of a facility's service area is not relevant to its obligations under these rules, unlike the community service rules, which require services to be available to all persons residing in the service area. The term has been defined for the community service regulations.

7. *"State agency"*: The suggestion that this term include State agencies other than the Title XV State agency has not been accepted. The Department does not believe that a viable arrangement with an agency of a State can be established absent compensation. At present the only authority under which Federal funds may be used for the assurances programs is section 1525 of the Act, the grant to the Title XV State agency.

8. *"Uncompensated services"*: This definition has been changed to make clear, as suggested by many comments, that the amount of uncompensated services excludes amounts charged following an eligibility determination, but not charges forgiven as a result of such a determination. The suggestion that only amounts actually collected should be deducted was not accepted because amounts charged after a determination that a person is eligible for uncompensated services, i.e. to a Category B patient, should not be credited towards satisfaction of the facility's obligation if they are not actually collected. These amounts are by definition amounts the individual was considered able to pay under the applicable criteria and therefore are no different than other uncollectible amounts.

III. Compliance Level

A. Background

The current regulations give facilities two options as to the amount of uncompensated services they must provide in a fiscal year: (1) the lesser of "3%" of operating costs or "10%" of Federal assistance; or (2) they may certify that they will turn no one away on the basis of inability to pay and will provide uncompensated services to those so admitted who are eligible for them. 42 CFR 53.111(d). This latter option is popularly known as the "open door" option. If a facility selects one of these options, the State agency may not set a higher compliance level for it. 42 CFR 53.111(h)(1).

The proposed rules proposed elimination of the open door option, leaving just one annual compliance level—the lesser of 3% of operating costs or 10% of Federal assistance. See proposed § 124.503(a). Although the 3% standard was left essentially unchanged, it was proposed to modify the 10% standard by requiring that the Federal assistance received be multiplied by an "inflation factor", so that the real value of services to be provided under this standard would stay constant. The inflation factor proposed was the national Consumer Price Index for medical care. If a facility could not meet the annual compliance level, it could ask the Secretary to set a lower level of compliance for it, following the procedures set out in proposed § 124.504.

B. Public Comment

Proposed § 124.503 generated the most comment of any section of the proposed rules. In general, these comments centered on the elimination of the open door option and the inflation factor. The lower level of compliance procedure received extensive comment in conjunction with the comments on the open door option, but those comments are discussed in section V below.

1. *Elimination of the open door option.* a. Providers opposed the elimination of the open door option. Many maintained the option is the most appropriate compliance method for the many hospitals that have an open door policy based on traditional practice or state and local laws. It was also claimed that the open door is the only option "that truly addresses the needs of individual communities," by permitting the facility to fulfill whatever level of need exists in the

community without having to submit to complicated administrative requirements for seeking annual exceptions.

Providers and State agencies claimed the proposed regulations will create problems for facilities that never turn anyone away, such as public-general hospitals, hospitals always maintaining an open door, hospitals that are the sole providers in the community, or hospitals that are mandated by state or local law to maintain an open door. Many providers argued that the elimination of the open door option would result in less uncompensated services being provided. They also urged retention of the option because it is easier to administer, stating that less paperwork and reporting was involved. Many also stated that a particular quota is unnecessary because most facilities provide care regardless of the individual's ability to pay. One community hospital asserted that removal of the open door option would increase its bad debts by \$35,000 annually.

Numerous providers objected to the removal of the option on the grounds that there was insufficient need in their communities to enable them to meet the 3% or 10% compliance levels. For example, one acute care 187-bed general hospital in Nebraska pointed out that in 1976 and 1977 its bad debts and charity care combined would not have met the 3% option. Some providers pointed out that community need fluctuates from year to year as employment and other local conditions change, and others that community need may be low in States where welfare benefits are high or people resent or refuse to accept "charity." The open door option, it was argued, enables facilities to adapt to such situations.

Many providers argued that the existing mechanisms are functioning and there has been no showing of substantial violation to substantiate the need for the new regulations. The Department's statistics were cited as showing that few complaints have been made to the State agencies; they were also cited for the proposition that open door facilities are providing their proportionate share of uncompensated services. Others pointed out that if the problem with the option lies in monitoring it, the remedy is not to eliminate it but to set up reporting requirements that will permit adequate monitoring. Alternatively, it was suggested that the option be eliminated for those facilities that abuse it.

Several comments stated that the option was most consistent with the statutory requirement that uncompensated services be "made available," not that they be "provided." Others argued that elimination of the option would constitute impairment of contract.

b. Consumer response to the proposed elimination of the option was mixed. For example, several legal aid societies opposed its elimination, arguing that it is the best opportunity for providing care to the needy. They argued that if the open door method has been misunderstood in the past, as represented in the preamble to the proposed rules, it was a result of inadequate and vague regulations. Although good data concerning facilities' use of the open door option is lacking and facilities have frequently

combined free care with bad debts and other uncompensated services, these comments emphasized that proof of compliance would not be impossible, given new regulations concerning recordkeeping, and written determinations of eligibility. Acknowledging that a carryover of any deficit would not be appropriate with the open door option, the comments suggest that the Department require the facilities to reimburse all costs incurred by an individual wrongly deemed ineligible.

A large number of consumers felt that because of past abuse of the open door option, its elimination is, as a general matter, a good idea. For example, some stated they agreed with the proposed policy because it has served as "a long standing 'dodge' for hospitals that sought to evade their responsibilities." One stated that, based on the unaudited reports of a group of Rhode Island hospitals, in only 7 out of 40 instances where open door facilities reported on their uncompensated services level did those facilities provide uncompensated services equal to the amount they would have been obligated to give under the 10% option. In response to the asserted concern by providers that eliminating the option might limit facilities' charitable intentions, comments suggested that the open door option be continued if no less than 3% or 10% is provided and advance, written individual notice is provided to patients.

2. *Inflation Factor.* a. Providers generally objected both to the use of the inflation factor and to the use of the percentage change in the national Consumer Price Index for medical care as the measure of inflation. The general theme of the comments was that a 200% return of the original aid was sufficient, and that use of an inflation factor changed the original terms of the contract and resulted in an impossible burden on facilities.

The inflation factor was characterized as being itself inflationary, resulting in imposition of additional charges on paying patients. Providers claimed that addition of the inflation factor could result in an institution's obligation increasing geometrically and overwhelmingly. Providers also stated that inflation reduces facilities' ability to provide uncompensated services, particularly should the Administration succeed in restricting the amount facilities can collect in revenue.

Providers also objected that if an inflation adjustment is to be added, the medical care component of the Consumer Price Index is not an appropriate measure of inflation. These comments claimed that the CPI includes inappropriate factors in addition to straight inflation. Providers also alleged that the proposed formula would discriminate against institutions and areas of the country where costs increases have been held to a level below the national average. Some providers suggested that instead of using the CPI, the regulations should provide for application of changes in the cost of money or the prime rate, since those most nearly reflect the opportunity cost of commercial construction money.

b. Consumers generally supported the use of an inflation factor. Some argued that if the

10% compliance level amounts to a higher level of care than the 3% level the facility should be required to choose the former because it is more logical to require free care in proportion to the grant or loan than in proportion to the facility's operating costs.

While praising the concept of the inflation factor, some comments argued that it should be applied retrospectively to the date the federally-assisted construction was completed or to 1972. Pointing to the past increase in the CPI for medical costs they noted the ease with which the computation can be made and stated that the failure to apply inflation retrospectively "condemned consumers to appreciate less than half of the Hill-Burton entitlement."

3. *Other comments.* a. A few comments suggested that the entire approach of proposed § 124.503 was inappropriate for public and private facilities that primarily serve the indigent. In such cases, uncompensated services far in excess of the compliance levels is provided. It was argued that to burden such facilities with the extensive procedural and administrative requirements of these regulations is unnecessary.

b. Several consumers urged that a mechanism for community and/or HSA review and approval of a facility's compliance level be built into § 124.503. It was argued that if "community need" were greater than what the facility was required to provide under that section, the compliance level should be adjusted upwards.

C. Department's Actions and Response

The final rules retain the compliance levels contained in proposed § 124.503(a), although the practical effect of those levels is considerably affected by the deficit and excess compliance provisions discussed below.

1. *Elimination of the open door option.* The Department continues to believe that elimination of the open door option is necessary, for the reasons stated in the preamble to the proposed rules and by many consumers. A clear dollar standard against which facility performance can be measured will simplify monitoring and administration, gain public confidence that a "reasonable volume" of services has in fact been made available, and will result in facilities shouldering relatively equal minimum obligations to serve the medically indigent. This decision will not result in less uncompensated services being provided, as argued by numerous comments. These comments miss the point of the annual compliance level requirement. That requirement is simply a minimum. It does not preclude facilities from exceeding it; indeed, they will get credit if they do. See § 124.503(c). Moreover, facilities are also specifically authorized to adopt a policy under which all persons needing services will receive them regardless of ability to pay. See § 124.507. The Department will only use the dollar compliance level as a standard to assure a minimum level of service.

The Department does not agree with the numerous comments arguing for retention of the open door option because it is cheaper

and easier to administer. Compliance with the option either requires eligibility determinations for virtually every person seeking admission, or individual notice and an opportunity for every such person to request a determination. This option is therefore more difficult and expensive to administer than the other option under the present regulations, which requires determinations only on request. It is clearly no easier or cheaper than these final rules. Indeed, these comments (and the comment suggesting that bad debts would somehow increase when the open door was eliminated) prove the Department's position that the option is "ill understood". They also illustrate the fallacy of the reported statistics, since those statistics by definition do not show how many persons who should have been provided uncompensated services by open door facilities were denied them. Moreover, the statistics themselves are based on aggregate reports by State agencies, and almost certainly reflect some erroneous reporting (e.g., inclusion of bad debts, or other forms of charity care).

The Department recognizes that the open door option, properly applied, would serve a valid purpose where there is insufficient community need fully to meet the compliance level for a particular year. Nevertheless, it does not believe that it is the only reasonable accommodation to such situations. Nor does it believe that insufficient need for a particular year should serve to reduce the total obligation for Title VI facilities. The deficit make-up provisions of the final regulations, together with the affirmative action requirement, therefore permit Title VI facilities to extend their compliance period to adapt to insufficient community need. See § 124.503(b) and § 124.504, discussed in section IV below.

2. Inflation factor. The Department continues to believe that the inflation factor is appropriate policy. The effect of the policy is to keep the value of the services provided constant, so that the indigent are not deprived of services by inflation. Moreover, since the value of the services provided will stay approximately constant, the Department cannot agree that what is not an "onerous burden" now will become one in the future. Nevertheless, in view of the costs of this policy (see Appendix II), the Department will reevaluate it in light of experience with it over the next three years.

The Department does not believe that this policy "impairs the contract" between assisted facilities and the government. As noted above, the "contract" is for the facilities to provide a "reasonable volume of services." Adjusting the 10% compliance levels by the inflation factor represents a reasonable Federal interpretation of what a "reasonable volume" is over time, and it also makes this compliance level consistent with the 3% of operating costs compliance level, since the latter automatically incorporates inflation as costs increase.

While the Department recognizes that the CPI for medical care does not perfectly reflect inflation in the cost of services from facilities, that index is the closest approximation available and hence has been retained. It is

used rather than the various measures of change in the cost of money proposed, since what is being measured is the required level of services, not the underlying base of Federal assistance. Although the Department recognizes that use of a national index penalizes those facilities whose cost have stayed below the national rate, it nevertheless believes that use of a national index is necessary in light of the compelling need to have readily ascertainable compliance standards, which the national CPI for medical care provides.

The consumer suggestions that the inflation factor be calculated from 1972 or an earlier date are rejected. To do so would subject assisted facilities to a suddenly increased obligation for which they have had no opportunity to plan. The argument that facilities be required to comply with the 10% compliance level where it is higher (as well as lower) than the 3% compliance level is also rejected. If such a rule were adopted, the resulting burden for facilities that had received substantial assistance in the past would by definition exceed 3% of their operating costs and—given the margins many facilities operate under—create ongoing financial problems for them.

3. Other comments. We disagree with the suggestion that the approach of the regulation, i.e., setting an annual compliance standard and minimum procedural requirements designed to assure compliance with the standard, is inappropriate as applied to those facilities that primarily serve the indigent. The Department notes that, under § 124.503(c) (discussed below), a facility may in effect adopt an "open door" approach to providing uncompensated services, and credit excess amounts of compliance against future years' obligations. This enables those facilities to "buy out" of the program and its procedural requirements early should they wish to do so, but retains the basic approach needed in those facilities that are not designed primarily to serve the indigent and therefore might not provide the required volume of services but for these rules. See § 124.503(c) and section IV below.

The consumer suggestion that "community need" be built into the compliance levels has not been adopted. It appears unworkable, in that it would result in potentially open-ended or not readily ascertainable compliance levels, which would preclude sound financial planning by facilities. Moreover, it is fundamentally unfair to subject facilities to different compliance standards, particularly where the effect of such a test would have the anomalous result of giving the heaviest burden to facilities that are located in the poorest communities and are therefore least likely to be able to afford the extra burden.

IV. Deficits and excesses in compliance

A. Background

The current regulations contain no provision for make-up of any deficit in the amount on uncompensated services provided in a fiscal year, although if a deficit occurs the facility is required to submit an affirmative action plan to the State agency. 42 CFR 53.111(e)(2)(iii). Under the proposed rules, where a facility did not meet the

annual compliance level or the lower level established under proposed § 124.504, it was required to make up the deficit in the following year unless the Secretary extended the period for make-up. See proposed § 124.503(b).

B. Public comment.

1. The deficit make-up provision was vigorously opposed by providers and a few State agencies. They argued that it would require facilities to give more care than is reasonably needed. Providers contended in general that this provision constituted impairment of contract or was *ex post facto* legislation. It was argued that where there is no suggestion of noncompliance with the procedures specified by the regulation, the requirement would constitute an unlawful expansion of the obligation. Rather, a number of providers urged that the deficit make-up be applied only where the facility has willfully failed to comply with the regulations, not merely where there had been a shortfall in the amount of uncompensated services provided.

Numerous providers also stated that if the carryover of a shortfall is to be applied, fairness demanded that a reciprocal carryover for excess uncompensated services which are provided be added.

2. Consumers uniformly endorsed the notion of a deficit make-up, occasionally suggesting stronger penalties or more vigorous application. For example, consumer comments suggested that the deficit make-up be applied retrospectively and that the amount to be made up include an inflation factor to deter facilities from carrying over deficits to future years when they can be paid in dollars cheapened by inflation. Similarly, other consumer comments proposed that if the durational limitation is to run from completion of the construction, a facility that selected the 3% or 10% option should be required to make up any deficit incurred since 1972. Arguing for deficit make-up for 1973-78, one comment pointed out that facilities have been on notice of their duty since 1972 and a failure to apply the make-up factor will let many avoid their obligation entirely.

Another consumer suggestion was that, in addition to retrospective application of the make-up, an add-on for facilities that substantially failed in their open door undertakings in the past be applied, requiring that an extra year of 3% or 10% or of open door services be provided for each year of past failure. It was also urged that in order to deter noncompliance, a surcharge of at least 10% of the facility's obligation in addition to its make-up quota be added for facilities that failed to comply with the regulations. Consumers suggested that the deficit make-up also be applied to years when a facility's application for a lower level of compliance was granted.

Another consumer suggestion was that the deficit be made up before section 1122 review or review of any proposed use of Federal funds by a facility is conducted by the HSA or State health planning and development agency. It was argued that only with such

sanctions would there be assurance that the deficit would be provided.

C. Department's actions and response

The deficit make-up requirement has been retained, but the application of it has been significantly modified. See § 124.503(b). The changes in the deficit make-up requirement parallel the other major change to this section, the addition of a provision enabling facilities to take credit for any excess in uncompensated services provided. See § 124.503(c).

The theory of both § 124.503(b) and § 124.503(c) is that facilities are obligated to provide a fixed "volume" of uncompensated services over the entire period of their obligation. As indicated earlier, for Title VI facilities, the precise amount of that "volume" is determined by looking to both their annual compliance level (including the rate of inflation) and their remaining period of obligation. Given a fixed obligation, it is illogical to allow the passage of time to enable facilities which have failed to meet that obligation to avoid it entirely. Similarly, as providers repeatedly pointed out, the logic of the deficit make-up requirement compels the conclusion that facilities that provide more than the compliance level of services in a fiscal year should be able to reduce their obligation in the future by an equivalent amount. The Department has therefore provided for such reduction.

What is critical for Title VI assisted facilities under this new approach is timing. The proposed rules would have permitted facilities to avoid the deficit make-up requirement by applying to the Secretary in advance for a lower compliance level. These rules eliminate that procedure entirely, with the result that Title VI facilities may no longer be excused from any of their obligation. Now, the only question is *when* those services are provided. Under these rules, the answer to that question depends on why the deficit occurred. If the deficit was due to the facility's financial straits or the lack of community need for the services, then the facility may decide when to make up the deficit; if the deficit was due to noncompliance, then the deficit must be made up in the next year, unless the Secretary extends this time.

The obligation of Title XVI facilities is not limited by time (see § 124.501 (b)(2)); the obligation is therefore defined solely by the annual compliance level. However, the statute requires the Secretary to "take into consideration" their financial condition in determining the amount of services they should provide. The regulations implement this by providing that to the extent a Title XVI assisted facility fails to meet its annual compliance level because it was financially unable to do so, the amount of uncompensated services provided constitutes its compliance level for that year. Similarly, where the deficit was due to insufficient community need for the services, the deficit clearly caused no "harm" to the community and it would therefore be anomalous to carry it forward. In such a situation, the amount of services provided likewise constitutes compliance. Where the deficit was due to

noncompliance, however, the same make-up rule for Title VI assisted facilities applies to Title XVI assisted facilities.

