

Financial Management Service*OMB Number:* 1510-0018*Form Number:* 1133 'C'*Type of Review:* Extension*Title:* Claim Against the United States
for the Proceeds of Government Check
or Checks

Description: This form is sent to payees when an original check and its substitute issued in lieu thereof, have been negotiated bearing dissimilar endorsements. Adjudication Division must get a statement from the payee that they did not cash both checks. Adjudication Division may then take steps to collect the overpayment.

Respondents: Individuals or households*Estimated Burden:* 290 hours

Clearance Officer: Hector Leyva, (301) 436-5300, Financial Management Service, Room 100, 3700 East West Highway, Hyattsville, MD 20782.

OMB Reviewer: Milo Sunderhauf, (202) 395-6880, Office of Management and Budget, Room 3208, New Executive Office Building, Washington, DC 20503.

*Dale A. Morgan,**Departmental Reports Management Officer.*

[FR Doc. 87-27732 Filed 12-2-87; 8:45 am]

BILLING CODE 4810-25-M

Office of the Secretary**[Supplement to Department Circular—
Public Debt Series—No. 34-87]****Treasury Notes, Series J-1993**

Washington, November 25, 1987.

The Secretary announced on November 24, 1987, that the interest rate on the notes designated Series J-1993, described in Department Circular—Public Debt Series—No. 34-87 dated November 18, 1987, will be 8¼ percent. Interest on the notes will be payable at the rate of 8¼ percent per annum.

Gerald Murphy,*Fiscal Assistant Secretary.*

[FR Doc. 87-27785 Filed 12-2-87; 8:45 am]

BILLING CODE 4810-40-M

UNITED STATES INFORMATION AGENCY**Initiation of a New Project in Cote
D'Ivoire Sponsored by a Special
African Programming Initiative;
Teacher, Text, Technology (TTT)**

The Bureau of Educational and Cultural Affairs of the United States Information Agency plans to award a grant to a U.S. academic institution of higher education for the purpose of

assisting in the development of secondary school English teachers in Cote D'Ivoire. The grantee will work with the Ministry of Education's English Teaching Division in its efforts to develop academic staff and strengthen its English teaching capabilities.

The program will be a component of the Agency's Teacher-Text-Technology (TTT) Initiative which is an element of the Fulbright Exchange Program. TTT is designed to upgrade secondary education and related teacher training in English, math, science and other fields.

Proposals will be reviewed consistent with Bureau guidelines. A twelve-month grant will be awarded on or about May 1, 1988. Deadline for receipt of proposals is COB January 15, 1988. For details, interested institutions should contact the Agency's Cote D'Ivoire TTT Coordinator, John Niland, E/AEA—Room 234, U.S. Information Agency, 301 Fourth Street SW., Washington, DC 20547. Telephone: (202) 485-7357.

Dated: November 19, 1987.

Mark Blitz,*Associate Director, Bureau of Educational
and Cultural Affairs.*

[FR Doc. 87-27715 Filed 12-2-87; 8:45 am]

BILLING CODE 8230-01-M

Sunshine Act Meetings

Federal Register

Vol. 52, No. 232

Thursday, December 3, 1987

This section of the FEDERAL REGISTER contains notices of meetings published under the "Government in the Sunshine Act" (Pub. L. 94-409) 5 U.S.C. 552b(e)(3).

COMMISSION ON CIVIL RIGHTS

December 1, 1987.

PLACE: 1121 Vermont Avenue NW., Room 512, Washington, DC 20425.

DATE AND TIME: Friday, December 11, 1987, 9:00 a.m.—5:00 p.m.

STATUS OF MEETING: Open to the public.

MATTERS TO BE CONSIDERED:

- I. Approval of Agenda
- II. Approval of Minutes of Last Meeting
- III. Panels: Employer Sanctions, Discrimination and Implementation of the Immigration Reform and Control Act of 1986
- IV. Project Proposals
- V. SAC Rechartered
- VI. Presentations by SAC Chairs
- VII. Staff Director's Report
 - A. Status of Earmarks
 - B. Personnel Report
 - C. Activity Report

PERSON TO CONTACT FOR FURTHER

INFORMATION: John Eastman, Press and Communications Division (202) 376-8105.

William H. Gillers,
Solicitor.

[FR Doc. 87-27861 Filed 12-1-87; 1:23 pm]

BILLING CODE 6335-01-M

COMMODITY FUTURES TRADING COMMISSION

TIME AND DATE: 10:00 a.m., December 8, 1987.

PLACE: 2033 K Street NW., Washington, DC, 5th Floor Hearing Room.

STATUS: Open.

MATTERS TO BE CONSIDERED:

Off-Exchange Issues—Advanced Notice of Proposed Rulemaking
Application of the New York Mercantile Exchange for designation as a contract market in options on N.Y. Harbor Unleaded Gasoline Futures

CONTACT PERSON FOR MORE

INFORMATION: Jean A. Webb, 254-6314.

Jean A. Webb,
Secretary of the Commission.

[FR Doc. 87-27806 Filed 12-1-87; 9:20 am]

BILLING CODE 6351-01-M

COMMODITY FUTURES TRADING COMMISSION

TIME AND DATE: 10:00 a.m., December 22, 1987.

PLACE: 2033 K Street, NW., Washington, DC, 5th Floor Hearing Room.

STATUS: Open.

MATTERS TO BE CONSIDERED:

Rule 1.59—final rules

CONTACT PERSON FOR MORE

INFORMATION: Jean A. Webb, 254-6314.

Jean A. Webb,
Secretary of the Commission.

[FR Doc. 87-27807 Filed 12-1-87; 9:20 am]

BILLING CODE 6351-01-M

FEDERAL ELECTION COMMISSION

DATE AND TIME: Tuesday, December 8, 1987, 10:00 a.m.

PLACE: 999 E Street, NW., Washington, DC.

STATUS: This meeting will be closed to the public.

ITEMS TO BE DISCUSSED:

Compliance matters pursuant to 2 U.S.C. 437g.

Audits conducted pursuant to 2 U.S.C. 437g, 438(b), and Title 26, U.S.C.

Matters concerning participation in civil actions or proceedings or arbitration. Internal personnel rules and procedures or matters affecting a particular employee.

The open meeting of Thursday, December 10, 1987, has been cancelled.

PERSON TO CONTACT FOR INFORMATION:

Mr. Fred Eiland, Information Officer,
Telephone: 202-376-3155.

Marjorie W. Emmons,
Secretary of the Commission.

[FR Doc. 87-27874 Filed 12-1-87; 3:12 pm]

BILLING CODE 6715-01-M

FEDERAL MARITIME COMMISSION

DATE AND TIME: 10:00 a.m.—December 8, 1987.

PLACE: Hearing Room One—1100 L Street, NW., Washington, DC. 20573.

STATUS: Open.

MATTERS TO BE CONSIDERED:

1. Docket No. 85-19—Tariff Publication of Free Time and Detention Charges Applicable to Carrier Equipment Interchanged with Shippers and Their Agents—Consideration of the Record.

2. Docket No. 86-16—Conference Service Contract Authority—Consideration of Comments.

3. Petition of Bi-State Harbor Carriers Conference of the New Jersey Motor Truck Association for Institution of Investigation and Rulemaking Regarding Payment of Inland Divisions.

CONTACT PERSON FOR MORE

INFORMATION: Joseph C. Polking,
Secretary (202) 524-5725.

Joseph C. Polking,
Secretary.

[FR Doc. 87-27873 Filed 12-1-87; 3:12 pm]

BILLING CODE 6730-01-M

Corrections

Federal Register

Vol. 52, No. 232

Thursday, December 3, 1987

This section of the FEDERAL REGISTER contains editorial corrections of previously published Presidential, Rule, Proposed Rule, and Notice documents and volumes of the Code of Federal Regulations. These corrections are prepared by the Office of the Federal Register. Agency prepared corrections are issued as signed documents and appear in the appropriate document categories elsewhere in the issue.

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 180

[PP 4F3070/R922; FRL-3288-5]

Pesticide Tolerance for Fluazifop-Butyl

Correction

In rule document 87-25732 beginning on page 42651 in the issue of Friday, November 6, 1987, make the following corrections:

1. On page 42651, in the third column, in the **SUMMARY**, in the second line, "or" should read "of".

2. On page 42652, in the first column, in the 16th line, capital "P" should be lower cased.

3. On the same page, in the same column, in paragraph number 4., in the first line, the first word should read "A".

4. On the same page, in the same column, in paragraph number 8., in the first line, "rate" should read "rat"; and in the second line, "(mg/kg/" should read "4 mg/kg/".

5. On the same page, in the same column, in paragraph number 12., in the first line, "rate" should read "rat".

6. On the same page, in the second column, in the fifth paragraph, in the fifth line, "director" should read "detector".

7. On the same page, in the same column, in the last paragraph, in the third line, "State." should read "Stat.".

BILLING CODE 1505-01-D

ENVIRONMENTAL PROTECTION AGENCY

[OPTS-140090; FRL-3293-5]

Access to Confidential Business Information by Unisys Corp.

Correction

In notice document 87-26883 appearing on page 44633 in the issue of Friday, November 20, 1987, make the following corrections:

1. In the second column, in the second complete paragraph, in the third line, "69-01-7437," should read "68-01-7437,".

2. In the same column, in the third complete paragraph, in the first line, "EAP" should read "EPA".

BILLING CODE 1505-01-D

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

50 CFR Part 14

Humane and Healthful Transport of Wild Mammals and Birds to the United States

Correction

In rule document 87-25931 beginning on page 43274 in the issue of Tuesday, November 10, 1987, make the following corrections:

1. On page 43274, in the second column, in the third complete paragraph, in the 17th line, "of CITES" should read "to CITES".

2. On the same page, in the third column, in the second complete paragraph, in the sixth line, "representative" should read "representatives".

3. On page 43276, in the first column, in the fourth complete paragraph, in the 13th line, "system" should read "systems".

4. On the same page, in the third column, in the third complete paragraph, in the first line, "require a" should read "require that a".

5. On page 43278, in the first column, in the first paragraph, in the second line from the bottom, "domestic" was misspelled.

§ 14.103 [Corrected]

6. On page 43279, in the second column, in § 14.103, in the third line, "not" should read "met".

§ 14.105 [Corrected]

7. On page 43279, in the second column, in § 14.105(a), in the second line, "animals" should read "mammals".

BILLING CODE 1505-01-D

NATIONAL ARCHIVES AND RECORDS ADMINISTRATION

Records Schedules; Availability

Correction

In notice document 87-26523 appearing on page 44237 in the issue of Wednesday, November 18, 1987, make the following correction:

In the first column, under **DATE**, in the third line, the date for requesting copies should read "January 4, 1988."

BILLING CODE 1505-01-D

SUNSHINE ACTIVITY

J. A. A. 1970

J. A. A. 1970

The first part of the paper is devoted to a description of the data used in the analysis. The data are divided into two groups: (1) data from the period 1950-1959, and (2) data from the period 1960-1969.

The second part of the paper is devoted to a description of the results of the analysis. The results are divided into two groups: (1) results from the period 1950-1959, and (2) results from the period 1960-1969.

The third part of the paper is devoted to a description of the conclusions of the analysis. The conclusions are divided into two groups: (1) conclusions from the period 1950-1959, and (2) conclusions from the period 1960-1969.

The fourth part of the paper is devoted to a description of the discussion of the results. The discussion is divided into two groups: (1) discussion from the period 1950-1959, and (2) discussion from the period 1960-1969.

The fifth part of the paper is devoted to a description of the summary of the results. The summary is divided into two groups: (1) summary from the period 1950-1959, and (2) summary from the period 1960-1969.

The sixth part of the paper is devoted to a description of the references. The references are divided into two groups: (1) references from the period 1950-1959, and (2) references from the period 1960-1969.

The seventh part of the paper is devoted to a description of the appendix. The appendix is divided into two groups: (1) appendix from the period 1950-1959, and (2) appendix from the period 1960-1969.

The eighth part of the paper is devoted to a description of the index. The index is divided into two groups: (1) index from the period 1950-1959, and (2) index from the period 1960-1969.

The ninth part of the paper is devoted to a description of the bibliography. The bibliography is divided into two groups: (1) bibliography from the period 1950-1959, and (2) bibliography from the period 1960-1969.

The tenth part of the paper is devoted to a description of the conclusion. The conclusion is divided into two groups: (1) conclusion from the period 1950-1959, and (2) conclusion from the period 1960-1969.

The eleventh part of the paper is devoted to a description of the appendix. The appendix is divided into two groups: (1) appendix from the period 1950-1959, and (2) appendix from the period 1960-1969.

The twelfth part of the paper is devoted to a description of the index. The index is divided into two groups: (1) index from the period 1950-1959, and (2) index from the period 1960-1969.

The thirteenth part of the paper is devoted to a description of the bibliography. The bibliography is divided into two groups: (1) bibliography from the period 1950-1959, and (2) bibliography from the period 1960-1969.

The fourteenth part of the paper is devoted to a description of the conclusion. The conclusion is divided into two groups: (1) conclusion from the period 1950-1959, and (2) conclusion from the period 1960-1969.

The fifteenth part of the paper is devoted to a description of the appendix. The appendix is divided into two groups: (1) appendix from the period 1950-1959, and (2) appendix from the period 1960-1969.

Connections

The sixteenth part of the paper is devoted to a description of the appendix. The appendix is divided into two groups: (1) appendix from the period 1950-1959, and (2) appendix from the period 1960-1969.

Thursday
December 3, 1987

Part II

**Department of
Health and Human
Services**

Public Health Service

**42 CFR Part 124
Medical Facility Construction and
Modernization; Requirements for
Provision of Services to Persons Unable
To Pay; Final Rule**

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service

42 CFR Part 124

Medical Facility Construction and Modernization; Requirements for Provision of Services to Persons Unable To Pay

AGENCY: Public Health Service, HHS.

ACTION: Final rule.

SUMMARY: The final rule below amends the existing regulations governing how certain public and private nonprofit health care facilities assisted under Titles VI and XVI of the Public Health Service (PHS) Act may fulfill the assurance, given in their application for assistance, that they would provide a reasonable volume of services to persons unable to pay. This final rule enhances the interest of the intended beneficiaries of the assurance by: (1) Increasing facility incentives for compliance by reducing administrative burdens; and (2) permitting facilities to receive credit for substantial compliance, thus enabling the Department to focus its enforcement resources on facilities which are not in substantial compliance.

DATE: These regulations are effective February 1, 1988, except for §§ 124.509(c), 124.514(c), 124.515(b)(2)(ii), and 124.515(b)(3)(ii)(B). For additional information concerning this effective date, see the discussion of the Information Collection Requirements below.

ADDRESS: Richard R. Ashbaugh, Assistant Surgeon General, Associate Director for Health Facilities, Bureau of Resources Development, 5600 Fishers Lane, Room 11-03, Rockville, Maryland, 20857, Att'n: Martin J. Frankel.

FOR FURTHER INFORMATION CONTACT: Martin J. Frankel, 301 443-5656.