The rules for Titles VI and XVI assisted facilities are the same with regard to use of the excess to reduce the annual compliance level. Since a facility with excess compliance in a fiscal year has by definition met its annual compliance level under § 124.503(a) for that year, it may decide when to use that excess to reduce its compliance level. A facility may thus "buy out" of the program in future years by providing more uncompensated services now; a specific methodology for this has been provided for Title VI assisted facilities. See § 124.503(c)(2). If a facility claims an excess that it did not in fact provide, the amount erroneously claimed in subject to the deficit make-up provisions. In addition, the regulation specifically provides that excess compliance credit will be given only if the excess was provided in accordance with this subpart. This means that to obtain excess credit the uncompensated services must be provided in accordance with the allocation plan, and that individual notices required by § 124.505(d) were given out and eligibility determinations required by § 124.508 were made throughout the period of time for which excess compliance credit is claimed.

Consistent with the theory underlying the inflation factor as applied to the annual compliance level—that the value of the "volume" of services provided should stay constant—the final rules apply the inflation factor to deficits and excesses. See § 124.503(d). This ensures that inflation does not cheapen the value of an excess to a facility when it is used in a future year; it will also remove any incentive facilities might have not to comply in the present so that their obligation becomes cheaper in the future.

The above policies incorporate many suggestions of the public comments. The consumer suggestion that the deficit be made retroactive has not been accepted. This proposal raises the same resource, recordkeeping and legal problems as were described in connection with the proposed retroactive changes in the applicability requirement in section I above. The other consumer suggestions for a federally mandated penalty and use of the health planning process for sanction purposes are considered to be unauthorized by the statute.

V. Lower level of compliance; Affirmative action plans

A. Background

The present rules provide procedures by which a facility may ask the State agency to establish a compliance level for it lower than the applicable presumptive compliance level of § 53.111(d). 42 CFR 53.111(h)(3). They also provide that where a facility fails to meet its presumptive compliance level in a fiscal year, it must provide an affirmative action plan to the State agency for the next year. 42 CFR 53.111(e)(2)(ii).

The proposed rules provided for a procedure by which a facility could request the Secretary to establish a compliance level for the fiscal year lower than the annual

compliance level. The procedures called for local announcement of the request, opportunity for review of it by the local Health Systems Agency (HSA), and decision by the Secretary as to the ultimate level for the fiscal year within approximately 4 months after the year began. The Secretary would establish a lower compliance level where either the facility was financially unable to meet the compliance level or there was insufficient community need for uncompensated services at the compliance level. See proposed § 124.504.

B. Public Comment

A large number of providers objected that the procedures for applying and obtaining a lower level of compliance were extremely cumbersome and lengthy, disrupting a facility's budget 120 days into its fiscal year and requiring facilities to engage in an almost continuous application process. Numerous providers also objected to the involvement of HSAs.

Some providers argued that the criteria for determining whether a lower level of compliance was warranted, particularly the imminent bankruptcy standard suggested in the preamble to the proposed rules, were too stringent, and the regulations too vague about the documentation required. One provider suggested that validation of a facility's request for an exception be carried out during the normal audit by the local Medicare fiscal intermediary.

A number of consumers voiced a fundamental disagreement with the notion of a lower level of compliance based on insufficient need, asserting that no place in the United States has "insufficient need for uncompensated services." Similarly, some consumers believed that there was no statutory basis for an insufficient need exception from the established reasonable amount. Suggesting that availability of public or charity hospitals in the area might justify a request for a lower level, one critic claimed that the lack of need exception would encourage dual hospital systems, one for affluent and whites, one for poor and minorities. As an alternative to a grant of a lower level on the basis of insufficient need, consumers suggested that the service area of the facility be expanded or that other measures be adopted designed to increase utilization of the facility's uncompensated services.

To deter the use of the lower level as a loophole, consumers recommended that, after the facility becomes economically able to provide services at the 3 or 10% level, it be required to make up the amount previously excused. A provider, noting the difficulty of determining in advance when bankruptcy was likely to occur, also recommended deferral of the obligation as part of the lower level procedure. Other comments stressed the need for a definition of "financially unable to provide uncompensated services" and specific criteria to be used in evaluating applications.

C. Department's Actions and Response

The Department has substantially altered § 124.504 in response to the public comments.

It agrees that the prior approval procedure of that section would be unduly burdensome and unworkable. Moreover, the "fixed obligation" approach for Title VI facilities discussed in the preceding section makes the prior approval approach unnecessary, since the obligation can now only be postponed, not avoided. Therefore the approach has been abandoned, and the following adopted in its place.

Calculation of a facility's success in meeting the annual compliance level requirement will now generally be determined by the Department only after the fiscal year ends. (In fact, the Department is presently exploring the feasibility of making a routine investigation part of the Medicare audit process, as suggested by the public comment.) As stated above, if a Title VI assisted facility's failure to meet the compliance level is due to financial inability or insufficient community need, it must make up the deficit in services, but can control the timing of that make-up, within limits. If it is due to noncompliance, the deficit must be made up immediately, as must the deficit for noncomplying Title XVI assisted facilities. See § 124.511(b)(1). If a Title XVI assisted facility's deficit is due to financial inability or insufficient community need, the deficit is excused.

As recommended by the public comment, indicators to enable the Secretary to determine financial inability have been added. They are those presently in use in the Title VI loan program to signal default potential. They contain no bright-line tests, but the Secretary anticipates that they will give him sufficient data to permit him to make an informed judgment as to the financial capability of the facility to meet the annual compliance level. See § 124.511(b)(1)(iii). The enforcement section of the regulation (§ 124.511) gives the Secretary, despite the general rule that compliance will be determined after the fiscal year, the ability to require a facility to increase the level of services it is providing when it appears that a lower level is not justified by the facility's financial situation.

The Department has not accepted the consumer contention that nowhere in the nation is there a community with a need for uncompensated services in any year that is less than the annual compliance level. Indeed, the experience of the 167-bed Nebraska hospital described above suggests that some areas simply do not have as great an annual need for uncompensated services as provided for in the annual standard. On the other hand, the Department does not have the data or resources to make the complex individual judgments that would be called for to evaluate a particular community's need for uncompensated services. More importantly, the Secretary has determined that a lack of need for uncompensated services at the annual compliance level in a particular year should not permanently excuse a facility from a portion of its total obligation, but rather the facility should satisfy the community's need over a longer period of time.

Under this approach, the only critical question is whether a facility has accurately reflected a community's need for

uncompensated services in any year in which it has incurred a deficit. The Department has resolved this question as follows: If a facility fails to meet its compliance level, it is required to devise and implement an affirmative action plan unless its failure was because of financial liability to provide services at the annual level. See § 124.504. The plan may include such steps as appropriate publication of the availability of uncompensated services through local media, expansion of the area served, expansion of the allocation plan to include additional types of services and expanded financial eligibility criteria, and establishment of referral arrangements with nearby overcrowded facilities. The plan is subject to review by the Secretary, who may require the facility to strengthen it or to take such specific additional steps as he finds appropriate under the circumstances. See § 124.511(b)(2). However, if a facility has an approved affirmative action plan in place, it is the Department's view that if it then fails to meet its compliance level, its failure is due to insufficient community need. In other words, compliance with the affirmative action plan requirement establishes the presence or absence of community need for a facility's uncompensated services. Of course, if a facility fails to comply with the affirmative action plan requirement although financially able to do so, its deficit will then be considered to be due to noncompliance, and the accelerated make-up requirement of § 124.511(b)(1)(i) will apply.

VI. Published notice

A. Background

The current rules require the State agency to publish annually, in a newspaper of general circulation in a facility's service area, the compliance level established for the facility. 42 CFR 53.111(h)(4). The proposed rules required each facility to publish in a newspaper 60 days before the beginning of its fiscal year notice of the amount of uncompensated services it would make available and its proposed allocation plan. The facility was also required to provide the notice to the local HSA. See proposed § 124.505(a).

B. Public comment

Providers generally considered the published notice requirement to be reasonable. However, some asserted that newspaper notices would encourage inappropriate shifts in referral and utilization patterns in areas where there are both Title VI and non-Title VI hospitals and create excess demand. Some providers also claimed that published notice was redundant, that HSA involvement was inappropriate, and that such notice would cause Title VI assisted facilities to be perceived as "charity institutions." An accounting firm proposed a combined newspaper report for area hospitals, instead of individual notices.

Consumers generally suggested refinement of the requirement. For example, a number of consumer organizations suggested that the required newspaper notice take the form of a block ad of a particular size and/or be run other than in the legal notices column of the

newspaper, be required to be "conspicuous" and written in lay language, and be multilingual if necessary. Consumers also suggested that the rules require wider distribution, a public hearing by the HSA and a copy of the published notice to be appended to the facility's compliance report.

C. Department's actions and response

The final rule changes the proposed rule in three respects: (1) facilities are required to explain the basis for any provision of services less than the required compliance level; (2) a requirement is added for provision of an additional notice to the HSA if a facility changes its allocation plan during the fiscal year; and (3) newspaper publication of the final allocation plan is not required since interested members of the public who participated in the development of the proposed plan will have more effective means for ascertaining the final plan. See § 124.505 (a) and (b).

The Department is retaining the proposed policy because it believes that the published notice requirement is the most appropriate vehicle for giving advance notice to community groups of the amount and kind of services a facility intends to provide, so that they may attempt to influence a facility to change its plans before they are put into effect. The changes to the rule described above are consistent with this purpose, in that they serve to alert the public as to relevant issues concerning the facility's uncompensated services obligation.

Since the primary target of the notice is local organizations and groups, which will be a comparatively knowledgeable audience, the Department does not believe that extensive requirements as to wording and size of the notice as suggested by consumers are necessary. Nor do they appear desirable, in light of the additional compliance and monitoring problems they would create.

The Department discounts the possibility, raised by providers, of the published notice changing demand, since the present published notice requirement does not appear to have had that effect. Nor does it agree that the notice is redundant since its main purpose, explained above, is clearly different from that of the posted and individual notices, which are designed to alert patients of the availability of uncompensated services when they are seeking services. With respect to the suggestion for combined notices, the Department notes that § 124.505(a) does not prohibit such notices, as long as its requirements are met. HSAs might be helpful in arranging for such joint notices.

The provider and consumer suggestions regarding HSA involvement are discussed at the end of section X of this appendix, since they are so closely related to many aspects of the comments on that section.

VII. Posted notice

A. Background

The current rules require facilities to post notice (which must be multilingual in a multilingual community) in appropriate areas of the facility regarding the availability of uncompensated services in the facility. The notice must direct inquiries to the business

office and provide the address of the State agency for the filing of complaints. When a facility's quota is met, it has the option of providing an additional notice to this effect. 42 CFR 53.111(i).

The proposed rules retained and clarified these policies, defining the term "multilingual" and spelling out size and legibility requirements. Procedure for complaining to the Secretary was added to the notice language, to reflect the proposed change-over to Federal administration of the program. The provision for additional notice was made mandatory. See proposed § 124.505(b).

B. Public comment

Providers objected to the text of the proposed notice as being "over-regulation" or "cast negatively" and not including the eligibility requirements. It was argued that omission of this information will also create misunderstandings of the obligation and unrealistic expectations, resulting in inappropriate applications and disappointed patients. Providers suggested that failure to explain the eligibility requirements could discourage payment by those who could afford it and who are not, in fact, eligible, while their inclusion would limit confusion and permit self-screening by patients. Numerous providers suggested changes in the language of the notice.

Some providers and governmental agencies stated that if individual notice is provided, posted notice is unnecessary. In general, however, providers appeared to accept the requirement. For example, some stated that, since facilities are currently required to post signs, § 124.505(b) would not create a major problem; they objected only to the expense of replacing existing notices. Providers and consumers alike suggested that rather than face disputes about what comprises "normal vision," the Department should require signs of some reasonable size to be posted in patient reception areas having unrestricted visibility by patients approaching the service desks or areas in such places. One provider group recommended a brief posted notice with details provided in the individual written notice. In addition to the above, consumers suggested that the Department print and disseminate copies of the notices to be posted, for ease of administration and enforcement, uniformity and standardization of print.

Providers noted several problems with the requirements that posted notices be multilingual whenever a group comprises 5% or more of the community: (1) the 5% requirement is inconsistent with other Department guidelines such as Program Policy Notice 78-32, which suggests a threshold of 10% for multilingual activities; (2) accurate data on the multilingual composition of communities is not available and would therefore require an estimate by facilities; (3) the proposed posting of separate and complete signs in several languages may be impractical in areas with several significant linguistic populations because of the required size of the signs and wall space limitations. (Chicago, with seven or eight ethnic communities, was cited as an example.) To

address this third problem, one provider group suggested that facilities be permitted to post a modified multilingual sign that provides the necessary sized heading, a basic statement of the obligation and eligibility requirements, and a reference to complete translations which are available at specified locations. Some providers requested that the Department provide the multilingual notices in the many languages needed.

C. Department's action and response

The Department is persuaded by and has accepted many of the suggestions above. To eliminate questions about the size and legibility of the signs, and the cost of preparing them, the Department will prepare the signs in English and Spanish, and provide them to facilities at no cost to the facilities. As suggested, the signs will refer to the community service obligation as well. The sign itself (and what therefore is required to be translated in multilingual communities) will be very brief. It will alert persons seeking services in the facility of the existence of the uncompensated services obligation and refer them to appropriate facility personnel and the more detailed individual notice for a fuller explanation of the scope of available benefits. It is noted that the Department's Office for Civil Rights is presently developing, under Title VI of the Civil Rights Act of 1964, bilingual guidelines to be applied in health and human development programs. When those guidelines are issued, any changes in these regulations that are necessary for conformity with them will be made. For the present, as suggested, the definition of "multilingual" has been changed to ten percent, to be consistent with Program Policy Notice 78-32.

Also consistent with that Notice, facilities are required to make reasonable efforts to communicate the contents of the notice to persons who cannot read. The provision for additional notice when the uncompensated services obligation is satisfied has been simplified and made optional. See § 124.505(c).

The above approach means that the posted notices will not contain eligibility information. However, the Department does not believe that the confusion or payment problems forecast will arise. As far as it can tell, such problems have not arisen with the present posted notices, which likewise do not contain such information. Moreover, any confusion that may arise should be dispelled by the individual written notice, which will contain the information.

The Department has dealt with the suggestions regarding requiring "prominent" posting as follows: (1) it intends to provide notices which are sufficiently noticeable to prevent them from being overlooked; and (2) it has required the notices to be posted in appropriate areas, such as the admissions office, business office and emergency room.

Finally, the Department notes that the posted notice requirement is not redundant, as argued by many providers. It backs up the individual notices, which may get lost in the bulk of materials given to many patients at admission. Moreover, it serves an independent notice function permitting

patient self-enforcement if the admissions staff does not hand out the individual notice as required, and as a general notice of the program if the facility suspends the giving of individual notices during part of the fiscal year when uncompensated services are not available. See § 124.505(d)(1).

VIII. Individual notice

A. Background

Aside from the possibility that individual notice would be required as part of an affirmative action plan, the current rules contain no requirement for such notice. The proposed rules required the provision of individual written notice to each person seeking services in the facility of: the availability of uncompensated services, the eligibility criteria, the allocation plan, and the availability of a prompt eligibility determination. The notice was required to be provided prior to service except in emergency cases; in such cases notice could be provided no later than the first bill. See proposed § 124.505(c).

B. Public Comment

Many providers challenged the Department's legal authority to require such notice except in cases of noncompliance. Numerous others stated that the requirement would promote fraudulent applications for uncompensated services, increase delays in treatment, intensify patient stress, duplicate the existing procedures of some facilities, and antagonize patients who "want nothing to do with charity."

The most common objection, however, was cost. One provider group stated that a substantial majority of the 123 million patients who are cared for each year in Title VI facilities are covered by insurance or are otherwise able to pay for their care. They therefore objected to the burden of providing 123 million notices to patients, many of whom clearly would not be eligible for uncompensated care. Widely varying but nonetheless high cost estimates were offered.

In light of these costs, providers requested discretion in handing out notices, or an exception for persons who because of third party coverage are obviously ineligible, or suspension of the requirement when the annual compliance level is met. One accounting firm suggested that instead of a separate notice, a waiver of uncompensated services be added to the admitting form.

Consumers generally approved the individual notice requirement but suggested numerous refinements to it. The following requirements were suggested: oral notice; braille notice; provision of interpreters for the deaf; standards for the use of interpreters for non-English speaking people consistent with the standards set for the use of multilingual notices; multilingual individual notices.

Some consumer (and provider) comments suggested that both the individual and the posted notice include a brief description of the source of the legal obligation to provide uncompensated care, on the ground that benefits may be more acceptable to individuals when they realize that they are part of a facility's obligation and not "welfare" or "charity." Other consumer

comments suggested that patients be required to sign a waiver or other form showing they have been notified of the availability of uncompensated care.

C. Department's Actions and Response

The Department has retained the individual written notice requirement. In its view, it clearly has the legal authority to impose such a requirement, if it believes (as it does) that the requirement is consistent with and necessary for proper and efficient administration of the program. See section 1602(6) above, as well as the decision in *Newson v. Professional Adjustment Service, Inc.*, 453 F. Supp. 401 (M.D. Tenn. 1978), holding that individual notice is required.

Under § 124.505(d) the content of the notice is changed only in minor respects from that proposed; the changes reflect the deletion of information from the posted notice.

The Department recognizes that the individual notice requirement will add to facilities' costs of administering their assurances. Nevertheless, it does not believe that it should abandon the requirement, assuming that it could. Since under these rules a facility's limited uncompensated services obligation will be used up by those eligible persons who first request the services, it is important to give all persons an equal chance to request them. If facilities were permitted not to give the individual notice to persons whose income or insurance coverage appeared to render them ineligible, those persons would not have an equal chance at the services should it later turn out that they were in fact eligible. Individual notice will also play a significant role in, assuring that the uncompensated services obligation is widely known, and will therefore permit self-enforcement by patients who need help in paying their bills.