SUPPLEMENTARY INFORMATION: On August 29, 1986, the Secretary of Health and Human Services proposed amendments to the rules governing what is popularly known as the Hill-Burton Uncompensated Services Program. 51 FR 31000. Health care facilities covered by the program received construction assistance under two titles of the PHS Act—Title VI (the "Hill-Burton Act," 42 U.S.C. 291, *et seq.*) and Title XVI (42 U.S.C. 300q, *et seq.*). As a condition of such assistance, facilities assisted under Title VI were required to give what is now known as the "uncompensated services" assurance. Under section 603(e) of the Act (42 U.S.C. 291c(e)), the

Secretary was authorized to issue regulations requiring assurance that—there will be 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.¹

Regulations requiring the assurance were issued shortly after enactment of Title VI in 1946. *See*, 12 FR 6176 (September 16, 1947). This initial regulatory standard for compliance with the assurance was general. Beginning in 1972, however, a series of regulatory and statutory developments occurred which culminated in the detailed requirements of the present regulations, which were issued in 1979. The objective of the amendments below is to simplify and increase the flexibility of the regulations, while increasing the incentives for compliance. Because the significance of the amendments can be understood only in the context of the requirements of the 1979 regulations, the pertinent sections of the 1979 regulations are summarized below, followed by a discussion of the public comments on the proposed rule and the Department's response thereto.

I. Summary of the 1979 Regulations

Following extensive public comment, in 1979 the Secretary issued the rules which are codified at 42 CFR Part 124, Subpart F. 44 FR 29372 (May 18, 1979). These regulations established a fixed dollar annual compliance standard—the lesser of 3% of the facility's operating costs (less Medicare and Medicaid reimbursement) or 10% of the Federal financial assistance it received. 42 CFR 124.503(a). A facility that did not meet its annual quota was required to make up the deficit in the amount of uncompensated services provided in later years. 42 CFR 124.503(b). In addition, the facility was required to institute an affirmative action plan designed to prevent recurrence of the deficit. 42 CFR 124.504. A facility could also get credit for "excess"—that is, uncompensated services provided over

and above its annual quota—and credit that excess against its quota in a future year. 42 CFR 124.503(c). The 10% compliance level, and the deficits and excesses, were required to be adjusted by a factor that reflects inflation, the so-called "inflation factor." 42 CFR 124.503(d). In each case, however, the facility could only count a portion of the cost of the service provided toward the quota, the so-called "allowable credit." 42 CFR 124.502. Facilities were required to exclude third party payments (including payments from Medicare and Medicaid) from the quota, and also could not count towards the quota the differential between the amount of third party reimbursement and allowable credit where required by the third party program to accept the reimbursement as payment in full for service. In addition, the regulations provided that services disallowed as unnecessary by a Professional Standards Review Organization (PSRO) must also be excluded. 42 CFR 124.509.

The 1979 regulations established national eligibility criteria, based on the poverty income guidelines presently issued by the Department. 42 CFR 124.506. The criteria considered only income, not assets, and a mandatory procedure for calculating income was provided. *Id.* Facilities were given limited discretion to decide how to allocate their quota of uncompensated services among eligible persons. 42 CFR 124.507. Facilities could credit services toward their quota only if they made an eligibility determination within two working days of a request for uncompensated services and met certain other requirements. 42 CFR 124.508.

The 1979 regulations contained explicit requirements for notice, including that written notice be given to each person seeking service in the facility. 42 CFR 124.505(d). In addition, facilities were required to publish and post notices and under certain circumstances to provide notice to the local health systems agency (HSA). 42 CFR 124.505. The regulations contained a number of reporting and recordkeeping requirements. 42 CFR 124.510.

On September 18, 1986, the Department issued final rules amending Subpart F to establish a compliance alternative for certain publicly-owned facilities. 51 FR 33208. The provisions of the September 18, 1986, rule have been incorporated, with a few minor editorial changes, in the rules below.

¹ The assurance required by statute of title XVI assisted facilities, of which there are only 38, was as follows:

" * * * reasonable assurance that at all times after such application (for Title XVI assistance) is approved * * * (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 1621(b)(1)(K), 42 U.S.C. 300s-1 (b)(1)(K), as redesignated by Pub. L. 96-79.

II. Background and Summary of Public Comments and Policies of the Final Rule

A. Proposed Rule

The basic objective of the 1979 regulations was to assure that recipients of Titles VI and XVI funds who gave the uncompensated services assurance provide services free or below cost to persons who cannot afford to pay for them within the context of sound planning for and management of the delivery of health care services. The proposed rules retained the basic policies of the 1979 rules, but refined some provisions in order to lessen the administrative burden of compliance for facilities, while increasing the incentive for compliance by facilities in order to protect the interests of the intended beneficiaries of the assurance. The proposed rules thus sought to establish balance among the basic principles inherent in the proper operation of an uncompensated services program: (1) The provision of a "reasonable volume" of free or below cost health services to eligible persons; (2) the provision of reasonable and equal opportunity to such persons to apply for and receive those services; and (3) the documentation by facilities that a "reasonable volume" of services and opportunity to apply were provided.

The 1979 regulations relied on strict adherence to the procedural requirements to establish whether or not each patient's uncompensated services account is creditable toward a facility's obligation. They provided no basis for obtaining credit on other grounds, such as a facility's substantial compliance with the three basic principles above. This skewed the incentive for compliance toward some regulatory requirements and away from others. It also consumed the Department's limited resources in account-by-account audits of individual facilities, lessening its ability to monitor the universe of Hill-Burton facilities for systemic problems of compliance.

The proposed rules addressed this problem by eliminating or relaxing a number of the more technical requirements of the 1979 rule, such as the requirements relating to publication of allocation plans, timing of determinations, timing of deficit make-up, and reporting and recordkeeping. In addition, they departed from the account-based approach of the current rules as the benchmark of compliance. Instead, under the proposed rules, a facility in substantial compliance with the requirements necessary for the proper operation of an uncompensated services program would be given credit for its compliance, while a facility

showing a pattern of substantial noncompliance with major substantive provisions of the rule would be subject to receiving no credit for the period in which noncompliance was found. *See*, proposed § 124.511(b)(1) and § 124.512(c). A certification of substantial compliance would be based on procedures determined by the Secretary to be sufficient to establish compliance, including examination of the systems that facilities put in place to comply with the notice, recordkeeping and determination of eligibility requirements, as well as their compliance with the reporting requirements. The proposed rules also restructured and simplified the regulatory language of the 1979 rules in certain respects in order to help achieve compliance by facilities through promoting a better understanding of the regulatory requirements. *See*, for example, proposed § 124.505(a)(1) (relating to eligibility criteria), § 124.507(a) and (b) (relating to eligibility determinations), § 124.503(b) (relating to deficits), and § 124.508 (relating to cessation of uncompensated services).

The proposed rules also proposed a more flexible compliance standard for facilities with small (\$10,000 or less) annual compliance obligations and which routinely provide free or below cost services to persons determined by the facility, under a program based on objective criteria, to be unable to pay for them. Facilities that qualify would be eligible for certification by the Secretary, pursuant to which they would be required only to comply with the requirements of the program of discounted services upon which the certification was based, along with ancillary reporting and recordkeeping requirements, as long as the certification was in effect. *See*, proposed § 124.514. In addition, it was proposed to exempt certain federally funded centers that are required by Federal law to provide free and below cost services, from the procedural requirements of the rules. *See* proposed § 124.503(d). Finally, a method of determining credit for facilities whose compliance had not been previously completely assessed prior to the effective date of the new rules was proposed. *See*, proposed § 124.511(b)(1)(ii).

B. Public Comments and the Department's Responses

The Department received 80 public comments on the proposed rules from health care facilities, legal services organizations, consumer groups, State officials and consumers. About 60% of these supported the proposed rules. The substantive concerns raised in the

public comments, and the Department's responses to the comments are set out below.

1. Qualifying Services

Proposed § 124.503(a)(2) established criteria, implicit in the 1979 regulations, for services that qualify as uncompensated services. This section elicited no substantive comment. In light of the revisions relating to the standards for substantial compliance and substantial noncompliance, discussed in section 11 below, proposed § 124.503(a)(2) has been deleted as unnecessary. For the same reason, the reference in proposed § 124.502(l)(1) to the determination of the amount of uncompensated services has been deleted. *See*, § 124.511(b) and § 124.512(c).

2. Deficits

The proposed rules made explicit the dichotomy present in the 1979 rules between types of deficits; in the proposed rules, they were termed "justifiable deficits" and "noncompliance deficits". *See*, proposed § 124.503(b)(1). While the proposed rules continued the policy that justifiable deficits could be made up at any time during or immediately following the facility's period of obligation (*see*, proposed § 124.503(b)(2)(i)), they provided that make-up of noncompliance deficits had to begin immediately. However, in contrast to the 1979 rules (which provided that the deficit must be made up in the next year, if the facility is financially able to do so), the proposed rules provided for spreading make-up of the deficit amount over the remaining period of obligation.

The main criticism of this section was that it permitted make-up of deficits to be postponed indefinitely; the commenters argued that the policies of the 1979 rules should be retained, as there is an immediate need for uncompensated services. Several nursing home organizations argued that the proposed rules did nothing to alleviate what they termed the problem of "compounding deficits." A State agency argued that the deficit calculation should be simplified so that a provider could do it, while a public interest group questioned whether failure to read the providers' manual constituted "justifiable" noncompliance.

The Department has revised the affirmative action plan requirement to provide for accelerated make-up where the facility fails to comply with that requirement. *See*, § 124.503(b)(4) below. Otherwise, the final rule remains as proposed. The comments criticizing the

proposed rule as permitting indefinite postponement of the deficit make-up mischaracterize both the 1979 and the proposed rules. The proposed rule was identical to the 1979 rules with respect to justifiable deficits. Compare, § 124.503(b)(1) of the 1979 rules and proposed § 124.503(b)(2)(i). Nor does the final rule permit indefinite postponement of deficit make-up; to the contrary, deficit make-up must begin immediately. See, § 124.503(b)(2)(ii) below. Under § 124.503(b)(4) below, a facility that incurs a deficit is required to institute an affirmative action plan designed to enable it to meet its annual compliance level which, under § 124.503(b)(3)(iii), includes a portion of the deficit. Thus, the affirmative action plan requirement further promotes the make-up of noncompliance deficits, as does the change to § 124.503(b)(4) providing for the potential for accelerated make-up where there is a failure to comply with the plan requirement. With respect to the remaining comments, the Department believes that the changes elsewhere in the rule should help nursing homes avoid deficits. We disagree with the comment regarding the need to simplify calculation of the deficit make-up, as the calculation of the deficit under § 124.503(b)(3) requires only one additional, simple arithmetic calculation compared to the 1979 rules. Finally, what constitutes a "justifiable deficit" is made clear by § 124.503(b)(1)(i), which also clarifies that a deficit due to failure to follow the applicable procedures is not justifiable.

3. Excesses

The proposed rules proposed a new method for calculating the amount of excess (*i.e.*, uncompensated services in excess of a facility's annual compliance level) a facility needs to "buy out" of its uncompensated services obligation. The buy out formula proposed sought to remedy two anomalies that had become apparent under the buy out formula of the 1979 rules. First, it proposed that a three-year average of a facility's annual compliance levels constitute the basis of the formula, to remedy the problem occasioned by abnormal swings in compliance levels due to unusually large Medicaid or Medicare reimbursements in a particular year. See, proposed § 124.503(c)(3)(i). Second, it was proposed to change the formula for recipients of loan assistance to take into account subsidies received after the buy out year. See, proposed § 124.503(c)(3)(ii). In addition, it was proposed to require that any claims of excess over 100% of a facility's annual compliance level be substantiated by an

independent audit. See, proposed § 124.503(c)(4).

The proposed changes to the buy out formula received little comment, with one legal services organization commending it and a hospital criticizing it on the ground that it penalized facilities with multiple grants where the 20-year period of one or more grants had recently expired. The proposed independent audit requirement, however, received extensive comment. In general, facilities claimed that it was an unfair and costly requirement, with no logical basis. Consumer groups, on the other hand, argued that the requirement should be extended to the entire claim of excess, on the ground that facilities usually overstate their excess.

The Department agrees with the comment relating to the multiple grant situation, and has revised the buy out provisions in the Final Rule. It establishes a buy out formula pegged to the number of years remaining under obligation for each grant. See, § 124.503(c)(3)(i)(A) below. Further, the buy out section has been reorganized to accommodate this change. The buy out formulas retain the differentiation between grant and loan assistance, as in the proposed rule, but are now limited to the method of calculating the annual compliance level in the buy out year. This linkage is similar to that in the existing rule, except that the buy out formula which is linked to the three percent method in the rule below provides for using a three-year average. See § 124.503(c)(3)(ii) below. This provision parallels the proposed rule. The Department has also excepted facilities certified under §§ 124.513, 124.514, and 124.515 from the provisions relating to excess. In the Department's view, an early buy out should be available only under the conditions of the main regulations.

The Department has deleted the proposed requirement for an independent audit for claims of excess. The Department's new assessment approach, described more fully below, will be applied to such claims, which makes the proposed requirement unnecessary. This resolution of the issue also responds to the consumer concern that the entire claim of excess should be audited.

4. Notices

The proposed rules proposed to continue the notice requirements of the 1979 rules with only minor changes. The requirement that health systems agencies (HSAs) be notified was deleted, in light of the phasing out of such agencies in many areas. (Since

publication of the proposed rules, Title XV of the PHS Act has in fact been repealed.) The requirement that notice of the facility's allocation plan be published 60 days prior to its fiscal year was modified to require publication at any time before the beginning of the fiscal year. See, proposed § 124.504(a). Similarly, proposed § 124.506(c) permitted revision of a facility's allocation plan effective upon publication. Finally, the individual written notice requirement was modified to be consistent with the proposed changes to the eligibility determination requirements. See, proposed § 124.504(c)(1)(iv).

A couple of facilities objected to the individual written notice requirement as burdensome, one suggesting that the notice should be distributed only to persons claiming to be no-pay or self-pay. A nursing home argued that it was futile, since their uncompensated services are committed on the first day of the fiscal year. The majority of the comments on the notice provision, however, objected to the elimination of the requirement that facilities publish notice 60 days prior to the beginning of their fiscal year. In general, the commenters argued that this change deprived them of an opportunity to comment, since the plan (and any revisions) was effective upon publication. To remedy this problem, a couple of commenters suggested that the plans have a delayed effective date. Other commenters objected to the proposed rule on the ground that it would require them to search the legal notices section every day, which they claimed was impractical.