The Department has tried to minimize the costs of complying with the notice requirements in § 124.505 as much as possible. First, it is eliminating much of the cost of the posted notice requirement by supplying notices. More important, however, as suggested by a few providers, the rules allow facilities to stop giving out the individual notice when uncompensated services are not available in the facility. See § 124.505(d)(1). The requirement that the eligibility and allocation criteria be set out in the individual notice should discourage frivolous requests for uncompensated services and consequent expense.

The Department agrees with the intent, but not the specific details, of many of the consumer suggestions that are designed to communicate the contents of the notice to persons unable to read it. The final rules require facilities to make "reasonable efforts" to convey the contents of the notice to such persons. We intend that facilities will make whatever arrangements are needed in particular cases to assure that such persons are aware of the potential benefits of the program. This appears to be a much more workable alternative than mandatory hiring of interpreters, use of braille, and other costly techniques. The Department has not accepted the various suggestions for written acknowledgement of receipt and waiver of

uncompensated services. It believes that such requirements would clearly be burdensome because of the recordkeeping that would be required.

IX. Eligibility Criteria

A. Background

The current rules provide that eligibility for uncompensated services is established according to criteria set by the State agency. 42 CFR 53.111(g). The proposed rules established a two-tier system of national criteria. Under the proposed rules, persons with incomes at or below the CSA Poverty Income Guideline ("Category A") would qualify for services at no charge; persons with incomes above that level up to twice that level ("Category B") would qualify for services at charges reduced in proportion to income. Two methods for calculating income were provided; while the facility could select the method, it had to use the same method for the entire fiscal year. See proposed § 124.506.

B. Public Comment

1. While some providers praised the uniform Federal eligibility standards as simplifying the determination process, most objected to it. It was asserted that the failure to recognize regional variations in income levels was an attempt at inappropriate uniformity that would create inequities. For example, in States where the cost of living and income levels are higher than the national guidelines, some individuals would not be eligible even though they are unable to pay; in lower cost and income States, persons who could pay might be eligible, thereby unduly burdening paying patients. Alleging that the Medicare and Medicaid systems recognize geographical differences, providers proposed that basic eligibility should be governed by State-by-State income guidelines, that Federal criteria provide for State-by-State variations, or that States with higher criteria be permitted to retain them.

2. Providers and governmental groups asked that the eligibility test be modified to permit consideration of resources such as property, securities, availability of insurance, pensions, rental income. Numerous providers pointed out that farmers, who may own substantial real estate, frequently have fluctuating incomes that could qualify them if income were measured only over a three month period. Providers also mentioned that the relationship between the size of the bill and income affected the patient's ability to pay and requested either a sliding scale matched to the bills, or an individualized procedure, with discretion in the facility to determine the reduced charge through a process of consultation between financial personnel and individual patients. Other providers, however, praised the use of a simple test based solely on income, without consideration of resources, as easier to administer and "less degrading" to individual applicants.

3. Providers pointed out problems with both the 3- and 12-month tests (the periods of time over which the applicant's income could be evaluated to determine eligibility) and requested that application of the particular test be left at the option of the hospital in the

individual case. Some governmental groups recommended use of only the 12-month test, to avoid aiding the patient whose income is "well above the poverty level" but who experiences a temporary loss of income.

Consumers agreed with providers that the annual choice between the 3- and 12-month options for income determination was a problem. Some consumers suggested that the 12-month standard be eliminated altogether since it could never account for recent reverses in an individual's ability to pay. Others suggested that the most advantageous of the two tests be used in any particular case. Another suggestion was substitution or addition of a test of the prior one month's income multiplied by 12, to include very recently unemployed individuals. By contrast, another group suggested that eligibility be based on current or anticipated income for the subsequent 30 days.

4. Consumers supported the general concept of the proposed national income standards, excluding consideration of resources. As one group explained, present rules leave such matters up to the whim of the State agency and facility, which may make "unreasonable demands." Accordingly, consumer comments were frequently directed toward eliminating elements of facility discretion. For example, many comments suggested that the Department prescribe a schedule for payments to be made by patients in Category B. Urging that the pay schedule be removed from the facility's discretion (least the facility turn it into a full pay program), some groups urged that the schedule be treated like the allocation plan, with publicity, a hearing, and HSA participation. A legal services organization suggested that persons in Category B pay the percentage of the allowable credit for the service by which their income exceeds the CSA guideline. Other comments suggested that the schedule set by the Department for persons in Category B relate the size of the bill and the person's income. Spend-down provisions, under which eligibility can be acquired once income in excess of the financial criteria is expended on medical care, were also suggested, to address the problems of a person with an income of \$20,000 but medical bills of \$50,000.

C. Department's actions and response

The final rules are the same as the policies proposed in the proposed rule, with two exceptions (explained below): (1) as suggested by some providers, a facility is given complete flexibility with regard to its policy for charging Category B patients, as long as it publishes its policy as part of its allocation plan; and (2) as suggested by some consumers, eligibility is established if the patient's income meets either the 3-month or the 12-month test.

The Department's response to the comments is as follows:

1. The Department continues to use the CSA Poverty Income Guidelines rather than the various State or locality-based eligibility criteria suggested by many provider and consumer comments. Use of the Guidelines has obvious administrative advantages for facilities as well as the Department over their

various State or locality-based counterparts. Furthermore, although median income and other income tests do vary from State to State, it does not follow that there are comparable variations in relative poverty levels. That is, someone with income at or below the poverty level in a low income State is likely to be as "poor" in terms of his purchasing power as a person with the same income in a high income State. The Department believes it is fair to assume that persons with incomes at or below the Guidelines (Category A), will be unable to pay for necessary medical care, and so should qualify for services without charge under this program.

The Department notes that the change in policy with respect to Category B patients described above will also enable facilities that do not consider persons with income at that level "poor" for their area to target their uncompensated services accordingly. If a facility can meet its annual compliance level entirely with Category A patients, § 124.506 permits it to do so.

2. The Department does not believe that the grant of discretion to facilities to set their charging policy for Category B patients will lead to the arbitrariness and discrimination that is of so much concern to consumers. Although facilities may control their charge policies for Category B patients, those policies must be published, and must be complied with once established. Thus, facilities will not be able to discriminate between similarly situated Category B patients. Also, since the charge policy must be published as part of the allocation plan, it will be subject to the public comment procedures applicable to that plan, as recommended by some consumers.

3. The Department is retaining an income-only test, rather than one based on both income and resources as advocated by many providers and consumers. The Department recognizes that this approach may lead to some inequities, but is convinced that the other approach will lead to significant problems of interpretation and application for facilities, lead to extensive delays in determinations and create substantial compliance problems. These considerations also led to the rejection of a "spend-down" approach.

X. Allocation Plans

A. Background

Although the State agency may establish allocation requirements for Title VI assisted facilities, the current rules contain no specific requirements as to how they are to allocate their uncompensated services among persons unable to pay. The proposed rules provided two options for how such services are allocated; facilities must either (1) divide their uncompensated services into approximately equal quarterly allocations and provide services to the persons who first request them, or (2) use another allocation plan. The latter approach could only be used if it were published in accordance with § 124.505(a), and provided for some distribution of services throughout the year, the provision of some services to Category A individuals, and provided that all persons

coming within the plan would receive uncompensated services until the obligation was met. See proposed § 124.507.

B. Public Comment

1. While providers praised the regulations for permitting facilities to develop their own allocation plans there was some objection to particular requirements.

a. With respect to the quarterly allocation requirement, providers argued that it incorrectly assumes that facilities experience community need greatly in excess of the presumptive compliance level and that all facilities cut off charity care when they meet their compliance level. Moreover, providers and governmental groups pointed out that the need for charity services is not constant but expands and contracts at different times during the year based on numerous factors and illness and in general is impossible to predict. Finally, they asserted that neither the patient nor the physician who selects a facility that has met its quota is likely to accept the suggestion of returning for care at a later time or shopping around for another Title VI assisted facility that has not met its obligation.

Providers and others also protested that the quarterly allocation requirement was inflexible. They objected that the system could exclude credits to a facility's obligation for services provided to eligible patients who were admitted just as the facility was reaching its quarterly obligation level. They also objected that the entire quarterly obligation could be used up by a few patients, and that the quarterly requirement could decrease the amount of uncompensated care available to summer migrant workers. Providers therefore feared that an allocation plan developed in good faith would result in unforeseen implementation problems and non-compliance by the facility.

b. Providers also criticized the role of the HSA and the community in the allocation process. It was pointed out that various community interest groups may disagree on an appropriate allocation, and the provision requires facilities to act as arbiters in situations where local employment conditions and inadequate government program benefits have created extensive demands for charity care. Providers also generally argued that the HSA role in formulating the allocation plan was inappropriate, as they are intended to be planning, not regulatory, bodies, a concern repeatedly expressed in connection with other provisions of the regulation and echoed by some planning agencies.

c. In addition, providers disagreed with the requirement in proposed § 124.507(b) that the facility provide all services of the facility to eligible persons. They objected that facilities are required to provide uncompensated services only in the facility or portion thereof which has received assistance.

2. Consumers generally regarded the proposed allocation system as an improvement over the present regulations. However, consumers also protested that the proposed regulations still left too much authority to the facilities. A number suggested that the HSA's comments must be

included with the allocation plan when submitted to the Secretary or that HSA and/or Department approval of any allocation plan other than first-come-first-served should be required. Numerous other specific consumer suggestions for divesting facilities of control over the allocation plan were also made, such as that a facility's allocation plan be based on community need and that public hearings be required. Consumers also advocated a far more decisive, regulatory role for HSAs in this, as well as other sections of the regulations.

C. Department's Actions and Response

The Department is persuaded by the numerous provider and governmental comments objecting to the quarterly allocation requirement, and has dropped it. Otherwise, § 124.507 below retains the policies of the proposed rules essentially unchanged, except that provision is added requiring the allocation plan to set out how Category B persons will be charged. This new requirement is consistent with the change in § 124.506 discussed in the preceding section.

The Department has not accepted the numerous consumer suggestions that it (or HSAs) regulate precisely how facilities allocate their uncompensated services. As discussed in connection with the affirmative action plan requirement above, the Department is unable to make complex judgments as to what constitutes "community need," as advocated by many consumers, and it does not believe that it can require HSAs to do it in its place. The Department believes that facilities are able to make sensitive and difficult judgments as to which services are needed locally and hopes they will be responsive to legitimate community need. The publication and HSA notice requirements of § 124.505(a) and (b) should help deter facilities from setting arbitrary policies totally unrelated to community need by exposing them to public comment and pressure.

In addition, the Department has made one change in the final rules that is intended to further clarify the facilities' obligation to consider community need when determining the type of allocation plan they wish to adopt. The final regulations specifically require facilities to take into consideration any comments as to whether proposed allocation plans are reasonably related to community need that are submitted to them by the HSA or others. In this manner, the Department seeks to promote the development of rational, community-wide programs for the allocation of limited uncompensated services in a manner most responsive to the needs of persons unable to pay. For example, one facility in a community may, after consideration of HSA and public comments, decide that its allocation plan should give greatest priority to emergency services. Another facility in the area might decide, in light of the services available in the first facility, to give greatest priority to those in need of inpatient care. Yet a third facility might decide to place highest priority on outpatient clinic services because of the excellence and uniqueness of its clinic. If this were to happen, the results of three allocation

plans would be a coordinated, balanced approach to meeting the needs of persons unable to pay in that community. We emphasize, however, that the final determination as to whether a facility's allocation plan is reasonably related to the need in the community for uncompensated services rests solely with the facility. The Secretary does not, under these regulations, have the authority to dictate the terms of a facility's allocation plan.

With respect to the provider comment that there is no legal basis for the requirement of § 124.507(b) that "all services" of the facility be made available, the Department notes that § 124.507(c) permits the facility to restrict its services to the "portion" of the facility assisted, so long as doing so is consistent with the underlying obligation.

The Department has not changed the role of the HSAs in the enforcement process from that proposed. Aside from questions about its legal authority to require a stronger role, it does not believe that increased requirements in this regard are presently feasible or advisable given the variation among HSAs in their ability to undertake a more regulatory role. In this regard, a few national planning organizations concurred that the balance of involvement by HSAs struck in the proposed (and hence, these) rules was the proper one. The Department has rejected the provider objections to the proposed HSA role of commenting on how uncompensated services are delivered in their area. This function is clearly appropriate given the planning and review functions of those bodies and their general purpose of promoting the proper use and distribution of health services.

XI. Eligibility Determinations

The current rules provide that in order to count services provided to a patient as uncompensated a facility must make a determination of eligibility for uncompensated services prior to their provision. However, there are several circumstances in which the determination may be made after services are rendered: in emergency circumstances, where the person's circumstances have changed, and where the determination is delayed by false or erroneous information provided by the patient. 42 CFR 53.111(f)(1). This section was adopted in response to the decision in *Corum v. Beth Israel Medical Center*, 373 F. Supp. 550 (S.D.N.Y. 1974), which declared invalid the prior provision of the regulation permitting facilities to count as uncompensated services services for which they had rendered a bill, on the ground that persons unable to pay should know whether or not they will be receiving uncompensated services before assuming liability for them.

The proposed rules eliminated the preservice determination requirement. Instead, they required that in order to count services provided as "uncompensated", a facility must make a determination promptly on request. To facilitate monitoring and compliance, specific requirements were set out as to what information the determination must contain; facilities were required to provide a copy of it to the patient. Facilities were required to provide written statements

of reasons to persons denied uncompensated services. It was also provided that facilities could condition the provision of uncompensated services on verification by individuals of their eligibility for them. See proposed § 124.508.

B. Public Comment

1. For the most part, providers favored the proposal that eligibility be determined "on request" rather than "in advance." Some providers insisted the prior determination requirement was better, arguing that permitting determinations upon request had the net effect of an open-door policy and required the facility to allow benefits at any time requested. It was protested that failing to require the patient to make a "timely" request would be expensive because patients would not request uncompensated services until after collection suits were filed.

Other providers displayed confusion about proposed § 124.508, apparently assuming that it would require eligibility determinations prior to billing. One facility protested that this was impractical since it billed patients four days after providing the service, while it might take weeks for eligibility for other benefit programs to be determined. Others asserted that only a conditional statement pending verification could be issued prior to rendering services. Clarification that eligibility determinations can be made after billing was requested.

Consumers generally approved the proposed change in the regulations concerning determinations of eligibility. For example, one group stated that they had found the 1975 post-*Corum* rules requiring preservice determinations to be inadequate, forcing patients to argue that they fell into one of the exceptional categories where a postservice determination of eligibility was permitted. Other consumers, however, recommended that the Department either maintain the present requirement of a prior determination of eligibility or require facilities to have the ability to make determinations to meet the *Corum* requirement that the patient be told in advance whether treatment will be uncompensated, and establish a deadline by which the determination must be made.

2. While some providers requested deletion of the phrase "on request," claiming that patients would not ask, others suggested that a written request from the patient be required. Consumers likewise recommended that the phrase "on request" be defined, but asked that it be defined broadly. Pointing out that the term "request" is used in several sections of the regulations, one asked that the phrase be given "some consistent and practical meaning, or eliminated." Another suggestion was that the term "on request" be broadly defined to include any expression or indication by a person seeking care of inability to pay.

3. A number of providers asked that a definition be provided for "promptly," as used in proposed § 124.508(a)(2). However, some—while requesting the clarification that determinations were permissible after services had been performed and bills rendered—stated that no specified uniform

specified time could be set: "what is prompt will depend in each case upon the individual facts of when the patient presents himself, how long he stays, and how difficult the investigation may be." A number of consumers also asked that the term "promptly" be specifically defined and suggested 2, 3, or 5 business days.

4. A number of providers asked for further clarification of the verification provision. Some predicted that the verification provision would be inadequate to prevent abuses resulting from individual notice. Other providers asked for a broad interpretation of the right to verify, such as by providing that an eligibility decision may be reversed if the information provided by the patient is not accurate.

Consumers raised a number of objections to the verification provision. In general, it was urged that the provision would be used to exclude eligible individuals or to discriminate against certain categories of low income persons, such as migrant farmworkers. Some groups voiced the fear that verification requirements would be used to harass and discourage eligible individuals from asking for uncompensated services.

If the provision is retained, consumers urged a number of modifications of it. Specifically, the Department was urged to: make the provision of services on an uncompensated basis conditional upon subsequent verification; require addition to the application form of a statement that knowing and willful provision of false or inaccurate information will subject the applicant to a denial of uncompensated care and to penalties for perjury; specify the evidence of income which the facility is allowed to obtain, clearly excluding confidential information; limit the information to be verified to income of the patient or responsible relatives during the relevant time period; limit verification to a single source; require facilities to adopt written standards and apply them uniformly; require that verification not be limited to particular methods but be permitted by any means that will reasonably establish the existence of the condition; and require that a facility not be allowed to deny an application for free care for lack of verification without advance notice.

5. Consumers suggested that the Department provide standardized forms for facilities' determination of eligibility including an explanation of the individual's right to complain or appeal a denial of uncompensated care. Citing the *Newsom* decision, a legal services group asked that the Department provide for review of an adverse decision within the facility or at the community level.

C. Department's actions and response

The policies of the proposed rule have been retained. The Department notes that in general both provider and consumer comments support the shift from "prior" determinations to determinations "on request." However, it has made the following changes in the proposed rule. First, as requested by many comments, a definition of "request for uncompensated services" has

been added. The definition adopts the suggestions of several consumer comments that any indication of an inability to pay for services be treated as a request. This definition will protect needy applicants without requiring facilities to make determinations of eligibility in cases where it is not needed because full insurance, Medicaid, or other source of payment is clearly available to the patient. See § 124.502. Second, as also requested, the term "promptly" has been eliminated and a requirement that the eligibility determination be made within 2 working days of the request for uncompensated services substituted. See § 124.508(b)(1). Third, the provision for verification has been modified to clarify that only facts relevant to eligibility may be verified. Fourth, to lessen the burden of the financial eligibility determination requirement, the requirement applies only when uncompensated services are available in the facility. See § 124.508(a). In all periods of the year, however, denials of uncompensated services must be explained by a statement of reasons. Of course, where the reason is that the allocation has been exhausted for the period, the statement may rely on this ground and a financial eligibility decision is not required.

The Department stress that these rules do not require a determination prior to service. Under § 124.508, the timing of the determination depends solely upon when the request for uncompensated services is made. The determination may be made after service (or even after institution of suit), if that is when the request is made. To clarify this, the words "at any time" are included in the definition of "request for uncompensated services." As for those comments concerned that the "on request" policy may prove more expensive than the "prior determination" requirement, the Department notes that facilities may minimize collection expense by making extra efforts to alert persons to the availability of uncompensated services early in the collection process.

The Department does not agree with the consumer comments that challenged the "on request" policy as inconsistent with *Corum*. Under the individual notice requirement, the applicant is told in advance of service that he can get a determination of whether or not he will get uncompensated services within 2 working days. This will permit persons who are so concerned about the cost of services that they are reluctant to incur them without assurance of payment, the situation which concerned the *Corum* court, to obtain that assurance in a timeframe that is consistent with sound medical care.

The change in the verification provision responds to the concern underlying many of the consumer comments, that verification not be used as a "fishing expedition" or to harass or discourage applicants for uncompensated services. However, the Department continues to believe that provision for verification itself is reasonable, as it will enable facilities to provide their uncompensated services to persons who in fact qualify for them. The Department interprets the requirement that verification be limited to information "necessary" to establish eligibility to mean

that any reasonable method of verification should be accepted and that duplicative forms of verification should not be demanded. The simple answer to the provider concern as to whether a determination of eligibility that subsequently fails to "check out" may be reversed is that it may. This is inherent in the provision of § 124.508(d) that verification may be made a "condition" of the provision of uncompensated services.

As suggested by some consumers, the Department intends to develop and make available forms for use or adaptation by facilities in the eligibility determination. However, it will not mandate use of such forms, since facilities may find it convenient to combine the eligibility determinations with other forms.

Although the Department does not oppose having facilities establish procedures for review of denials of uncompensated services, it is not requiring that they do so as a condition of compliance. The governing statute does not require facilities to establish review procedures, and at the present time the Department does not have a sufficient factual basis for concluding that review procedures are necessary for proper administration of the assurances.

XII. Exclusions from uncompensated services

A. Background

The current rules provide that the cost of services provided in the following circumstances cannot be counted as "uncompensated": (1) where the facility has received or is entitled to receive payment for the services under a governmental program or from a third party insurer; and (2) where the facility would be entitled to receive payment under such a program if it participated in it. 42 CFR 53.111(f)(2). The proposed rules added the following circumstances: (1) where the facility was reimbursed by a program under which it had agreed or was required to accept such payment as payment in full for the services; and (2) where the services were disapproved by a PSRO under section 1155(a)(1) of the Social Security Act. See proposed § 124.509.

B. Public comment

1. Providers objected to the exclusion from uncompensated services under proposed § 124.509(b) of any difference between the amount reimbursed under certain third party payment programs and the actual expense of providing the services. It was argued that this exclusion is inappropriate particularly with respect to Medicaid, because in many States Medicaid reimburses at rates substantially below the actual expense of providing the services.

A similar problem was raised in connection with a locally funded medical care program. Under that program, the facility provides for the care of the medically indigent and is reimbursed by the program for approximately one-quarter of the average cost of the services provided. The facility stated that, should the interpretation of this section be that none of that difference could be counted toward meeting the Title VI obligation, it

would have to consider seriously not renewing its provider agreement.

2. Providers asked that the regulation require that persons eligible for but not receiving Medicaid benefits be required to apply for such benefits before applying for uncompensated care.

3. Providers urged deletion of proposed § 124.509(c) on the ground that it fails to recognize problems that frequently result from implementing PSRO decisions. For example, when a PSRO determines that a patient should be transferred from acute care to skilled nursing care and there are no skilled nursing beds available in the area the facility frequently has no option but to continue providing care to the patient until a skilled nursing bed is available. Consumers, on the other hand, generally approved of this exclusion.

4. Few consumers commented on proposed § 124.509. In general, they endorsed the underlying policy of making this program one of "last resort". However, it was requested that facilities be responsible for making preliminary determinations of eligibility, rather than simply referring all uncompensated care applicants to the local welfare office whether they are likely to be eligible for Medicaid or not.

5. Consumers also asked that the regulations expressly exclude bad debts or provisions for uncollectible accounts from the computation of uncompensated services, as well as unreimbursed emergency care which the facility had an independent obligation to provide under Federal, State, local or common law.

C. Department's actions and response

Both the provider and consumer comments indicated no substantial disagreement with the policies of the present rules, carried forward in the proposed rules. They are thus retained in § 124.509 unchanged. The additional policies set out in the proposed rules (§ 124.509(b) and (c)) are likewise retained, for the following reasons.

1. The Department continues to believe that it is reasonable to prohibit providers from charging off as uncompensated services the cost of services for which they have been partially reimbursed when they have agreed or are required to accept that payment as payment in full. In those situations no uncompensated services are actually provided to the applicant, who is not obligated for any part of the cost of care. Therefore, a contrary policy would, we believe, provide a "windfall" to facilities in such cases, and that windfall would be at the expense of other persons unable to pay.

2. The provision respecting exclusion of services disapproved by a PSRO has been retained, as the Department believes in general that facilities should not provide "unnecessary" services on an uncompensated basis.

3. With respect to the provider and consumer suggestions regarding conditioning uncompensated services on application for Medicaid and other programs, the Department stresses that the effect of the exception to § 124.509(a) is that a facility may condition provision of uncompensated

services on an applicant's applying for benefits under other programs. While this choice is left up to the facility, the Department notes that the decision to impose such a requirement is clearly consistent with its view of uncompensated services as a "last resort payment" program. However, the Department also notes that nothing in § 124.509(a) permits a facility to delay an eligibility determination under § 124.508, once requested. Thus, these requirements together mean that where an eligibility determination is requested and a question as to third party coverage exists, the facility must make a determination within 2 working days, although if eligibility exists it may condition the provision of uncompensated services on the applicant's following through to obtain whatever third party payment he is entitled to. Then, if the third party payment subsequently materializes, the facility must exclude the services provided from its uncompensated services account.

4. No explicit provision for bad debts or uncollectible accounts, as those terms are generally used, has been made in these rules. The effect of permitting a request for uncompensated services to be made "at any time," including after institution of suit for collection by the facility, is to allow certain accounts that could otherwise be considered to be "bad debts" to qualify as uncompensated services. Specifically, the rules permit facilities to claim credit only for services provided to persons determined to be eligible. A facility may not assume that all uncollected accounts are eligible and claim credit for these accounts or that basis. Since these rules do not treat all "bad debts" or "uncollectibles" in the same way, and permit some to be credited as uncompensated services, i.e., those in which eligibility for uncompensated services is established, we think that use of those terms would be confusing and misleading.

5. The Department does not believe that it is appropriate to deny uncompensated services credit for emergency services provided to individuals because of requirements of local law. If some of the individuals would qualify for uncompensated services, they should not be denied that benefit; concomitantly, the facilities should not be denied appropriate credit if they forego their right to bill for such services.

XIII. Reporting and record maintenance requirements

A. Background

The current rules provide that facilities must file an annual statement with the State agency not later than 120 days after the end of their fiscal years. The annual statement must set forth the facility's operating costs, the amount of uncompensated service provided in the prior year, a proposed budget and a justification and affirmative action plan for any past or projected shortfall in the amount of care. 42 CFR 53.111(e). The current rules contain no specific requirements concerning maintenance of records relating to compliance with the assurances.

The proposed rules required facilities to submit an annual report not later than 60 days after their fiscal year, reporting

financial data and compliance information similar to that currently required. The Secretary could also request other compliance reports in writing. Facilities were required to report to him the institution of any compliance suit against them within 10 days of suit. See proposed § 124.510 (a), (c). The proposed rules also required facilities to maintain relevant records for a period of five years. See proposed § 124.510(b), § 124.508(a)(2).

B. Public comment

1. Many providers criticized as impractical and unreasonable the requirement that the report be submitted within 60 days after the close of the fiscal year. Providers suggested an extension to 90 or 120 days after the close of the fiscal year, on the ground that the Medicare cost report is completed 90 days after the close of the fiscal year.

2. Several providers and auditors objected that the regulations would require a costly expansion of the scope of audits to review individual determinations for compliance. The references to "other information" and "other documents" which could be required by the Secretary were also opposed by providers as "overbroad" and "overregulation."

3. Providers suggested various ways of minimizing the reporting obligations, mainly by relying on existing mechanisms. For example, a State hospital association suggested that for data and records that are routinely prepared for other purposes, the format and filing dates for information required under the Title VI regulations should be consistent with already required reports. Another comment suggested that reporting take the form of additions to the current Medicare cost report. Providers also recommended that if a facility is in compliance with its Title VI obligation, routine reporting be eliminated or streamlined.

4. Providers also opposed the requirement in proposed § 124.510(b) that various documents be made available to the public for inspection. For example, some providers strongly objected to public inspection of facilities' budget and other financial data, on the grounds that such a disclosure would substantially impair the competitive position of those facilities. They suggested that publication of only those portions of the budget which are "material" to the program should be required. Finally, some facilities protested only that the phrase "any other documents" was too broad and could compel disclosure of medical and other confidential records.

Providers also objected that the record retention requirement of five years was burdensome, and bore no relation to the needs of the Department or of consumers for monitoring.

5. There was some protest against the requirement of proposed § 124.510(c) that the facility notify the Department of legal actions brought against it as burdensome.

6. Consumer comments generally praised the reporting and disclosure requirements. However, according to a number of comments, in light of the limited resources

available to the Department for monitoring and enforcement, it is important to explore the potential for expanded compliance monitoring through expansion of the reporting form itself. Accordingly, additional requirements to be imposed on facilities were suggested. Various comments suggested that the final regulation should explicitly require maintenance of numerous items of data such as specific numbers of patients, specific amounts of care provided and other pertinent details that will allow for detection of patterns of discrimination or non-compliance, copies of all written eligibility determinations, and so on.

7. Many consumers supported the requirements of § 124.510(b) (and the parallel requirement of § 124.604(b)) that financial information related to Hill-Burton compliance be disclosed to the public. In addition, many asked that copies of the annual report and other compliance records be made readily available to the public at the facility and at the local HSA to facilitate independent monitoring by local consumer groups and the press.

C. Department's Actions and Response

1. The Department is persuaded by the many provider comments concerning the timing of the required reports and the need to minimize reporting burdens by coordinating the timing of the reporting under this subpart with other required reporting. Accordingly, it is requiring that the reports be submitted at the same time as the Medicare cost reports. Since much of the data generated for the Medicare cost report will be useful for preparation of the required assurances compliance report, this requirement will enable facilities to coordinate their preparation. See § 124.510(a)(1). More significantly, the Department is also persuaded that annual reporting is unduly burdensome for facilities that are meeting their annual compliance requirement. Thus, § 124.510(a)(1)(i) requires facilities to report only once every three years (on a staggered schedule, to be subsequently prescribed by the Secretary). However, where a facility falls short of its annual compliance level, or the Secretary determines, based on other information available to him, that more frequent reporting is needed, then the facility must report more often than once every three years. See § 124.510(a)(1)(ii). This latter requirement is needed for monitoring: where possible noncompliance exists (as in the case of a deficit), the Department obviously should be alerted to it and obtain the relevant facts as soon as possible, rather than allowing two or three years to go by while relying solely on the complaint mechanism to catch those situations.

2. The report requirement is very general, and does not require numerous specific items of information as advocated by the consumer comments. Nevertheless, the Department believes that this general authority will enable it to require many of the specific items of information suggested while at the same time enabling it to change the requirements based on experience with the reports and changes in its needs. The consumer and provider suggestions for the specific content

of the report are being considered in the development currently underway of the reporting form under section 1602 of the Act.

As for the provider concern that a general approach is "overbroad", § 124.510(a)(2) clearly limits what may be required to information relevant to compliance. As long as providers are told in advance what is required of them, and they will be, the Department does not believe that such a requirement is either unreasonable or in excess of its authority. See the last two sentences of section 1602. Moreover, it notes that any specific reporting forms it issues are subject to 44 U.S.C. 3509, so that the process insures that reporting burden will be taken into account in developing the form.

3. The Department is not persuaded by the provider comments criticizing as burdensome § 124.510(a)(4), regarding notifying the Secretary of institution of suit. An analogous provision arguably implicitly exists under the current rules (42 CFR 53.111(k)(2)). In any event, the Department believes that this requirement is reasonable in view of the Secretary's responsibility for enforcing the assurances.

4. The Department is persuaded by the thrust of many of the consumer comments that what is really needed for adequate monitoring and enforcement is facility records that are adequate to establish compliance. However, it also recognizes a concomitant provider interest in knowing what records facilities must maintain and in not maintaining those records for any longer than the minimum time needed. Thus, it has added a new provision to clearly establish that relevant records must be kept and spell out more precisely what the recordkeeping obligations of facilities are. See § 124.510(b). That section also ties the duration of the requirement to the Secretary's investigation under section 1612(c) of the Act. This will give the public an opportunity to bring discrepancies in the records or inadequacies in the investigation to the Department's attention promptly, but will not prolong the recordkeeping requirement indefinitely.

5. The record maintenance requirements retain provision for public access to and inspection of compliance records. The Department considers this provision to be clearly authorized by and consistent with section 1612(c), which gives persons a "private right of action" to enforce compliance. Moreover, the Department believes that assisted facilities should be accountable to the community in their fulfillment of the assurances, and that interested members of the public working closely with facilities can be helpful in assuring compliance without federal intervention. Providing consumer advocates access to records as a routine matter should discourage the filing of suits simply to get access to records through discovery. Of course, facilities may—and indeed are encouraged to—protect confidential records and information. Thus, if what is sought is information regarding the dollar amounts charged off to uncompensated services, patient accounts could be provided with the information which would publicly identify the patients deleted.

XIV. Enforcement

A. Background

The current rules give the State agencies primary enforcement responsibility. Under § 53.111(j), the Title VI State plan is required to include provision for handling complaints about facilities' compliance with their assurances, and appropriate sanctions.

In enacting Title XVI, Congress expressed dissatisfaction with the enforcement of the Title VI assurances by both the State agencies and the Secretary. See S. Rep. No. 93-1285 at 61. In addition to requiring the Secretary to issue regulations concerning compliance and require periodic reporting under section 1602 above, it gave him explicit enforcement responsibilities for both Title VI and Title XVI facilities under section 1612(c):

The Secretary shall investigate and ascertain, on a periodic basis, with respect to each entity which is receiving financial assistance under this title or which has received financial assistance under title VI or this title, the extent of compliance by such entity with the assurances required to be made at the time such assistance was received. If the Secretary finds that such an entity has failed to comply with any such assurance, the Secretary shall take the action authorized by subsection (b) or take any other action authorized by law (including an action for specific performance brought by the Attorney General upon request of the Secretary) which will effect compliance by the entity with such assurances. An appropriate action to effectuate compliance with any such assurance may be brought by a person other than the Secretary only if a complaint has been filed by such person with the Secretary and the Secretary has dismissed such complaint or the Attorney has not brought a civil action for compliance with such assurance within 6 months after the date on which the complaint was filed with the Secretary.

The proposed rules took these changes in the assurances program into account by providing for Federal, rather than State, administration of enforcement. See discussion at 43 FR 49956. They provided that the Secretary could enter into an agreement with any State agency designated under section 1521 of the Act by which that agency would assist the Secretary in carrying out part of his monitoring and enforcement functions, but the primary responsibility would be the Secretary's. See proposed § 124.512. With respect to those responsibilities, the proposed rules set out specific requirements for the filing of complaints (see proposed § 124.511(a)(1)) and required facilities records and information to be made available to the Secretary (see proposed § 124.511(a)(2)).

B. Public Comment

1. Providers generally urged that administration of the assurances program be left with the Title VI State agencies. They argued that the proposed shift to Federal administration was unwarranted by the history of the program and would add administrative problems for both the Government and facilities, without benefit to

the program. It was urged that State-level administration is far more appropriate, since both community needs and resources are better known at that level. Providers also asserted that the regulations are inconsistent in that they justify Federal administration because of insufficient funding at the State level, but also refer to limited Federal resources. It was also asserted that the Department has no authority to remove administrative functions from the States.

A California consumer group urged that enforcement should remain at the State level in California, on the ground that local agencies are more accessible and responsive. It also pointed out that resources for frequent on-site visits and financial audits are necessary and questioned whether the necessary Federal resources exist. Similarly, a Massachusetts comment pointed out that a few State agencies have recently begun to enforce the assurances actively. For indigent patients in such states, a change to Federal monitoring and enforcement, with attendant long delay and procedural complexities, would represent a serious step backward. Continuation of the State agency role was urged.

Consumers who regarded their State agency's enforcement of Hill-Burton assurances as lax generally supported the proposed transfer of administrative responsibility to the Department. For example, a Georgia legal aid society recommended that before a State agency be allowed to contract with the Department to administer the assurances under § 124.512, satisfactory documentation of adequate past enforcement and monitoring efforts be required. Other groups recommended that the Secretary handle all enforcement functions.

A migrant group expressed fear that a State which poorly administered a program in the past might enter into agreement with the Department to continue to do so, and criticized as unclear the role of the States in the monitoring and administration of the program in the proposed regulation. Other comments argued that the proposed rules seemed to leave room for wide variations in monitoring by States and suggested enhanced uniformity in the administration of the assurances program.