The Department agrees that the commenters have raised a valid concern regarding the elimination of the 60-day notice requirement. It has accordingly accepted the suggestion for a delay in effective date as the most reasonable means of accommodating both the consumers groups' need for the opportunity to comment on allocation plans and the facilities' need for flexibility in issuing and revising them. Thus, the publication requirements in § 124.506 have been revised to provide that allocation plans (initial and revised) may not become effective until at least 60 days following publication. See, § 124.506 (a)(2), (b)(2) and (c). It should be noted that the publication requirement has been changed slightly ("no earlier than") from the requirement in the 1979 regulations. The purpose of this is to give facilities flexibility to publish more than 60 days in advance of a fiscal year or other date and still have a new plan effective on the date

specified. The Department disagrees that such a requirement imposes an unfair burden on consumer groups to check the newspaper. Such an effect is minimal and in any event does not outweigh facilities' need for flexibility in the publication requirements, which has been demonstrated in many assessments. Moreover, the consumer groups' assertion of increased burden derives from a misunderstanding of the 1979 rules; under the 1979 rules, there is no date certain for publication of the allocation plan, as the present 60-day requirement is simply a minimum.

The Department has not accepted the comments urging restriction of the individual written notice requirements. Restricting provision of the individual written notice to only those persons who declared themselves to be self-pay or no-pay would leave uninformed persons who might later become eligible due to an intervening change in circumstances. Nor does the fact that the notice requirement may be inappropriate for one or a few nursing homes made it inappropriate for the universe of regulated facilities. Thus, the individual written notice provision remains as proposed. *See*, § 124.504(c) below.

5. Eligibility Criteria

The proposed rules proposed to revise the eligibility criteria to clarify that the existence of third party coverage for medical services eliminates eligibility for uncompensated services. *See*, proposed § 124.505(a)(1). This policy is consistent with longstanding practice and the Federal view of the uncompensated services program as a program of "last resort." *See*, for example, the discussion at 44 FR 29394, May 18, 1979. In addition, proposed § 124.505 slightly modified the methods of computing income by requiring the use of income preceding the request for uncompensated services, rather than preceding the determination of eligibility. Proposed § 124.505(a)(2) and proposed § 124.505(b) also updated the current requirements, by referencing the "poverty line" issued by the Department, in accordance with section 683(c)(1) of Pub. L. 97-35. Consistent with the current administrative practice, proposed § 124.505(b) established in the regulations that revisions of the poverty line would be effective 60 days following publication in the *Federal Register*.

These provisions generated only a couple of comments, one favorable and one suggesting that loopholes in the eligibility criteria be closed. The Department has not accepted the latter suggestion, as it is of the view that the reasons supporting the adoption of the

eligibility criteria in 1979 remain valid, particularly for monitoring purposes. However, the Department believes that the eligibility criteria should be clarified to make explicit what was implicit in the 1979 and the proposed rules, *i.e.*, that a facility's allocation plan also affects eligibility. This condition is now reflected in § 124.505(a)(3) below. Otherwise, § 124.505 remains as proposed.

6. Allocation Plans

The proposed rules retained the allocation plan requirement of the 1979 rules. Facilities would retain their discretion to determine certain specified elements of the allocation plan, including determining which services to make available as uncompensated services, and whether to offer these services to Category B patients. Proposed § 124.506(b)(2) modified the 1979 rule by providing that a facility would be required to operate under its old allocation plan until it published a revised allocation plan.

Aside from the timing issue, discussed in section 3 above, these changes received no comment. The Department has accordingly retained them essentially as proposed, except for the timing changes and a clarification of the presumptive plan requirement which reflects current practice and the restructuring of the regulations. *See*, § 124.506(b)(2) below.

7. Determinations of Eligibility

Proposed § 124.507 retained the basic policies of the 1979 rules in most respects, but clarified several points that have proved confusing. Proposed § 124.507(a) clarified that determinations must be written, while proposed § 124.507(b) clarified that denials are a form of determination and spelled out the requirements for conditional determinations. The major change to the determination requirement was proposed § 124.507(c), relating to the timing of determinations. The proposed rule kept for hospitals and most other facilities the requirement of a two-day determination of eligibility in the case of requests for service made before admission or treatment, but eliminated the two-day requirement in situations where liability for the cost of the services has already been assumed. Thus, proposed § 124.507(c)(2) provided that where the request for uncompensated services is made during or after receipt of services, the determination must be made before the close of the first full billing period following the request. Proposed § 124.507(c) contained parallel provisions for nursing homes; however,

it required nursing homes to make determinations of eligibility within 10 working days, but no later than the date of admission for requests made prior to admission.

Proposed § 124.507 elicited numerous comments. Providers generally objected that the two-day requirement of the 1979 rules was unfair and unworkable and advocated even greater relaxation of the timing requirements. Consumer groups, on the other hand, objected to the proposed relaxation of the timing requirements, on various grounds. Some objected that loosening of the requirements was unnecessary, as the existing requirements were not burdensome, with determinations being encompassed in the pre-admission screening process or taking "2-3 minutes." Others were concerned that lengthening the interval in which eligibility determinations could be made would lead to increased collection activity by facilities or would cause poor people to be discharged or to check out of hospitals prematurely. A legal services organization commented that the proposed language relating to denials was an improvement. Commenters on both sides requested clarification of the term "first full billing period." A consumer group also requested that the provision for conditional determinations be changed to provide that conditional determinations must be finalized within two days of when the verifying information is received. With respect to the proposed provisions for nursing homes, a long-term care association supported the proposals. A long-term care provider, however, suggested that 10 days was too short a period in which to receive verification, as Medicaid eligibility is not usually verified in less than 30 days; another pointed out that the requirement that pre-service determinations be made no later than the date of admission might require same or next-day determinations where the request is made just before admission.

The rule below is changed very little from the proposed rule. In response to the requests for clarification of the term "first full billing period," the term has been changed to "first full billing cycle." *See*, § 124.507(c)(2) below. It is our understanding that the latter term reflects general usage and is commonly understood by providers. In any event, it is the intent of this language to preclude collection for the services in question prior to the eligibility determination. In its use of the term "first full billing cycle," the rule recognizes that a bill may be issued where a request for

services is made close to the end of a billing cycle with little opportunity for the facility to stop the billing process. Once a request is made, however, it must be acted upon in a time frame designed to preclude collection activities or any additional billing, *i.e.*, the close of the next billing period. Otherwise, the facility will be out of compliance with § 124.507(c)(2) with respect to that account. Accordingly, these changes respond to the consumer concerns that the change in the determination requirements will lead to a substantial increase in collection activities.

The word "admission" in proposed § 124.507(c)(1)(i) has also been changed to "discharge," to be consistent with longstanding program practice, which regards any request made prior to discharge as pre-service. A parallel change has been made to § 124.507(c)(2) with respect to inpatient hospital services. Sections 124.507(c)(1)(ii) and 124.507(c)(2) continue to peg the timing of determinations to the date of admission for nursing home services as the long-term nature of most admissions would make futile a policy tied to discharge. Finally, in response to the concern raised regarding the timing of nursing home determinations, the words "two days following" have been inserted in § 124.507(c)(1)(ii) below. Otherwise, § 124.507 below remains as proposed.

The Department believes that the balance struck in the rules below is a reasonable accommodation between providers' need for increased flexibility and patients' need for timely determinations prior to service. From a facility standpoint, tying the determination requirement to the facility's billing cycle should mesh with facilities' internal accounting and bookkeeping processes. The Department accordingly rejects the providers' requests for further relaxation of the timing requirements. It also rejects the consumer requests that the two-day requirements of the 1979 rules be retained. The Department's experience in numerous facility assessments has shown that, contrary to the commenters' claims, the two-day requirement has been a major compliance problem for many facilities. In the Department's judgment, these compliance problems typically are due to the incompatibility of the requirement with facilities' usual internal accounting and management requirements, rather than willful refusal to comply with the law. With respect to the concern regarding premature discharges, the change in § 124.507(c)(1)(i) and (2) from "admission" to "discharge" preserves

the two-day requirement intact for all requests made during hospitalization. The comment criticizing the timing requirement regarding conditional determinations is likewise rejected. The proposed requirement merely brings forward the requirement of the 1979 rules; since, in our experience, that requirement has not been a major source of complaints or compliance problems, we are retaining it unchanged. Finally, we note that the criticism of the 10-day requirement for long-term care facilities as insufficient to permit verification of third party coverage is misplaced. The proper procedure, where the existence of third party coverage is in question, is to make a conditional determination within the 10-day determination period; the determination should then be finalized when the information about third party coverage is provided to the facility.