2. Providers expressed numerous objections to the investigation mechanisms described in § 124.511. For example, they alleged that the proposed split of investigative responsibility between HRA and OCR, described in the preamble to the proposed rules, would impose burdens on the Government, on providers, and on beneficiaries of the program. They also opposed any accelerated right-to-sue notice the Department might provide to individuals (also proposed in the preamble to the proposed rules) on the ground that both exhaustion of remedies and avoidance of unnecessary litigation should be encouraged. A few provider and governmental groups argued that the investigative and enforcement mechanisms should operate strictly on a complaint basis.

Consumer groups asked that the frequency of investigation be specified in the regulation. With respect to the complaint mechanism,

consumers criticized it as too demanding. Consumers suggested that the Department provide a standardized complaint form and afford greater opportunity for participation by the complainant in the investigation process. Consumer groups also asked that the regulations specifically permit groups as well as individuals to file complaints. Generally, consumers supported the concept of a right-to-sue notice.

3. The suggestion that the preamble to the proposed rules the Department might add mediation procedures was endorsed by a few providers, on the ground that it would help determine which complaints are legitimate, minimize the cost of nuisance complaints, and lessen the investigative workload of the Department. This comment anticipated that the State could be involved in such a process through the inclusion of local citizens on mediation boards. The American Arbitration Association also supported the mediation principle.

In general, however, providers and consumers were opposed for varying reasons to addition of a mediation mechanism. Some providers and consumers opposed mediation because they believed the issues involved were factual ones to be determined based on official standards, not negotiated through bargaining power. Some providers foresaw mediation as a source of more complaints and cost increases. A State board of health suggested that the facility instead provide an ombudsman and an appeal process. Consumers also objected to erecting another administrative hurdle and both providers and consumers suggested instead that the regulation require that all administrative complaints sent to the Secretary be sent to the facility as well, thereby giving the facility the opportunity to cure the alleged violation on its own. Another suggestion was that the regulations should require a local impartial review of denials to resolve individual denial disputes, so that the Department could focus on systemic noncompliance investigations.

Consumers groups argued for enhanced remedies for complaints. Their suggestions included the following: defendants in collection actions should be permitted to raise a facility's alleged violation of its assurance as a defense; the inflation factor should be added to the deficit amount; a penalty equal to 10% of the deficit should be added to the deficit; Federal reimbursement under Medicare and Medicaid attributable to the depreciation allowance on assets financed with Title VI or XVI funds or other forms of Federal financial assistance to facilities found out of compliance by the Department or a court should be terminated.

C. Department's actions and response

1. The Department has retained the proposed changeover to Federal administration of the program. See § 124.511. It is unpersuaded by the provider comments advocating continuation of the *status quo*, since that *status quo* has resulted in unsatisfactory enforcement in many places. It believes also that it will be able to provide more vigorous enforcement than has generally been the case. Moreover, since it now has by statute an undeniable

enforcement role, it believes that the federalization of the enforcement program will minimize possible duplication of effort and inconsistency of administration that might have occurred had the present scheme been continued.

As for those consumer comments urging continuation of the State role based on the performance of a few States that are performing well, the Department notes that those States, or any others, may seek to enter into an agreement with the Secretary under § 124.512 and thereby continue their activities. In addition, a provision has also been added to clarify that these regulations do not supersede independent remedies available to States under State law. See § 124.512(d). Thus, States are free to impose additional requirements and to make available additional legal remedies, so long as the Secretary's right to enforce the requirements of these regulations is not impeded. For example, States may work to obtain and use authority to review allocation plans, and eligibility criteria, to require more reporting, and to impose more rigorous sanctions. Accordingly, the Department believes that it has fully answered the concerns expressed by those comments.

The Department shares the concern expressed by many consumers that States unable to do a good job of monitoring and enforcement should not be given shared responsibilities with the Department under a State agreement. The regulation specifically provides that only States "able" to do the job will be given the opportunity to enter into an agreement with the Secretary. In making this decision the Secretary will certainly take into consideration State performance in administering the current rules as well as any additional information bearing on their ability to assist in administering these rules in the future. Moreover, the final regulation gives the Secretary (and the State) the right to terminate an agreement on 60 days' notice. This will permit the Secretary to terminate an agreement when State performance is inadequate.

2. The complaint procedure has been retained. The most significant change is that a provision for early, nonsubstantive dismissal of complaints has been added, as advocated by many consumer comments. See § 124.511(a)(4). This will mean that complainants whose complaints the Department is not able to dispose of within the six month waiting period before court action may be instituted will not be delayed by six months of inaction. The Department will grant such dismissals either at the request of the complainant or on its own initiative based on enforcement priorities. This will enable the Department to concentrate resources on the most significant and far reaching compliance issues. In order to help facilities avoid unnecessary litigation, however, the Department has also provided that it will promptly notify facilities of any complaints filed against them, and will not dismiss any complaint for a minimum 45 day period. This will enable the facility to begin negotiations with the complainants promptly should they wish to do so.

The Department has retained the requirements for filing of complaints. It does not think they are too burdensome, and believes they are the minimum needed for effective use of staff time. The information required in a complaint has also been simplified. For example, the "location" rather than specific address of the facility is required. In addition, the Department intends to make every effort to obtain the required information from complainants when missing from the complaint. Moreover, the Department is looking into the feasibility of providing standardized complaint forms or formats, suggested by some consumers.

As for the suggestion that the Department's investigative efforts operate on a complaint-owned basis, the Department does not believe that this is unauthorized. The first sentence of section 1612(c) requires the Secretary to undertake periodic investigations. While the Department is not committing itself in these rules to any particular frequency of investigations because it needs flexibility to tailor the frequency to its resources and the need it sees for such investigations based on experience, it does intend to do investigations on a regular basis.

3. The Department has accepted the majority of comments opposing adoption of a mediation process. Such a process may not be suitable for this program, at least until more experience is gained operating under the new rules. Also, the revised complaint and dismissal procedure, with early notice to facilities will enable facilities to settle complaints short of Department or court action.

4. With regard to the question of enforcement and sanctions, the proposed rule has been changed to provide for Secretarial determination of whether a facility was financially unable to meet its annual compliance level to conform to the changes made by the elimination of the procedure for the advance applications for lower levels of compliance. Consistent with the framework explained in connection with § 124.503 above, provision is also added for prompt make-up where a deficit is due to noncompliance. See § 124.511(b)(3)(i). Finally, a provision is added to make clear that a facility that has wrongly denied uncompensated services to a person unable to pay who should have received them under the facility's allocation plan must correct its action to be in compliance with the assurance. See § 124.511(b)(2). These corrective steps must include, where appropriate, termination of collection action (including lawsuits) and repayment of bills wrongfully collected.

The Department believes that the above changes should provide it with the tools necessary for effective enforcement, by providing significant disincentives for noncompliance. It thus believes it has answered the general consumer concerns in this area.

COMMUNITY SERVICE

I. Applicability of the rules

A. Background

The present rules, set out at 42 CFR 53.113, apply only to Title VI facilities. Unlike the uncompensated services obligation, however, which applies only for the 20-year period following completion of construction, the obligation to provide a community service is not time-limited. The proposed rule applied to both Title VI and Title XVI-assisted facilities, and similarly had no time limit. See proposed § 124.601.

B. Public comment

Some providers objected to the unlimited duration of the community service obligations, claiming that it places an unreasonable burden on facilities.

C. Department's actions and response

The Department has left proposed § 124.601 unchanged except for minor editorial changes. As pointed out in the preamble to the proposed rules (43 FR at 49955), a regulatory 20-year limitation on the duration of the community service assurance as it then applied to Title VI facilities was struck down in *Cook v. Ochsner Foundation Hospital*, Civil No. 70-1969 (E.D. La. 1975), and *Lugo v. Simon*, 428 F. Supp. 28 (N.D. Ohio 1976). Section 1604(b)(1)(J) of the Act specifically provides that the community service assurance applies to Title XVI facilities "at all times after [the] application [for assistance under that title] is approved."

II. Definitions

A. Background

The definitions set out in the proposed rules (§ 124.602) represented no substantive change from those contained in the present regulations (42 CFR 53.113(b)), except for the necessary expansion of coverage to include facilities assisted under Title XVI (see definition of "Applicant" in proposed § 124.602).

B. Public comment

The public comment focused on the need for a definition of the "service area" of the facility, to clarify the requirement of proposed § 124.603(a) that a facility must make its services available "to all persons residing (and, in the case of applicants under Title XVI of the Act, employed) in the area serviced by the facility. . . ."

Both consumers and providers pointed to the need for such a definition. Some providers suggested that facilities' "service areas" be derived from their long-range planning; others that they reflect certificate of need applications or other planning documents. Consumer groups proposed that a facility's service area be deemed equivalent to or broader than the health service area (designated under Title XV, PHS Act) in which the facility is located, or that HSAs participate in the definition process.

While some suggested the use of medical trade areas as described for purposes of State medical facilities plans developed under Title XVI, the fear was also expressed that other aspects of health planning could be hampered

by using the Title XVI plan for that purpose. It was also suggested that service areas could be based on patient origin data submitted by each facility. Finally, it was pointed out that some publicly-owned facilities are established to serve particular areas.

C. Department's actions and response

The Department agrees that a definition of the term "service area" is needed in order to avoid confusion as to the scope of a facility's community service obligation. In searching for a useful definition, however, the Department found the suggestions offered by the public to be generally unsatisfactory. Reliance upon planning documents developed by facilities themselves for other purposes was considered unwise, since those documents either do not necessarily reflect current situations or do not presently exist for all covered facilities. Adoption of health service areas is simply unworkable as a general matter, since those areas are unrelated to the areas served by individual health facilities. (Many entire States, for example, are health service areas.) Title XVI State medical facilities plans are not yet developed, and will not be in the near future, since no funds have been requested to carry out the Title XVI allotment program this year.

The Department, as suggested in the preamble to the proposed rules, has chosen to base its definition of the term "service area" on the most recent Hill-Burton plan approved by the Secretary for the State in which a particular facility is located. These plans are, in the Department's view, the best articulation currently available of health facility areas of service. It is recognized that Title VI plans will not accurately reflect the current areas of service of all facilities, since in some States the plans have not been updated since the early 1970's. For that reason, each facility is given the opportunity to propose, for the Secretary's approval, a service area that differs from that contained in the most recent Hill-Burton plan where it can demonstrate that the former area no longer applies. In evaluating such requests, the Secretary will apply the criteria that guided the Hill-Burton State agencies in their delineation of service areas for Title VI State plan purposes: Population distribution, natural geographic boundaries, and transportation and trade patterns (see 42 CFR 53.1(d)). For the most part, however, it is expected that those areas will be satisfactory.

III. Provision of services

A. Background

The language of proposed § 124.603, which set out the principal requirements for compliance with the community service obligation under the proposed rules, differed in certain important respects from the analogous provision of the present regulation, 42 CFR 53.113(d), although many of those changes were intended for clarification or to make explicit what was already implicit in the present regulations.

Proposed § 124.603(a) explicitly stated what was implicit in § 53.113(d)(1), namely that a facility may not discriminate in the provision of its services on the ground of

race, creed, color, or national origin. This language was added for clarification purposes and, as pointed out in the preamble to the proposed rules, complaints of discrimination that raise questions of compliance with other acts (such as the Civil Rights Act of 1964) will be investigated under those other acts.

The proposed regulation further provided that a facility may not discriminate on "any . . . ground unrelated to an individual's need for the service or the availability of the needed service in the facility," and specifically stated that a facility would be considered to be out of compliance with its community service assurance if it should adopt an admissions policy having the effect of excluding persons on grounds other than need for or availability of the services. However, the proposed rule would have permitted facilities to deny services to persons who are unable to pay and have no source of payment. Concern was expressed in the preamble that admission policies such as preadmission deposit requirements and admission only through physicians with staff privileges have served to limit access to facilities by persons in need of their services, particularly beneficiaries under governmental programs such as Medicaid. Comment was specifically invited on the possible prohibition of preadmission deposits for Title VI and Title XVI facilities.

Proposed § 124.603(b) essentially followed the present § 53.113(d)(2) in requiring that services be provided to beneficiaries of governmental programs, in accordance with the holdings in *Cook* and *Lugo*, *supra*, that discrimination against such beneficiaries is inherently inconsistent with the community service assurance.

B. Public comment

Not surprisingly, proposed § 124.603 provided the area of greatest controversy in the proposed community service regulations. Providers generally argued that regulation of admissions procedures is inappropriate and improper, and requested that preadmission deposits not be barred. Consumers supported an explicit ban on such deposits.

1. Numerous providers pointed out that only doctors have authority to admit patients to a hospital, and asserted that they (hospitals) have no power to provide services not ordered by a physician or to require staff physicians to participate in governmental programs; that if there is no physician who participates in a governmental program who will order the admission or service, compelling the hospital to provide the service will result in violation of local law or other requirements; that the regulations would have the effect of driving doctors away from Hill-Burton facilities; and that the Secretary has no direct authority to require doctors to treat particular classes of patients.

2. In response to the Secretary's request for comment on whether preadmission deposits should be barred, many hospitals supplied analyses of the effect on their financial situations of such a ban. While some of these hospitals expressed understanding of the Secretary's concern that preadmission deposits limit access to required health

services, all opposed an outright prohibition. Consumers generally supported such a prohibition.

The following is a summary of the comments received from providers and provider organizations:

a. Provider organizations asserted that a prohibition on preadmission deposits would be illegal, inasmuch as Titles VI and XVI both state that the provision of assistance to a facility thereunder does not confer Federal control over the administration or operation of the facility.

b. Many hospitals insisted that preadmission deposits are necessary to their financial stability, and that barring them altogether would impair their cash flow and cause an increase in bad debts, and would result in a reduction in hospital accessibility. For example, one large medical center in the Southwest stated that it receives approximately \$550,000 in preadmission deposits per year, a large portion of which is obstetrics. Because a large percentage of these patients make no further payment for services and these accounts are subsequently written off as bad debts, this facility estimates that elimination of the preadmission deposit would reduce collections by an estimated \$300,000 per year (the cost of delivery and care for 291 mothers and babies).

c. Some hospitals characterized their preadmission deposit policies as screening processes to identify individuals who are unable to pay. Thus, it was argued that preadmission deposits do not exclude patients from admission. The hospital's financial counseling departments are able to work with patients to assist them in obtaining assistance from families, governmental programs, etc. If none of these are available, services may be provided under the uncompensated services obligation or general charity.

d. Many providers, while recognizing that preadmission deposits might be used to exclude the medically indigent, asserted that their own do not have that effect because of the availability and frequent use of waivers of the preadmission deposit requirements. These providers generally argued that elimination of all such requirements would be unduly harsh, and recommended instead that the regulations require a determination of eligibility for uncompensated services before a preadmission deposit could be requested.

e. Some facilities explained that they use advance deposits for specific elective procedures or for maternity cases, as a method for installment payment that eases the financial burden of hospitalization, particularly important for those without insurance or with limited maternity coverage; and that without this collection tool, bad debts and costs to paying patients would increase.

Many consumers and their organizations requested that an explicit ban on preadmission deposits be placed in the regulations. One suggestion was that such deposits be forbidden in all cases where the prospective patient (1) is eligible for uncompensated services; or (2) is in need of services on an emergency or urgent basis; or

(3) desires elective services and is willing to sign a promissory note with a reasonable payment schedule.

3. A number of consumer organizations proposed the deletion from the proposed regulation of the language which permits a facility to deny services to persons unable to pay after the facility's uncompensated services obligation for a given period has been satisfied, on the ground that the community service assurance bars discrimination in admission on the ground of inability to pay.

4. Consumers generally supported the language of proposed § 124.603(a) concerning admission policies which have the effect of excluding persons on grounds unrelated to their need for and the availability of the service. One comment suggested substitution of "maintain" for "adopt," to emphasize that current as well as new policies which have the effect will be considered violations of the assurances. Some consumers and providers requested enumeration of specific policies that might come within the provision, and examples of ways to remedy the problems created by such policies.

5. One legal services organization urged inclusion of more specific language to ensure survival of the community service benefit when a federally-funded facility closes or relocates.

6. Several consumer comments urged the inclusion in the regulations of a public notice requirement similar to that required under the uncompensated services provisions.

7. A number of comments from consumers and consumer-oriented groups urged the addition in the regulations of provisions to check "dumping" of financially undesirable patients by nonprofit private facilities.

C. Department's actions and response

Following consideration of the comments summarized above, the Department has altered the regulation in a number of significant respects. See § 124.603.

1. The Department has retained the provision prohibiting the use of admissions practices that have the effect of excluding persons residing in the service area on grounds other than need for or the availability of the services when requested. In this regard, the rule refers to "use" of practices and policies to make clear that it applies to new or existing practices and policies. With an important exception described in paragraph 2 below, facilities may deny services to persons who are unable to pay or who have no source of payment unless they are eligible for uncompensated services under Subpart F.

Facilities assisted with federal funds agreed to make their services available to all persons in the service area, and the Department believes that this agreement is not fulfilled when methods of admission are used to prevent such persons from taking advantage of the available services.

As an aid to facilities and consumers, the regulation now includes three illustrative applications of the rule. These examples are intended to illustrate some of the situations that may arise in which policies or practices of the facility have an exclusionary effect,

and to outline the Department's view of some of the alternatives that facilities may adopt to ensure that the services are fully accessible to the community. The examples are not intended to be exhaustive of the rule's application.

Facilities are encouraged to take any or all of the actions suggested in the illustrations, or to develop other alternatives that will similarly counteract the exclusionary effect of current policies or practices. It is emphasized that no specific admissions policies are required. So long as persons in the facility's area are not excluded on the prohibited grounds, the facility is free to use any policies it considers appropriate. Cooperation with medical staff is encouraged so that systems can be devised that provide access to all community residents, and that will work smoothly.

The Department disagrees with those comments that suggested that facilities might lack the authority necessary to implement some of the alternatives set forth in the regulation. It is the Department's view that a hospital has the legal right to condition a physician's membership or renewal of membership on a medical staff on the physician's agreement to take actions reasonably necessary to permit the hospital to fulfill its legal obligation under these regulations. We are aware of no courts that have taken a contrary view, and in fact, the case law relating to termination of physician staff privileges very clearly supports the hospital's right to impose reasonable conditions on staff privileges. While some courts have held that certain conditions imposed on physicians by the governing board of a hospital were unreasonable, we are aware of no instance in which conditions reasonably related to the hospital's ability to carry out obligations prescribed by federal law were held to be unreasonable.

The standards set forth in the accreditation manual for hospitals, published by the Joint Commission on Accreditation of Hospitals and relied upon by the vast majority of hospitals as well as the Department, also lend support to a hospital's authority to impose reasonable requirements on its medical staff. For example, Standard 7 (p. 51 of the 1979 edition) states that "the governing body, through its executive officer shall take all reasonable steps to conform to all applicable laws and regulations." Throughout the chapter on governing bodies, the JCAH manual emphasizes that the governing body has corporate, legal control over all of the hospital's operation and cannot delegate away that responsibility to anyone, including the medical staff. (See, for example, p. 47.) The medical staff is responsible to the governing body and the governing body may, and in some cases must, place requirements on the medical staff to ensure that the hospital is providing quality care of the kind needed by the community.

In addition to placing conditions on physician staff privileges, the Department also expects that some facilities will choose to hire or contract with physicians to assist them in carrying out their obligations under these regulations. We are aware of no state laws that would preclude facilities from

hiring or contracting with physicians to perform medical services on behalf of the hospital. Quite apart from the requirements of these regulations, hospitals are increasingly turning to such arrangements to ensure that appropriate medical care is provided within the hospital. Hospitals routinely contract with emergency room physicians, radiologists and pathologists; many hospitals, including the U.S. Public Health Service hospitals and public hospitals operated by state and local government, have a staff of salaried physicians. Such arrangements may well be useful to a facility in complying with its community service assurance.

Again, the Department emphasizes that the choice of how best to assure that services are available to all residents is up to the facility.

2. As mentioned, facilities may generally deny services to persons without a source of payment. However, the Department does not believe that a facility is fulfilling its community service assurance if it denies services needed on an emergency basis because the person cannot establish an ability to pay. Where a facility has an emergency capability it may not refuse emergency treatment. Persons served may be billed and collection actions instituted, or the facility may, if it wishes, credit some or all of the services provided on an emergency basis towards the uncompensated services obligation, if not already exhausted. The facility would simply include emergency services in its allocation plan to the extent it wishes to get uncompensated services credit.

The requirement that emergency services be made available without regard to ability to pay does not prohibit the transfer or discharge of a patient once the emergency is treated. Transfer or discharge is acceptable so long as there is no substantial risk of deterioration in the patient's medical condition, as determined by the appropriate medical personnel of the facility. This means personnel generally responsible for making such determinations for the facility.

The Department has not interpreted the community service assurance as requiring facilities to provide nonemergency services to persons unable to pay who do not qualify for uncompensated services. While persons unable to pay have a legitimate need for all medically indicated services, requiring service in nonemergency cases could have a serious impact on facilities' financial stability. In these nonemergency cases there is at least an opportunity for alternative arrangements to be made for the needed care.

3. After considering the many comments received on the issue of preadmission deposits, the Department has decided against imposing an outright ban on such deposits at this time. We shall continue to monitor the effect of preadmission deposit requirements on hospital accessibility, however. It is emphasized that where such requirements (or any others) have the effect of excluding persons on grounds other than need for or availability of services, facilities that impose them will be considered out of compliance with their community service obligation. As the illustration in the regulation indicates, a deposit may not be used if it results in services being denied to a person who can

ultimately pay (e.g. is employed, or has some other future source of income) but is unable to come up with the ready cash to meet the full deposit requirement before services are provided.

4. We think the issue of whether the community service benefit survives the closing or relocation of an assisted facility is adequately covered by other existing statutory and regulatory provisions. In short, the effect of those provisions is that while the benefit can be transferred to another facility, in many cases, there are some instances in which the benefit will not survive. Under section 609 of the Public Health Service Act, 42 U.S.C. 291i, the United States is entitled to recover from either the transferor or the transferee its proportionate share of the value of a facility with respect to which Title VI grant funds have been paid where the facility, within 20 years after completion of construction, either ceases to be a facility for which a grant could have been made under Title VI or is transferred to any entity which either is not qualified to apply for a Title VI grant or is not approved as a transferee by the State agency. Title XVI contains a similar provision (section 1631, PHS Act; 42 U.S.C. 300s-1). The Secretary, for good cause, may waive recovery. Among the elements to be considered by the Secretary in determining whether recovery may be waived is where a facility "ceases to be" a facility for which a grant could have been made under Title VI (see 42 CFR 53.135) are (a) whether the facility will be devoted to a public or nonprofit purpose which will promote the purpose of the Act, and (b) whether other substantially equivalent facilities will be utilized for the purpose for which the facility was constructed. These criteria are adequate to assure that waivers of recovery will only be granted where the needs of the community will continue to be served. Where such waivers are not granted, the community service obligation of the facility ceases upon recovery by the United States of its proportionate share of the value of the facility.

5. The final regulations have been changed to include a requirement that public notice of the community service obligation must be provided. See § 124.604. The Secretary will supply the notices in English and Spanish. See the discussion of the comparable provision in the uncompensated services regulations, above.

6. The final rules include a definition of "resides" to make clear that migrant workers and others who reside in the service area of Title VI assisted facilities may not be denied services on the ground that they are not permanent residents. Persons who reside in any area permanently or who have no present intention to leave the area are, of course, covered as area residents. In addition, persons residing in the area for purposes of employment, i.e. who are looking for a job, are on a job, or have recently completed a job, are also covered, as are family members living with them.

Appendix II.—DHEW Regulatory Analysis of the Cost Impact of Title XVI Assurances Regulations (April 1979)

Executive Order 12044, on Improving Government Regulations, was issued by President Carter on March 23, 1978. The Order requires, among other things, that regulations be drafted to assure that compliance burdens, including both program and paperwork costs, be held to a reasonable minimum. The Order also requires that regulations with "major economic consequences" receive a "Regulatory Analysis."¹ This document, as required by the Executive Order, represents the HEW Regulatory Analysis which accompanies the Title XVI Assurances Regulation and its preamble.

Highlights²

Titles VI and XVI of the PHS Act can be characterized as an expression of two major principles. First, this legislation stresses the premise that health facilities³ obtaining Federal financial assistance or Federal dollars generally continue to provide charitable services, consistent with the historical practice of providing such services. Second, it reaffirms the Federal commitment to assure provision of health care services in a non-discriminatory fashion. The predominant objectives of the regulation are: to prescribe a standard for a reasonable volume of uncompensated services which ensures that a constant amount of care is provided from year to year independent of changes in the cost of care; and to allow facilities maximum flexibility in the way they choose to distribute these services consistent with the first objective.

The cost analysis for the Title XVI Assurances Regulations focuses on the cost of providing uncompensated care and the cost of administering the regulations in the institutions and Government.

On an overall basis, if all facilities use 10% option with the inflation factor, the uncompensated care liability for all obligated institutions involved goes from \$395 million in 1980 to \$537 million in 1984 (\$467 million in 1982). Actually, some facilities will find the 3% option to be less and thus the actual total liability for all institutions will be less than this.

—Assuming that previous regulations had been rigidly enforced, the above costs would not represent new costs associated with the regulation (except for the inflation factor noted below, and other technical differences).

—A number of distributional and other technical effects also act to reduce the

¹ The threshold level for "major economic consequences" is an annual cost of \$100 million.

² The terms included in this brief section are clarified and elaborated upon as the reader continues through the text.

³ Almost 7000 institutions received Hill-Burton grants. 5284 still fall under the 20 year assurances obligation period, their grant amounts totalling \$3.275 billion. These include 3572 inpatient (83% of funds awarded), 462 nursing homes, and 1250 outpatient and other health care facilities. In addition, 368 institutions receive Federal assistance (on loans and loan guarantees) in the form of interest subsidies estimated to total eventually to \$531 million.

increment in service costs imposed by the regulation.

In terms of uncompensated care, a significant new cost is incurred by the inclusion of an inflation factor with the exercise of the 10% option. The annual increment due to this factor alone, assuming all obligated institutions exercise this option, ranges from \$39 million in 1980 to \$199 million in 1984.

—This cost is somewhat lower than otherwise due to incorporation of an alternative approach for including interest subsidies in the base which reduces the added costs due to the inflation factor as much as \$18 million by 1984.

—The Department will reassess its position on the inflation factor *before* it results in added costs of \$100 million annually. This level of additional costs will probably not be reached until some time in 1982.

Administrative costs of the provisions in this regulation may amount to the equivalent of one staff person year annually in each institution, and perhaps as much as an additional 100 or so staff/person years in the Government. At \$12,000/staff person year, total costs will approximate \$58 million for the institutions and just over \$1.5 million for the Government.

—Not all administrative costs to the institutions are new. It is assumed that under the previous regulation, some administrative costs were borne by the institutions. Had the previous regulations been fully enforced, however, then it is reasonable to assume that the administrative cost of these new regulations would only be slightly different than in the past.

—Although the Federal Government may experience an increase of \$1 million, the savings to those States which no longer monitor and enforce these regulations (as under the old regulations) offset the additional Federal costs. (Potential savings in State administrative costs are not estimated in this Analysis).

—The final regulation reduced the administrative burden that would have been imposed by the NPRM. Changing the requirement for lower level of compliance applications may have saved as much as \$4,000,000. Reducing reporting requirements from once a year to once every three years may annually save the Government and the institutions over \$4,000,000.

Background

The Hospital Survey and Construction Act (Hill-Burton) as originally passed in 1946 authorized the Secretary to require facilities which received Federal money through the Act to: (1) make their services available to all persons residing in the facility's area (the community service assurance); and (2) provide a reasonable volume of uncompensated services to persons unable to pay (the uncompensated care assurance).

The community service obligation as it stood in the original Act, specified that Hill-Burton grantees were not to discriminate on grounds of race, creed, or color. During the first 20-25 years, the provisions for regulating

the Act were extremely general. Various court cases led to changes in the regulations: deletion from the Act of the "separate but equal" language in 1963; and a 1972 series of changes which specified that State Hill-Burton agencies were to administer the assurance compliance, set eligibility criteria for persons unable to pay, and conduct a monitoring and enforcement program. These 1972 changes also specified new compliance options: three percent of operating costs, 10 percent of Federal assistance, and the "open door" option (in which a facility agreed to admit and provide uncompensated services to persons who could not pay). Various court cases filed after 1972 upheld the 3 and 10 percent options, as well as language in the regulations which limited an aided-facility's compliance to 20 years for grants or to the time the loan remains unpaid for loans and loan guarantees.

The Hill-Burton regulations were again amended on October 6, 1975. This amendment required that facilities make prior determinations of eligibility in providing uncompensated services and post notices of the availability of these services.

In January 1975, Congress passed Pub. L. 93-641 which replaced the Title VI program of assistance with Title XVI. The language in Title XVI made several changes in the assurance program. The most important of these were: (1) facilities would be obligated for an unlimited period after receiving aid under Title XVI, (2) facilities which received aid under Title VI or XVI were required to file periodic reports on their compliance with assurances, (3) rather than a joint State-Federal monitoring and enforcement process, the Secretary was now solely responsible for determining compliance and conducting investigations, and (4) individuals could file complaints with the Secretary charging noncompliance by a facility.

Proposed regulations for these provisions were issued October 25, 1978. Nearly 1,000 comments were received during the public comment period. During that same period, two days of public hearings were held. We stipulated under court supervision we would publish the assurance regulations by the end of March 1979. HEW subsequently requested and received a 30-day extension to this deadline.

Internal HEW analysis of the many comments received has resulted in significant adjustments in the NPRM. These key changes are summarized in the following section. Subsequent portions of this Analysis are concerned with a discussion of alternative adjustments considered by the Department, with respective cost implications, and further detail concerning the cost estimates used in this Analysis.

The Regulation: Changes, Objectives, and Cost Implications

The predominant objectives of the regulation are to prescribe a level of uncompensated services that must be provided, and to allow as much flexibility as possible to each facility in the way it chooses to distribute these services. The regulation, thus, focuses as much as possible on defining the amount of uncompensated services

required and *whether* they are actually provided, and as little as possible on *how* they are provided.

The regulation establishes a standard of performance that is measured over the full 20-year period during which Title VI assisted facilities are presently obligated to provide uncompensated services. However, facilities may meet the standard in *less* than the 20 years, or in *more* than the 20 years so long as they follow the minimum required procedures in good faith. The 20-year standard works as follows:

1. An annual compliance standard is established at the lesser of three percent of operating costs or ten percent of Federal construction assistance received. The latter standard is adjusted each year after 1979 to account for inflation in the cost of medical care.

2. If a Title VI facility provides less than the annual standard for *any* reason it must make up the deficit even if that means that the 20-year period will be extended. The deficit may be made up at any time, but the inflation factor will be applied to the deficit when it is made up. Also, if the facility has not complied with the requirements of the regulations, the Secretary can require it to speed up the pace at which it is providing uncompensated services.⁴

3. If a facility provides more than the annual standard, it gets credit for the "excess in compliance," thereby permitting the facility to end its obligation in less than 20 years.

This new approach has permitted the Department to eliminate the burdensome and speculative process under which applications would be filed with HEW for prior approval of a lower compliance level. Under the NPRM the lower level would have been based either on an alleged lack of community need or a facility's financial inability to meet the required level. Under the final regulation, if fewer persons request free services than are needed to meet the annual standard, the facility is required to establish an outreach plan, and then provide uncompensated service for any additional persons who seek services under that plan. If the facility cannot afford to provide the annual level of care in any year, it need not do so. In either event, however, facilities assisted under Title VI must make up the deficit in future years. Facilities assisted under Title XVI are also required to make up deficits which are due to noncompliance but may not have to make up deficits due to financial inability.

Several aspects of the changes in the regulations and its cost impact are worth stressing. First, it is not possible to develop a precise estimate of the additional service costs which the proposed regulation would impose. Such an estimate would depend on previous knowledge of the costs of the current regulation. These costs are simply unknown. Moreover, the Department intends to enforce the regulation vigorously; but there is no current or foreseeable basis for

⁴Title XVI assisted facilities will be required to make up deficits only when they violate procedures in the regulations. The difference in treatment is appropriate because, unlike Title VI facilities, Title XVI facilities are forever obligated to provide uncompensated services.

estimating the costs resulting from improved enforcement. Finally, a significant proportion, perhaps the majority, of the costs involved under the regulation are not "real" costs, but involve shifts in financing for services which would be provided in any event. (This point is developed later in this paper.)

Second, this regulation changes NPRM requirements on how institutions administer the regulation: it allows a much more flexible procedure for determining an allocation plan; it reduces reporting requirements; it simplifies and clarifies recordkeeping requirements; it eliminates the requirement for individual written notices after an institution meets its annual compliance level for any given year; and it provides greater flexibility in regard to when a determination of eligibility for free care must be rendered.

The net overall effect of the administrative requirements associated with the regulation will result in a need for just over one staff person year per institution (see Table 6 later in this report). It is difficult to know the difference between this requirement and requirements for administrative resources under the previous regulation. However, we can estimate savings among the alternatives considered for this regulation (see Tables 3, 4, 5, and 6 later).

A major saving in administrative cost arises due to the elimination from the NPRM of procedures for requesting lower levels of compliance—resulting in administrative savings of perhaps as much as \$4 million annually to the institutions and the Department (see footnote 2 in Table 6). Furthermore, the new deficit and excess provisions also make it easier to reduce the overall reporting requirements associated with the regulation, from an annual to a triennial requirement savings perhaps another \$4 million annually.

Third, these regulations represent significant changes over past regulations in the matter of computing the annual compliance level for amount of uncompensated care to be provided by an institution. The final regulation eliminates the so-called open-door policy as the measurable standard for compliance. However, there is nothing to stop institutions from continuing an open-door policy on their own part. The regulation also adds to the base for calculating the 10 percent compliance standard, assistance received under certain supplemental Federal programs. This provision results in additional costs over previous regulations amounting to \$14.1 million in 1979 rising to \$22.5 million in 1984.

These regulations, like the NPRM, include an inflation factor in order to retain an equivalent amount of uncompensated services provided by facilities from year to year irrespective of increases in hospital costs after 1979. This is not a problem with facilities using the three percent of operating costs option. Their obligation automatically increases in direct proportion with increases in operating costs. As stated above, the inflation factor would add no more than 39 million in 1980, 118 million in 1982, and 199 million in 1984.

In view of these costs, the regulation also indicates that the Department will

continually track the impact of the inflationary factor. When additional costs due to this factor approach \$100 million (not until sometime in 1982), the Department will reassess its position in this regard and take appropriate action in the light of evidence accumulated to that point.

Analysis of Policy Alternatives: In the course of developing the Title XVI regulations, the Department sought input from providers and consumers of health care services as well as from interested State agencies and local health planning agencies. Through testimony offered at the public hearing held on December 5 and 6, 1978, written comments on the proposed regulations, and advice offered orally during informal consultations with members of various groups, the Department was provided with a wide range of alternatives on almost every issue addressed in the regulations.

The decisions reflected in the final regulations are the results of careful consideration of many substantive and procedural alternatives. They represent the Department's attempt to establish a set of feasible, enforceable regulations which implement the statutory uncompensated care and community service assurances without imposing unfair or unmanageable burdens on institutions, the Government or the public. This section highlights the decisions the Department has made on major policy issues, including a brief description of the alternatives considered for each. A fuller discussion of each regulatory provision, including an analysis of the public comments received and the implications of decisions made, is provided in the Preamble to the final regulations.