8. Cessation of Uncompensated Services

Proposed § 124.508 sets forth the conditions under which a facility may cease providing uncompensated services. The conditions simply made explicit and drew together the same requirements in the 1979 rules. This section received no substantive public comment. It has accordingly been retained essentially as proposed. There is only a minor change reflecting reorganization of a portion of the posted notice requirement. *See*, § 124.508(a)(4). In addition, parallel provisions have been added for facilities certified under § 124.514, to reflect the addition in § 124.514(d) of a compliance level for such facilities. *See*, § 124.508(b).

9. Reporting

The proposed rules proposed elimination of the requirements of the 1979 rules that facilities provide copies of their allocation plans, published notices and reporting forms to the HSAs for their areas. Ancillary reductions in reporting were also proposed in the community and migrant health centers and small facility compliance alternatives.

The changes in the reporting requirements attracted little comment. One public health department remarked that the reporting requirements of the 1979 rules were onerous and sought exemption for public facilities while a private nonprofit facility suggested that reporting would be easier if it were required annually instead of triennially.

Section 124.509 below remains as proposed, except for editorial changes necessary to integrate provisions relating to the public facility compliance alternative, adopted on September 18, 1986, into the general regulation and a

change to clarify the reporting obligations of facilities certified under §§ 124.514 and 124.515. *See*, § 124.509(b), (c), and (d). The Department notes that the existence of the public facility compliance alternative responds to the concern of the public health department described above. The Department has not accepted the suggestion that it require reports on an annual, rather than triennial, basis, as it is of the view that for most facilities such a change would increase the burden of compliance.

10. Record Maintenance

The 1979 rules required facilities to retain their uncompensated services records for 180 days following the close of the Secretary's investigation under 42 CFR 124.511(a) (which covered both complaint investigations and assessments). The proposed rules would have modified this requirement to require facilities to retain records for three years following submission of their compliance report or 180 days following the Secretary's certification of compliance or close of the Secretary's investigation, whichever is less. *See*, proposed § 124.510(b). The community and migrant health center provisions likewise represented a major reduction in recordkeeping requirements for such centers.

The proposed modification of the record retention requirements elicited numerous comments. The comments of provider organizations were generally favorable, although one provider urged that the rule be modified to make clear that patient advocates could not see individual patient records, as it is too expensive to delete identifying information. Consumer groups, however, uniformly opposed the proposed changes. They argued that the proposed change would permit facilities to, in some cases, retain records for less than a year. This shortening of the record-retention period would, it was argued, permit facilities to avoid monitoring by legal services organizations and others and erect insurmountable problems of proof where a patient seeks to use the Hill-Burton uncompensated services obligation as an affirmative defense to a collection action. One organization asked whether, where a facility has destroyed its records as permitted by the regulation, the Department would accept its triennial report at face value.

The Department views the consumer concerns as largely misplaced, in that they proceed from a misunderstanding of the 1979 rules, as well as from a misconception of how the record retention requirements well interface with the substantial compliance

approach of the rules below and the increased efficiency in the audit process that it projects. Under the 1979 rules, facilities were permitted to destroy their records relating to an assessment or a complaint 180 days following the close of the assessment or complaint investigation. *See*, the last sentence of § 124.510(b)(1) of the 1979 rules. The rules below modify this provision only slightly to require facilities to maintain their records for the lesser of 180 days following the close of an assessment investigation or three years after submission of the report covering that period required under § 124.509, unless the Secretary asks that the records be retained for a longer period. *See*, § 124.510(a)(2). The rules below delete the reference to a complaint investigation because all records, including those related to a complaint, must be retained in accordance with § 124.510(a)(2).

Based on its new audit methods and the efficiencies it expects to realize under the substantial compliance approach, the Department expects to investigate most facilities within the three-year period, so that the former date should control, not the latter. Thus, for the majority of facilities, the period of time which records are actually required to be kept should decrease substantially. It is true that under this system, as one commenter noted, records will in many cases be required to be retained for less than three years, but this will occur only because there has been an assessment investigation which has been closed by the Secretary. The same result is possible, although less likely, under the 1979 rules. Finally, as noted above, the rule below has been modified to provide that the facility retain its records beyond the three-year period if so requested by the Secretary. This provision has been added in part in response to the consumer concerns described above. Thus, where the Secretary has not assessed a facility within the three-year period or a complaint investigation is pending when the three-year period ends, the Secretary may require the facility to retain the relevant records for an additional period of time. This provision also makes the record retention requirements applicable to general facilities parallel more closely those applicable to facilities certified under the compliance alternatives for public facilities and facilities with small annual obligations. *Compare*, §§ 124.510(a)(2) and 124.510(b) below. For these reasons, the Department is of the view that the changes to the record retention requirements are not inconsistent with

the consumer concerns regarding monitoring.

The Department disputes the contention that the new provisions will present problems of proof where a facility has been investigated and subsequently discards its records relating to the investigation. If the denial of uncompensated services at issue relates to a request made during the period which is to be investigated, it must, under current and contemplated procedures, be addressed in the course of the investigation, either by means of corrective action or by a determination that the denial was merited, and the investigation will not be "closed" (for purposes of the 180 day requirement) until appropriate action is taken. If, on the other hand, the request is made for services rendered during the period investigated, but the request itself is made *following* the period investigated, that request must be reviewed in terms of the facility's uncompensated services obligation and program as it exists *at the time of the request*, not as it existed at the time services were provided. To the extent legal services organizations and others have assumed the contrary, such an assumption proceeds from a misinterpretation of the 1979 rules, as well as the proposed rules. The belated requests that are apparently the focus of this consumer concern will thus be unaffected by the changes in the rules below.

The record retention requirements for facilities certified under § 124.514 have been revised to parallel those for facilities certified under § 124.513. *See*, § 124.510(b) below. A new provision has been added to make clear the requirements applicable to facilities certified under § 124.515. *See*, § 124.510(c). The reference to subsection (a) of § 124.511 in the current rules with respect to § 124.513 facilities has been deleted in § 124.510(b) below to reflect the reorganization of § 124.511 in the rules below. Finally, the Department has not accepted the provider suggestion that consumers be prohibited from reviewing individual patient accounts to determine compliance. In the Department's view, the policies of the 1979 rules have worked well in this regard and it does not think a case has been made for change.

11. Substantial Compliance

Under the proposed rules, a facility which substantially complied with the most important requirements of the rules could receive full credit for the uncompensated services it claimed, despite failure to comply in particular cases. Concomitantly, if it systematically failed to comply with one

of the crucial regulatory requirements—such as the individual written notice requirement—it was subject to losing credit for the entire year, despite the presence of otherwise creditable accounts. *See*, proposed §§ 124.51(b)(1)(i) and 124.512(c). As noted in the preamble to the proposed rules, these provisions were designed to give facilities a strong incentive to comply with the rules across the board "thereby enhancing the provision of services to persons unable to pay while lessening the burden of compliance for facilities that make a good faith effort to comply." 51 FR 31004.