1. *Twenty year limitation on Title VI obligations to provide a reasonable volume of free or below cost services to persons unable to pay.* The 20-year limitation on the provision of uncompensated services, as adopted by HEW regulations in 1972, has been retained, but with some qualifications. Under the new regulations, if a facility does not fully satisfy its annual compliance level in a given year, the deficit will be carried over to future years, potentially extending beyond 20 years the time required to fulfill the obligation. On the other hand, the new regulations also provide that if a facility exceeds its annual compliance level in a given year, the facility may receive credit toward the satisfaction of its obligation in future years, thereby possibly shortening the duration of its total obligation to less than 20 years.

A number of other alternatives were considered with respect to the "twenty years" issue. Among other things, the Department considered the following: retaining the 20 year limitation but beginning it in 1972 (the date of the regulation establishing the limitation) rather than in the year the grant or loan was given; retaining the 20 year limitation, but beginning it in 1979 with the issuance of new regulations to ensure that only those years of demonstrated compliance would be credited toward the 20 years; deleting the 20 year limitation altogether since there is no such limitation in

the statute; retaining the 20 year limitation without any further qualifications.

The 20 year limitation in conjunction with the compliance levels has been accepted by the courts as a reasonable standard for measuring the volume of services a facility is obligated to provide under the law. The Department is concerned, however, that this volume of services be actually provided and that a facility not escape its obligation through the passage of the 20 years. Thus, the Department has chosen to retain the 20 year limitation but has adopted a deficit make up provision and an excess compliance credit provision to ensure that at least subsequent to the effective date of the new regulations all facilities provide a reasonable volume of care. (See discussion of deficit make up and excess compliance credit below).

The Department seriously considered requiring facilities to demonstrate that they had been in compliance with the 1972 regulations during each year since 1972, and if they could not, to make up the deficit. However, due to lax enforcement in the past, much of the documentation necessary for determining compliance since 1972 is simply not available. The Department has determined, therefore, that the best use of its resources is to focus on and ensure compliance in the future.

Thus, in the interests of ease of administration and to minimize burdens for the facilities and HEW, the Department chose not to mandate institutions in general to make up previous deficits simply because they are not able to demonstrate past compliance. This final regulation does, however, clarify the intention that a facility which received Title VI assistance must make up all future deficits incurred for any reason.

2. *A facility which fails in any year to provide its annual level of uncompensated services will be required to make up the deficit in subsequent years.* As explained in the preceding discussion of the 20 year limitation, the deficit make up provision is critical to ensuring that Title VI facilities are not excused from their obligation to provide a reasonable volume of uncompensated services merely because 20 years have gone by irrespective of whether they have met their annual compliance levels. The excess compliance credit provision complements this deficit make up provision. It ensures that if a facility provides more than its annual requirement, then the facility will get credit for the excess in compliance and potentially allow the facility to end its obligation in less than 20 years. In this later case, the facility's administrative burden would thereby be reduced in proportion to the number of years it could eliminate by virtue of its excess compliance credits. In both the case of deficits and credits, the new regulations apply to those deficits or credits which occur in any year after the effective date of the regulations.

An additional advantage to the deficit make up procedure established in the new regulations is that it eliminates the need for a facility to request a lower annual compliance level in a year in which it is financially unable to provide the requisite amount of

uncompensated services.⁶ Instead, the facility will provide whatever it can afford, report to HEW at the end of the year, and tack the deficit on to its obligation in future years. Unless HEW later finds that the facility unjustifiably provided less than its annual compliance level in any given year, the facility would not be out of compliance with the regulations despite the fact that it is providing a lesser amount of uncompensated services than otherwise required. However, the facility's obligation will continue until the deficit has been erased.

The Department adopted this procedure in lieu of the NPRM scheme that required prior applications by facilities requesting permission to provide a lower level of services in any years. The Department estimates that the administrative costs to facilities and to HEW will be eased considerably (\$1.6-4 million a year—see footnote 2 in Table 6) by eliminating the applications and prior approval process and relying instead on the facility's judgment of its financial capabilities, subject to later verification by HEW audit.

3. *The annual level of uncompensated services that a facility must provide (not less than the lesser of three percent of operating costs or ten percent of the Federal grant or interest subsidy received) will be adjusted each year after 1979 to account for inflation in the cost of medical care.* This inflation adjustment will ensure that a facility will provide in each year of its obligation a volume of services equivalent to that required in 1979 in direct proportion to the rising cost of care.

The Department considered a number of other alternatives before settling on the inflation adjustment described above. For example, the Department seriously considered calculating the inflation factor back to the year in which the facility received its grant or loan. However, because this method would have imposed upon the facilities a sudden, extreme increase in their uncompensated services obligation—an increase which they were unable to plan for during the years prior to 1979—the Department decided against it. For example, a \$500,000 financial assistance base that began in 1970 would approximately double by 1979 if it were to have been inflated from 1970 to 1979. Thus, rather than providing 50,000 in uncompensated care in 1979, the institution would have been required to provide \$100,000. In contrast, the inflation adjustment adopted by the Department in the new regulations imposes a gradual increase in the facility's obligation, merely keeping pace with inflation from now on. The gradual adjustment allows the facility to plan and budget for the provision of an increased level of uncompensated care, just as the costs of most other items in an institution's budget are adjusted upward each year to allow for inflation.

Another alternative that the Department considered would have applied the inflation

factor only to the deficit incurred by a facility in any given year; that is, the basic dollar amount of services to be provided each year would not increase to adjust for inflation, but if the facility failed to meet its annual compliance level, the deficit would be inflated and added on to the amount of uncompensated services due in the following year (see Table 7 later). The Department decided against this alternative primarily because it would not be sufficient to counteract the erosion due to inflation of the actual volume of services to be provided. Without an overall adjustment of the total assistance base, less and less uncompensated service would be provided each year and soon the "volume" would become "unreasonably" small.⁶

Finally, the Department considered using no inflation factor at all. However, for the reasons already stated, the Department determined that an inflation factor was necessary to appropriately and fairly retain in future years a reasonable volume of uncompensated services equivalent to that initially required in terms of actual services rather than dollar cost. Thus, under these regulations, the inflation factor would be applied equally to deficits, excess credits, and to the base amount of the grant from which the annual compliance level is calculated. As noted earlier, this option adds about \$39 million to the cost of the regulation in 1980, rising annually to \$199 million in 1984. Nevertheless, in 1981, the Department will begin a reassessment of its decision based on information collected between now and then.

4. *Loan Payout.* On Federal loans and loan guarantees the assistance base for calculating the 10% option is related to the amount of interest subsidy paid by the Federal Government. Prior to this final regulation, the assistance base was taken to be the total amount of the interest subsidy to be paid over the life-time of the loan. Institutions would have been required to provide each year from year one of their loan, an amount of free care related to payments which were not going to be made by the Government until later years of the loan. Thus, for example, an institution with a typical \$1,000,000 loan would have been required to provide \$42,000 of uncompensated care in the first year of the loan, but would have received only \$30,000 in interest subsidies that year. And beyond that the care liability increases with inflation every year and the interest subsidy decreases as the loan principal decreases.

This was judged by many to be inconsistent with the basis for computing the 10% option for grants. In the case of grants, the institution received all of its money at the time of award. But as noted above in the case of loans, it was given only small portions of its money each year, not receiving the last amount until the final year of the loan repayment period. Thereby, the Department felt that this requirement when amplified by

the inflation factor under the 10% option was unnecessarily onerous. Instead it simply adjusted this requirement to include in the Federal assistance base only that amount of interest subsidy received by an institution up to and including the current fiscal year. This alternative has been dubbed the "payout" method. Under the 10% option with the inflation provision, the "payout" method turns out to require \$40 million less care in 1980, rising gradually to roughly \$46 million less care in 1984, as compared to the total subsidy method required previously. The Department, therefore, uses the payout method in the Final regulation to define the Federal assistance base related to interest subsidies.

5. *If a facility does not provide the required level of uncompensated services in any year due to insufficient demand or for any reason other than financial infeasibility, the facility must adopt an affirmative action plan.* Under this provision, the facility will be required to take such steps as the following: widely publicize the availability of free care, adjust eligibility requirements for uncompensated services to enlarge the pool of eligible patients, expand its definition of service area if the current definition limits the area from which persons seeking free care must come, and establish arrangements with other providers in the area to refer persons needing uncompensated services. If after instituting such a plan, a facility still falls short of meeting its annual compliance level of uncompensated care, the remaining deficit will be made up in the following year or years until the full obligation has been satisfied.

The Department adopted this procedure in lieu of the "open door" provision in the current regulations. Under the "open door" provision, no dollar amount of care was established as the compliance standard; a facility needed only to agree to provide uncompensated services to any person unable to pay. The "open door" has been an unsatisfactory standard primarily because compliance cannot readily be monitored, and the Department found substantial evidence of past noncompliance with the "open door" provision. However, the Department recognized that some facilities might be in compliance with all other portions of the regulations but have trouble providing the required dollar amount of uncompensated services due to insufficient demand for such services in their area. Thus, a better alternative to the "open door" was sought.

One alternative considered was to require facilities that anticipated such a problem to apply early in the year for permission to provide a lower level of uncompensated services. However, the burdens on both facilities and the Department under this alternative would have been substantial. Instead, the Department chose to establish an affirmative action plan as described above, linked with the deficit make-up requirement. This alternative will eliminate the burden of unnecessary paperwork, ensure that the full obligation of a facility is met, and yet not stigmatize a facility which in good faith attempts to provide the required level of uncompensated services but is met with

⁶ However, it should be noted that those Title VI facilities which might have been granted lower levels of compliance previously will now have to carry any deficits forward. Effectively, a greater total amount of uncompensated care will therefore be delivered under this regulation as compared with the proposed rule.

⁶ It should be noted that the inflation factor as described applies only to the 10% option. Since operating costs of a facility usually rise each year with inflation, no additional inflation factor will be applied to the level of uncompensated services under the option requiring 3% of operating costs.

insufficient demand for the services. Without this additional minimal administrative requirement, it would not have been feasible to eliminate requests for lower level of compliance, and thus the consequent larger savings there would not have been realized.

6. *In addition to published and posted notice, facilities must provide individual written notice that uncompensated services are available.* In the Department's view, no other alternative for notifying potentially eligible persons of the availability of free care would be as effective as individual written notice. Further, the burden on facilities of providing such notice is anticipated to be very small, and the benefits to the public are anticipated to be substantial. Finally, if a facility meets its compliance level during its fiscal year, it may stop providing individual written notices and making eligibility determinations for the remainder of that fiscal year. Thus, although posted notice and written denial requirements continue to apply, this results in a valuable reduction of an institution's administrative burden as compared to requirements of the NPRM.

7. *Each facility must adopt and publish a plan for allocating its available uncompensated services.* The Department considered a number of alternative allocation requirements, including the following: mandating a first-come, first-serve plan for all services provided at the facility; mandating that a mix of inpatient, outpatient, and emergency room services be provided; and mandating that a certain proportion of services be provided on a part-pay basis and a certain proportion be provided totally free. The Department instead decided that the primary purpose of the allocation plan—to ensure that uncompensated services are distributed fairly and to provide advance notice to the public of what kinds of services are available and how they will be allocated—could be achieved without mandating through regulations the content of the allocation plan. Under the new regulations, a facility may decide for itself how to allocate its services, and simply notify the public and the local Health Systems Agency (HSA) of its plan. The regulations permit and encourage community input into the plan through HSA involvement, but HSA involvement and approval of the plan is not mandated. Final discretion in this area is left to the facility.

8. *Determinations of eligibility for uncompensated services must be made on request, but may be made either before or after the provision of services to the person.* Under the current regulations, with a few limited exceptions, determinations of eligibility are required to be made prior to the provision of services if the facility is to credit such services to its uncompensated services obligation. This requirement was intended to prevent facilities from writing off "bad debts" as part of their uncompensated services obligation, and to give patients advance notice that they would not have to pay the bill they were about to incur. Many institutions pointed out the complexity and costliness of this provision in their administration of the regulation, and

consumer groups pointed out that it would be beneficial if in some cases determinations of eligibility could be requested after services have been provided.

As a result, under the new regulations, the Department has adopted an alternative which will be less burdensome for both facilities and eligible patients. Under this provision, the institution has two working days within which to answer any request, either for elective or emergency admission; and the patient has the right to request and receive a determination of eligibility any time before or after receiving care. If the person is determined to be eligible and to come within the allocation plan, the facility may add the uncompensated cost of that person's services to its total for the year, even if so doing results in an excess compliance credit. Thus, the new provision includes all the safeguards of the "prior determination" rule, but is less burdensome and more beneficial to both the facilities and potentially eligible patients.

9. *Facilities which provide the required annual level of uncompensated services must submit reports to the Department every three years. Facilities which provide less than the annual compliance level must submit a report in each year for which a deficit is determined.* The Department considered a number of reporting alternatives to implement the statutory requirement of "periodic" reporting. Yearly reports for all facilities were considered. Reports every four or five years were also considered. The Department determined that yearly reporting was burdensome and not necessary as a general rule, but that for facilities which were not providing the required level of uncompensated services, yearly reporting was critical to allow for proper compliance monitoring. The resultant savings over NPRM administrative costs to the institution and Government amount to over four million dollars annually (see footnote 4 in Table 4).

10. *Although the assurances program will be federally administered, the Department may enter into agreements with State agencies that are able and willing to do so to assist in administering the program in their States.* A number of States have developed effective programs for monitoring and enforcing compliance with the uncompensated services and community service assurances. Although Title XVI places primary responsibility for the program with the Federal Government, some States may wish to continue to use their own resources to enforce the assurances. In fact, State Health Planning and Development Agencies may use funds received under section 1525 of the Act for expenses of this sort. States can be effective in reducing non-compliance and in mitigating the need to process complaints. If this happens, the costs to the Department will be decreased and Federal resources can be focused more sharply on enforcing the regulations in other States.

Cost Analysis Review and Detail

The cost analysis presented in this report, as indicated earlier, focuses on the total cost of providing uncompensated care and the cost of

administering the regulations in the institutions and Government. Under the 10% option and using the NPRM method for including interest subsidies, the uncompensated care liability for the 5392 institutions obligated in 1980 is \$435 million, and for the 4164 institutions still obligated in 1984 it is \$583 million. If inflation is ignored, these totals would go instead from \$396 million in 1980 to \$366 million in 1984. Thus, the annual increment due in this case to the inflation factor⁷ alone ranges from \$39 million in 1980 to \$217 million in 1984. Using an alternative approach for including interest subsidies in the base would reduce the inflated totals about \$40–45 million per year and the non-inflated totals about \$41–28 million per year. For most facilities, the 3% option would require a higher liability than the 10% option. Some will find the 3% option to be lower, however, and thus the actual total liability for all institutions will be less than the figures given for the 10% option.

Administrative costs were much more difficult to estimate. Four subsets of these administrative costs were examined: lower level of compliance, investigation and enforcement, other general activities, and elimination of requests for lower levels of compliance. The general activities were assumed to be relatively invariable in terms of alternative approaches. Thus, we assume each institution would need about 1 staff year (includes professional and support) annually to perform them (see Table 4). In estimating costs of investigation and enforcement, we used three alternative approaches which varied to the extent that reports or complaints were cross-checked or audited. Totals for the Government ranged between 5.7 and 57 staff years annually (see Table 5).

In view of the high estimated cost of administering requests for lower levels of compliance as proposed in the NPRM, a fourth alternative was developed for the final regulation. The alternative approach, while still requiring the same total amount of uncompensated care to be provided by each obligated institution, allows each institution to vary the yearly amounts delivered according to annual demand and financial conditions until its total obligation is exhausted. It also requires affirmative action in some cases. The first three alternatives differ in the extent to which required data was available or had to be collected from

⁷ As noted earlier in the text, the Department intends to reassess the cost implications of the inflationary factor before its effect adds \$100 million annually (probably not until 1982).

scratch. Total institutional costs were 29 years, 157 years, 288 years, and 79 years, respectively. The Government costs were 65, 131, 196 years, and 74 years, respectively (see Table 3).

Uncompensated Care Liability

The provision for uncompensated care liability (UCL) discontinues the "Open Door Option" and requires either a 10% or 3% option. The 10% option means that an institution's UCL is 10% of the amount of their Federal assistance plus a yearly adjustment for inflation. The 3% option means the UCL is 3% of the difference between annual operating expense and Medicare/Medicaid receipts.

The Federal assistance base consists of Federal grants and interest subsidies. The proposed rule requires grants to be included for 20 years and interest subsidies for the life of the loan. The NPRM set the value of the interest subsidy at the sum of all subsidy payments due over the life of the loan.

Thus, institutions would have been

required to provide each year from year 1 of their loan, an amount of free care related to payments not made by the Government until later years of the loan. Thus, we adopted an alternative way to include interest subsidy in the base, namely, the "Payout" method. This method includes in the base only that amount already paid out by the Government.

The current regulatory provision of UCL differs from the last version of the regulation in that it discontinues the open door and requires that the Federal assistance base for the 10% option be increased yearly by the inflation rate. Table 1 shows the uninflated UCL vs. the inflated UCL under the 10% option for two ways in including interest subsidies, total and payout.

It is not possible to estimate the effect of eliminating the open door option. Some suggest there is simply a distributional effect (see the later section on distributional effects). The effect of inflating the base under the 10% option can, however, be estimated. It is shown in Table 2.

Table 1.—Uncompensated Care Liability

(In \$1,000,000 units)

	Assistance base				10% option		3% option	
	Active grants		Interest subsidies		Not inflated		Inflated	
	VI & XVI	Other	Total	Payout	1+2+3	1+2+4	1+2+3	1+2+4
	1	2	3	4	5	6	7	8
Year:								
1980	3,286	141	537	173	396.4	355.7	435.4	395.0
1981	3,233	141	537	204	391.1	354.7	474.2	432.7
1982	3,155	141	537	232	383.3	350.0	510.3	467.5
1983	3,075	141	537	258	375.3	344.8	537.6	504.4
1984	2,981	141	537	262	365.9	338.0	582.9	537.0

Notes:

1. Column 1 excludes those amounts (see Table A3) for which the 20 year obligation expires in the respective year.
2. These grants include: D.C. Construction Act, Public Works, Appalachian.
3. Column 3 is total of yearly interest subsidy payments due over the life of the loan.
4. Column 4 is cumulative amount paid through the respective year (see Table A4).
5. Columns 7 and 8 are inflated by HEW rates: 1979—9.84%; 1980—10.38%; 1981—9.81%; 1982—9.84%; 1983—8.94%.
6. Column 9 involves a straightforward compounding of Column 5. Column 8 compounds the sum of Column 1+2 and inflates Column 4 according to the respective year of payout.
7. Column 9 comes from Table A2 in the Appendix.

Table 2.—Effect of Inflating the Base

	Grants and total interest subsidies ¹	Grants and interest subsidy payout ²
1980	39.0	39.3
1981	83.1	78.0
1982	127.0	117.5
1983	162.3	159.6
1984	217.0	199.0

¹ Column 7 minus Column 5 from Table 1.

² Column 8 minus Column 6 from Table 1.

The estimates in Tables 1 and 2 assume all institutions choose the 10% option or that all choose the 3% option. In fact, institutions will choose whichever provides them a lower UCL. Nevertheless, the total National UCL will not exceed the amounts calculated under

the assumption that every institution uses the 10% option. If an institution chooses the 3% option because it is lower, the National total UCL would then be reduced from the 10% option totals in Table 1.

Administrative Costs

This section reports estimates of the administrative costs of the assurance program. Estimated costs are provided for each section of the proposed regulation where explicit activities are identified.⁸ In cases where feasible, three optional levels of activities are provided; thus decision-makers may choose among activities on the basis of their estimated costs. For the most part, the tables in which the estimated costs are

⁸ In Tables 3, 4, and 5, staff days are divided by 220 to conservatively calculate staff years.

presented are self-explanatory. A few general comments are provided below.

Table 3: We anticipate that applications for a reduced level of compliance would have been submitted by some 60 percent of the obligated institutions. To a certain degree, the burden of administration would have varied with the requirements for justifying and documenting requests imposed by the final regulations. Thus, we have estimated costs for four alternative levels of documentation.

These levels are (1) from existing institutional data; (2) from existing institutional data supplemented by demographic and other information available from the census, HSAs, HSP, or SHP, and other general sources; (3) from the above source plus primary data that must be developed by each institution for its specific request; and (4) requires a report if the intention to provide less care is due to financial reasons and an affirmative action plan if for other reasons.

Table 3.—Lower Level of Compliance

Level of Documentation	L1 ¹	L2 ²	L3 ³	L4 ⁴
ACTIVITY				
Applications ⁴	2,886	2,886	2,886	1,443
Effort/facility.....	2 days	2 weeks	4 weeks	2 days
Total Effort.....	26.2 yrs	131 yrs	262 yrs	13.2 yrs
Publication of Notice (or Affirmative Action Plan) ⁴				(Assume 20% will reacquire AAP)
Effort/facility.....	1 day	2 days	2 days	3 weeks
Total Effort.....	13.1 yrs	26.2 yrs	26.2 yrs	65.6 yrs
Review Application ⁵ (or AAP's).....	1 day	2 days	3 days	2 days/report 3 days/AAP
Incorporate Public Input/Application.....	4 days	8 days	12 days	8 days/AAP
Total Effort.....	65.5 yrs	131 yrs	196.5 yrs	74.3 yrs

¹ Requires only a form report requesting data available within institution.

² Requires L1 plus generally available data.

³ Requires primary data to be developed by applicant.

⁴ Borne by applicant. From Table A5, average number of obligated facilities between 1979-84 is 4,810. Assume 60% or 2,886 apply under L1, L2, L3, and under L4 that 30% of facilities, or 1,443, annually claim and report to the Secretary that they were financially unable to meet compliance level.

⁵ Borne by Government.

⁶ This option eliminates the need for institutions to request a lower level of compliance. Instead an institution need only report their intention to provide less care if due to financial inability to meet their established compliance level, or file an affirmative action plan if due to other reasons.

Table 4: No variable elements are considered to be present in the facility cost of administering the elements of the proposed rule included in table 4. Thus, total personnel cost has been estimated. In the estimate, the cost of reporting pursuant to Sections 125.510 and 124.604 have been combined. We have not attempted to estimate the legal costs which will be borne by institutions.

Table 5: The estimated costs to the Government of investigation and enforcement activities are shown in Table 5. The table shows activities required by both Sections 124.511 and 124.605. Three optional levels of enforcement activity are shown: E1) a presumptive level, predicated on the presumption that facilities are in compliance, in which monitoring and enforcement is limited to receiving and processing facilities reports and investigating complaints; E2) an

extension of E1 which provides additional confirmation of reports and investigation of discrepancies in reports and of facilities with above average frequencies of complaints; and E3) which involves a preventive approach to enforcement through on-site audits of 1/3 of the obligated institutions reporting in a given year.

The estimates for investigation and enforcement assume that the Government will receive 1,200 complaints per year under each subpart, of which 48 per year under each subpart will be found to require further action.

Because of the absence of provisions for funding, it has been concluded that few states will wish to make agreement pursuant to § 124.512 and 124.606.

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Table 4

Notices, Eligibility, Exclusion, and Reporting^{1/}

<u>Section</u>	<u>Activity</u>
.505 --	Notice of Availability Promulgation of notice, testimony @ HSA hearings
.508 --	Determination of Eligibility Interview applicants; determine eligibility; verify information
.509 --	Exclusion from Uncompensated Service Processing third party claims, billing and collection
.510 -- .604	Reporting ^{4/}

Effort/facility	1/2 time staff @ 15,000/year	7,500
Cost/facility ^{2/}	1/2 time sec'y @ 9,000/year	4,500
		<u>12,000</u>

Cost all facilities^{3/} 4810 x \$12,000 = \$57,720,000

^{1/} These costs are assumed to be roughly equivalent to the administrative costs of the most recent Title VI regulations.

^{2/} The effort estimates are meant to allow for staff time spent by others in the institution who will be occasionally involved in the routine conduct of activity under these sections.

^{3/} Average of 4810 facilities between 1979-84 (see Table A5).

^{4/} Assuming an average of 4810 institutions (see Table A5) and 10 staff days per report (including support staff), and assuming it takes two staff weeks to prepare a report, annual reporting would require 218 staff years each for both the Government and institutions. Triennial reporting reduces this from 536 staff years to about 179 years for a savings of over \$4 million (357 x \$12,000).

Table 5
Investigation and Enforcement

Enforcement Level	E1	E2	E3
Activity			
Processing Reports (Sections 124.511 and 124.605 inclusive)	Acknowledge and check reports; automatic data processing	E1 plus cross- checking with HCFA audits and reports	E1 + #2 plus preventive audits of 1/3 reports annually
# of Reports Effort/report	1604 2/day	1604 1/day	1604 1/3 @ 2 days
Total Effort Report	3.7 yrs.	7.4 yrs.	E1 + E3: 8.6 yrs. E2 + E3: 12.3 yrs.
Processing Complaints Section 124.511	Acknowledge and check complaints	E1 plus remote audit of each facility gen- erating an excessive number of com- plaints per year (assume 10% of facilities)	E2 plus pre- ventive audits of 1/3 of all institutions annually
# of Complaints/yr.* Effort/Complaint	1200 6/day	1200 E1 + 10% @ 1/day	1200 E2 + 1/3 @ 3 days
Total Effort-Complaint	1 yr.	1.5 yr.	21.5 yrs.
Processing Complaints for Section 124.605	Same as for 124.511	Same as for 124.511	Same as for 124.511
Total Effort, 124.605	1 yr.	1.5 yrs.	21.5 yrs.

Enforcement	Institutions	Government
Section 124.511		
Fact Finding/Mediation-48 cases/year	3 weeks/case	2 weeks/case
Total Effort	3 years	2 years
Litigation - 12 cases per year to be forwarded to OGC		

Section 124.605
Forwarded to OCR - 48 cases/year

* Assumes five times recent volume.

Table 6
Summary Table ^{1/}

	Institution				Government			
	L1	L2	L3	L4 ^{2/}	L1	L2	L3	L4 ^{2/}
.504 Compliance Level	39.3	157.2	288.2	78.8	65.5	131	196.5	74.3
.505 Notice .508 Eligibility .509 Exclusion .510 Reporting .604 Reporting	1 staff year/institution Average of 4810							
Investigation and Enforcement	E1	E2	E3		E1	E2	E3	
.511 & .604 Reports					3.7	7.4	9-12	
.511 Complaints					1	1.5	21.5	
.605 Complaints					1	1.5	21.5	
.511 Enforcements	3	3	3	3	2	2	2	
Total Staff Years	4852	4970	5101	4892	74	145	254	E1:82 E2:87 E3:132

^{1/} Entries are total staff years for all institutions as summarized from Tables 3, 4, and 5.

^{2/} Savings from adoption of L4 over NPRM options can be calculated by subtracting L4 and L3/L2 columns. $L2-L4 = 4970-4892 + 145-87 = 136$ years; $L3-L4 = 5101-4892 + 254-132 = 331$ years. At \$12,000/staff year this totals about \$1.6 million and \$4 million, respectively.

Alternatives to Administering Lower Levels of Compliance

In view of the high estimated cost of administering Section 124.504 as proposed in the NPRM, alternative approaches were considered. One approach involved eliminating the proposed annual compliance requirement in favor of a system in which obligated facilities carry a balance of uncompensated care outstanding which they eliminate over a period of years as demand and/or financial circumstances permit.

In the proposed system, a facility would begin with a balance of uncompensated care owed the public equal to the sum of its annual uncompensated care liability over the remaining years of its obligations. Each year, the amount of uncompensated care provided would be deducted from the balance. If the amount provided in a year were less (or more) than the 10% option called for, the

difference, inflated by the current year's rate of inflation, would be added to (or deducted from) the facilities balance due. The balance due will also be inflated each year by the current rate of inflation before being carried forward to each succeeding year (for an example, see Table 7).

In this way, each facility is obligated to provide an amount equal to its remaining uncompensated care obligation, valued in 1980 dollars, over a period of years depending on the community's need and the institution's financial condition. The fact that the period of the payout is optional will negate the need for institutions applying for waivers and thus eliminate the large administrative burden depicted in Table 3 and summarized in Table 6 in the first row. Under this option, administrative costs of investigating and mediating complaints may be increased by a modest amount above that estimated in Table 5.

instead of municipal or county charity hospitals. Non Hill-Burton hospitals may reduce their charity load. Thus, the burden on some hospitals will decrease and on others increase. In the particular case of municipal hospitals, some costs will be shifted from the city taxpayer to private sources and, in some cases, the suburban taxpayer.

Much of the effect on charity hospitals (many of which are among the largest recipients of Hill-Burton funds) will be a wash. These hospitals will recategorize their existing patients, and the local public budget will still pay the costs.

Medicare and Medicaid, which together pay on average about 40% of all hospital charges, do not reimburse for "unrelated" costs such as free care or bad debts. Unless current policy is changed, Medicare and Medicaid will not be an offsetting source of funds.

Most of the redistribution will involve a shift to increased charges to (a) non-poor uninsured private persons (a small population), (b) privately insured persons (e.g., Blue Cross), and (c) philanthropy.

Table 7.—Calculating Accounts (Alternative to Lower Level of Compliance)*

Year:	Inflation rate (percent)	FAB ¹	UCL ²	UCD ³	Account ⁴	Payoff at beginning of year ⁵
1980	10	\$1,000,000	\$100,000	\$90,000	\$-10,000	\$2,000,000
1981	10	1,100,000	110,000	90,000	-20,000-11,000	2,090,000
1982	10	1,210,000	121,000	90,000	-31,000-34,100	2,178,000
1983	10	1,331,000	133,100	193,100	+60,000-71,610	2,262,700
1984	10	1,464,100	146,410	176,410	+30,000-12,771	2,342,560

¹FAB—Federal Assistance Base increases annually by inflation rate.

²UCL—Uncompensated Care Liability computed as 10% of current FAB.

³UCD—Uncompensated Care Delivered during current year * * * may be more or less than UCL.

⁴Account—Difference between UCD and UCL plus last year account balance increased by this year's inflation rate. For example, in 1981, UCD fell short of UCL by 20,000; 1980's (last year) account balance was 10,000 which was inflated by 10% to 11,000. In 1982, UCD fell short of UCL by 31,000; 1981's account balance was 31,000 which was inflated by 10% to 34,100.

⁵Payoff—Present value of UCL summed over the remaining life of the loan. Because future UCL is rising by the inflation rate, and because we use the inflation rate to discount future dollars of UCL to the present, the Payoff is equal to the current year's UCL times the remaining years in the life of the obligation. For example, if in 1980, the loan obligation had 20 years to go, the payoff at the beginning of 1980 is $20 \times 100,000$, or 2,000,000. Similarly, the payoff in 1982 is $18 \times 121,000$, or 2,178,000. Taken another way, the payoff is always equal to the inflated difference between the previous year's payoff, less the previous year's UCL. For example, the 1981 payoff equals 2,000,000 less 100,000, or 190,000, inflated by 10% to 2,090,000. Similarly in 1983, the payoff is 2,178,000 less 121,000 or 2,057,000, times 1.10, or 2,262,700.

⁶Obligation—If an institution delivered an amount of care equal to this year's payoff less last year's account balance, their obligation would be satisfied. Thus, any time this year's payoff less last year's account balance goes to zero or below, their obligation is satisfied.

Distributional Effects

The service costs imposed by the proposed regulation are not necessarily additional "real" costs, as ordinarily defined in economic theory. To a substantial degree (probably well over half),⁶ these services will go to persons who would otherwise be served, either on a fee basis or in charity hospitals. As a result, the proposed regulation will affect the incidence of health care financing. The following effects are likely to be significant:

Under a rigorous enforcement scheme, hospitals will have incentives to identify as free care patients some persons who

otherwise would have been required to pay from own sources. Income redistribution from other sources (see below) to the poor will occur.

Some patients will utilize Hill-Burton facilities (or different Hill-Burton facilities)

⁶If one assumed that all persons who require hospitalization already received it, the effects would be completely redistributive. However, there are persons refused admission on the basis of inability to pay, who fail to request admission because of inability to pay, who are sent home early when a longer stay is medically indicated, etc. While these phenomena are undoubtedly small in the population as a whole, they are likely to be significant in the populations most affected by Hill-Burton—e.g., poor, male headed families (in some states), poor singles, and the uninsured near poor.

Appendix A

Table A1.—Federal Assistance Plan

	Obligated Facilities as of 1979	Estimated Federal obligations (millions)
Grand total	5,392	\$4,040.1
Grants	5,284	
Title VI		3,275.1
Title XVI		51.0
Loans: Interest subsidies	106	1,573.0
Federal supplements	(?)	
D.C. Const. Act:		
Grants		31.3
Interest subsidies	(?)	
Accel. Pub. Works		15.8
Appalachia:		
Sec. 214		93.9
Sec. 202		(?)
Other regional commissions (coastal plain, etc.)		(?)

¹Estimated as 43% of loan principal over average maturity of 23.5 years.

²368 facilities now receive interest subsidies, but 260 of these also have grants and are thus included in the total of 5,284 above.

³Estimate not yet available.

Table A2.—National UCL for 3-Percent Option

[In billions of dollars, except as noted]

Year: ¹	Operating costs all hospitals ²	Less 40 percent for medicare medicaid reimbursements	Obligated hospitals as percent of all hospitals ³	Adjusted costs: 3 percent UCL for obligated hospitals	Obligated hospitals	Estimated ⁴ for all institutions
1980	\$60.0	\$36.0	59.8	\$21.5	0.645	0.777
1981	67.2	40.3	58.4	23.5	0.705	0.849
1982	74.2	44.5	56.0	24.9	0.747	0.900
1983	81.5	48.9	53.0	25.9	0.777	0.936
1984	89.5	53.7	40.4	27.1	0.813	0.980

¹Figures in the table are from previous year except in last column.

²HEW estimates but similar to AHA estimates for non-Federal short-term general and other special hospitals.

³Entries in this column are the totals from Table A5 divided by 5973, the number of non-Federal short-term general and other specified hospitals, as reported by AHA for 1977.

⁴83% of all Title VI grants went to these inpatient facilities; thus adjust by dividing previous column by 0.83. The accuracy of this adjustment depends to the extent that operating costs at institutions other than hospitals maintain similar relations as those represented in these columns for hospitals.

Table A3.—Expiration of 20 Year Period

Year:	No. of institutions	Title VI grant funds
1979.....	198	39,572,421
1980.....	215	53,034,788
1981.....	291	77,832,317
1982.....	245	80,785,144
1983.....	279	93,695,120

Table A4.—Interest Subsidy Payments ¹

[In millions of dollars]

	Annual	Cumulative
73-78.....	95.6	95.6
79.....	34.3	129.9
80.....	42.9	172.8
81.....	30.8	203.6
82.....	28.3	231.9
83.....	26.1	258.0
84.....	23.9	261.6

¹ Includes interest subsidies paid during construction periods only for years 1973 through 1980. Remaining paragraphs are estimated from amortization schedules effective after construction. However, after 1980, very few projects are expected to be in construction.

Table A5.—Annual Number of Obligated Institutions

	Total	Inpatient	Nursing home
1979.....	5,392	3,572	462
1980.....	5,194	3,490	445
1981.....	4,979	3,342	431
1982.....	4,688	3,166	418
1983.....	4,443	3,010	398
1984.....	4,184	2,823	377
Grand total.....	28,860		
Average.....	4,810		

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