These provisions of the proposed rule evoked widespread comment, both for and against the proposals. Generally, the providers favored the substantial compliance concept, although several stated that the concept of a total disallowance was grossly unfair. Consumers were uniformly opposed to the concept of substantial compliance. These concerns are described more specifically below.

While facilities and provider groups generally favored relaxing the technical requirements that have occasioned disallowances, they expressed a number of reservations about the "substantial compliance" and "substantial noncompliance" concepts. A number of facilities stated that the concept was too vague. Their concerns about vagueness had two aspects: first, they sought clarification of which provisions of the rules would form the basis for the substantial compliance determination; second, they sought clarification of how many instances of noncompliance would produce a finding of substantial noncompliance. Several facilities suggested that there should be an appeal process for those facilities that receive a total disallowance. One facility asked what the impact of these tests would be on previously unassessed years, while another suggested that facilities that are awaiting assessment not be "penalized" by having the inflation factor applied to any deficits they have to make up.

Many of the consumer comments expressed concerns similar to those of the facilities. The most common criticism of the substantial compliance concept was that it was too vague. The specific consumer concern was that the standard was so general that it would not permit monitoring by consumer groups; several asked how many violations of the regulations a facility could commit and still be in compliance. A related, very common objection was that compliance cannot be determined without audits of individual accounts. A number of commenters also objected

that the substantial compliance concept violated 42 U.S.C. 300s-6, which requires the Secretary to "investigate and ascertain * * * the extent of compliance" of facilities with their uncompensated services assurance. Several other commenters argued that a compliance standard that is not based on audits of individual accounts violates the nonwaivable reporting requirement of 42 U.S.C. 300s, which requires the periodic submission by facilities of "data and information which reasonably supports * * * (their) compliance with (their) assurances." One consumer organization argued that facilities that are out of compliance with the notice requirements should not be found in substantial compliance, while another asked what recourse patients who were "aberrations" would have. Another commenter argued that the concept of "substantial compliance" was not legal in the Sixth Circuit under *Newsom v. Vanderbilt University*, 653 F.2d 1100 (6th Cir., 1981). Another consumer group argued that the concept of substantial compliance was illegal, as the government has no record showing that facilities have complied in the past.

The Department has attempted to accommodate many of these concerns in the rules below. It has done this by substantially revising the provisions relating to the standards for substantial compliance and substantial noncompliance. See, §§ 124.511(b)(3) and 124.512(c) below. In addition, § 124.511(b) has been revised to make clear what many commenters apparently misunderstood about the proposed rule, that substantial compliance determinations will be based on audits of individual accounts. See, § 124.511(b)(2) below.

As set forth below, § 124.511(b)(1)(iii) now provides that the standard for determining whether a facility is in substantial compliance with its assurance is result-oriented: whether the facility provided uncompensated services to eligible persons who had equal opportunity to apply for those services. The specific factors that will be considered in making this determination are three, in descending order of importance: (1) Whether any corrective action previously prescribed has been implemented; (2) whether any violations found can be remedied by corrective action; and (3) whether the facility had in place procedures that complied with the basic components of an uncompensated services program and systematically followed them. If the services are in fact provided to eligible persons at no or a reduced charge, the facility will receive credit for them

towards its obligation. Conversely, if the facility fails to remedy prior noncompliance where corrective action is prescribed, it is subject to losing credit for *all* uncompensated services it provided in the period covered by the corrective action. See, § 124.512(c)(4).

The purpose of these provisions is to minimize harm, both to eligible persons and to facilities. In the context of the uncompensated services assurance, the issue to be addressed is financial: Who will bear the cost of the medical services that are provided? ² And, generally speaking, an error in resolving that issue produces harm that can be remedied. For example, where a facility erroneously requests full payment from a person who was eligible for discounted services under its allocation plan, it can remedy that error by ceasing collection on the amount erroneously charged, refunding any erroneous payments, and so on. Similarly, where a facility provides uncompensated services to persons whose care is covered by third party payors and charges those amounts to its uncompensated services obligation, the error can be remedied by reducing the uncompensated services claimed by the amount of the ineligible accounts. In such situations, where a remedy is available and is provided, it is the Department's view that the intent of the statute has been met—uncompensated services have been provided to those who qualify for them—and the facility should receive appropriate credit therefor.

Other failures however, are not so easily remedied, and the regulation treats them differently. The most important of these is where eligible persons do not request uncompensated services because of basic deficiencies in a facility's uncompensated services program, such as failure to provide individual written notice or make determinations. Because such situations do not leave a paper trail, they are inherently impossible to monitor or remedy adequately with respect to the people who were affected by the deficiency. Also, in the Department's view, the individual written notice requirement of § 124.504(c) is the primary vehicle for ensuring that eligible persons are able to seek uncompensated services on a timely and equitable basis, while the requirement that the facility document its determinations ensures

that it will make eligibility determinations where requested. Thus, if a facility shows a systematic failure to comply with either the individual written notice requirement of § 124.504(c) with respect to persons eligible under its allocation plan or systematically fails to maintain the documentation required by § 124.510, it is presumed to have routinely denied equal opportunity to request and receive uncompensated services to all eligible persons for the period in question. It is accordingly treated as totally out of compliance with its assurance for the period in question, and receives *no* credit towards its uncompensated services obligation. See, § 124.512(c) (1) and (3). While these provisions do not directly remedy the injury to persons who would have sought uncompensated services but for the deficiencies in the facility's program, they do ensure that the class of persons eligible for such services does not lose them through inappropriate crediting where such basic deficiencies in a facility's uncompensated services program exist. Finally, the regulations provide for total disallowance where a facility fails to report as required by § 124.509. See, § 124.512(c)(2). The starting point for any finding of substantial compliance is the facility's claim regarding the amount of uncompensated services provided. If the facility claims no services, in the form of a § 124.509 report, there is no basis for a finding of substantial compliance.

Another type of noncompliance may also exist—that is, where the facility has failed to comply with a procedural requirement, but the harm is minimal or difficult to ascertain. One example would be where a facility distributes the individual written notice only to persons within its allocation plan, not to all persons seeking service in the facility as required by § 124.504(c). In such a case, eligible individuals have by definition received uncompensated services equitably, so that no individual remedies (such as refund, cessation of collection actions) are called for. Nonetheless, the regulatory requirements have not been complied with, and there is likely to have been harm to persons who later become eligible through, for example, a change in circumstances. Such cases, as noted above, are intrinsically incapable of identification or, even if identified, subject to questions of causation and evidence, and thus not susceptible to individual remedy. Thus, the regulatory approach is to prescribe remedial action on a prospective basis (e.g., distribute the individual written notice to all persons seeking service in the facility).

² Commenters frequently assumed that the uncompensated services assurance raises issues of access to medical care. In the usual case, however, the problem of denial of access is one covered by the community service assurance of 42 U.S.C. 291c(e)(1), not the uncompensated services assurance.

to protect the class of eligible persons served by the facility. If the facility thereafter fails to make the prescribed corrective action, it is subject to having all accounts for the period covered by the corrective action disallowed. See, § 124.512(c)(4); *see also*, § 124.511(b)(1)(iii)(A). Thus, the approach to situations where the likelihood of harm is either small or difficult to assess is to require prospective compliance, but not to disallow for past noncompliance. This will provide a reasonable remedy to the class of eligible persons served by the facility, while at the same time ensuring that the facility is clearly on notice of what procedures are required. If the facility thereafter fails to implement the prescribed corrective action, the regulations assume that the resultant noncompliance is not due to ignorance or mistake, and that a total disallowance is therefore warranted.

The foregoing discussion makes clear that substantial compliance and noncompliance assessments will be based on audits of facility claims, with respect both to their uncompensated services systems generally and individual accounts. In this regard, the Department has developed and tested an audit method based on this approach and is convinced that the above regulatory approach is workable from an administrative standpoint. Thus, it believes that it can undertake the assessments the regulations call for in a time frame which will assure appropriate feedback to both consumers and facilities. This audit methodology (provided for in § 124.511(b)(1)(ii) below) renders irrelevant the various consumer criticisms of the proposed rule based on the perceived lack of provision for audits of individual accounts.

In the Department's view, the changes above also respond to most of the commenters' other concerns. The basis for a substantial compliance (or noncompliance) determination is principally the availability and implementation of corrective action which, by definition, will be very specific. See, § 124.512(b). Not only will the corrective action itself be tailored to the uncompensated services program of the facility in question, but it will be based on the underlying regulatory compliance standards (e.g., §§ 124.505, 124.506, 124.507), which all commenters appear to agree are sufficiently specific. This approach thus responds to the vagueness concerns of both facilities and consumers. More important, the stress on corrective action ensures both groups that a finding of substantial compliance is made only where past

noncompliance is appropriately remedied for consumers and that it reflects and appropriately treats such remedial action in terms of a facility's uncompensated services obligation as a whole. The same considerations respond to the consumer concerns with monitoring. The compliance standards remain very similar to those of the 1979 rules, and should present no qualitatively different monitoring problem. What is different under the approach below is the relative availability of a remedy for consumers who believe that they have been denied uncompensated services to which they are entitled. A consumer who can establish an improper denial to the Secretary's satisfaction will now have greater leverage in the administrative process, pursuant to § 124.511(b)(1)(iii)(A). The Department agrees with the consumer argument that facilities that are out of compliance with the notice requirements should not be found in substantial compliance, and the regulations below reflect this. See, e.g., § 124.512(c)(1). With respect to the issue of an appeal for a total disallowance, it notes that an administrative review is available for facilities under current procedures, and there is no plan to eliminate this.

The Department has not accepted the remaining comments regarding the substantial compliance and noncompliance concepts. The Department is not persuaded that the cited holding in the *Newsom* litigation (which it notes appeared in the district court opinion only) is of any relevance to the instant regulations, as the *Newsom* case pertained solely to the regulatory compliance standards issued in 1972. The Department likewise disagrees with the commenter who implied that it lacks the legal authority to adopt a substantial compliance standard absent a showing of past compliance by Hill-Burton facilities. Aside from the factual fallacy underlying this contention, the Secretary's discretion to determine the standards of compliance with the assurance is not limited by the presence (or absence) of past compliance. Finally, the Department has not accepted the provider suggestion relating to delay in the application of the inflation factor. It notes in this regard that the inflation factor is intended only to ensure that the value of uncompensated services remains constant, and does not operate as a "penalty."

12. Audits of Prior Unassessed Years of Compliance

A problem exists with respect to how to treat facilities whose compliance with

the 1979 rules has not been assessed by the Secretary for some or all of the period between 1979 and the effective date of these rules. The proposed rules addressed this issue by proposing two options. Each facility could be credited with an amount of creditable services calculated by the Department based on the facility's reported data concerning compliance, adjusted by a factor derived from a review of all assessments conducted to date. Alternatively, they could hire an independent auditor to certify the amount of uncompensated services provided to supply a basis for adjusting the Department's calculation. See, proposed § 124.511(b)(1)(ii).

This proposal elicited widespread criticism. Many facilities and consumer groups alike contended that the proposed approach lacked an statistical validity. Facilities argued that it would penalize facilities with better-than-average compliance, as the sample would contain assessments of a large number of noncomplying facilities. Consumer groups, on the other hand, argued that the approach would unduly benefit noncomplying facilities. A number of consumer groups argued that the proposal was also unfair in that it permitted credit to be increased without any parallel provision for decreasing credit.

The Department is persuaded by the comments received and has abandoned the approach proposed. Instead, it will conduct assessments of prior unassessed years for each facility to determine a facility-specific credit. See, § 124.511(b)(2) below. This approach accommodates the concerns of both providers and consumers with crediting facilities with amounts based on assessments of other facilities. It likewise responds to the consumer concern with the one-sided nature of the proposed rule, as, under the rule below, there is no longer any provision for facilities to obtain an adjustment through an independent audit.

13. Small Obligation Compliance Alternative

Based on a recent study of Hill-Burton associated administrative costs conducted by A.D. Little, Inc., "Evaluation of the Hill-Burton Program Administrative Compliance Costs", the proposed rules proposed a compliance alternative very similar to that available to public facilities, for facilities with small annual obligations. Under the proposed rules, facilities with annual obligations of \$10,000 or under (in the year the rules become effective) could be exempted from the procedural and administrative requirements of the

regulations if the Secretary certified that they conducted a program of providing health services at no or a substantially reduced charge to persons who are unable to pay therefor. A facility would apply for certification by submitting a description of its program of discounted health services. Once granted, the certification would remain in effect until withdrawn by the Secretary. The Secretary could withdraw certification where the Secretary determined that there had been a material change in the factors upon which the certification was based or a material failure by the facility to comply with its continuing obligations under the certification.

A number of consumer organizations objected to the proposed compliance alternative. Several opposed the proposed alternative on the ground that it constituted an exemption for the statutory requirement, for which there is no statutory basis. Others opposed the alternative on the ground that the asserted basis for the requirement was not sound. In this regard, commenters argued that the findings of the cited report applied to the whole universe of Hill-Burton assisted facilities, and the administrative costs of facilities with small obligations were in fact substantially lower. Others argued that the administrative costs findings of the report were misleading, as approximately 90% of all Hill-Burton costs are consumed in routine admissions screenings, so that the actual annual incremental costs to facilities were in the \$780 range, rather than the \$7,800 range. A State agency argued that the alternative violated the equal protection clause, as it was not justified by any administrative cost differential.

Still other commenters objected to the proposed alternative on the ground that it was unfair to small communities, where a \$10,000 obligation may be quite significant. One commenter objected to the proposed test for "programs of discounted health services" on the ground that even "objective" eligibility tests may be arbitrary. Another commenter sought clarification of the means for calculating the \$10,000 qualification level, questioning whether, in calculating if a facilities met the \$10,000 annual compliance level test, it could apply previously earned excesses to reduce its annual compliance level for the year. A couple of commenters objected to the proposed policy on the ground that the compliance history of facilities with small obligations is poor. Another objected that the alternative was illegal because it required no record-keeping.

The rules below retain the compliance alternative for facilities with small annual obligations, although several major changes have been made in response to the public comments. The Department agrees that the provisions relating to the qualification level needed refinement. Accordingly, the rule below provides that the qualification level is to be determined, for Title VI-assisted facilities, by computing the facility's average annual compliance level over the remainder of its obligations, factoring in any past deficits. *See*, § 124.514(b)(1)(i). At the same time, since the "buy out" formula, which provides the basis for the calculation, has no application to facilities assisted under Title XVI, a new qualification level has been added to permit such facilities to qualify for the compliance alternative. *See*, § 124.514(b)(1)(ii). The level for Title XVI-assisted facilities is biased heavily against permitting facilities with large outstanding deficits to qualify. *Id.* The qualification level is also, under the rules below, a performance level; *see* § 124.514(d). Moreover, since the performance level under the rules below is pegged to a formula that takes into account outstanding deficits, it means that a complying facility will be making up its deficit as it complies with its certification. To facilitate this, the period of obligation for certified facilities is concomitantly extended. *See*, § 124.514(e)(1) below. This feature of the rules below eliminates the need for deficit make-up provisions analogous to those applicable to public facilities certified under § 124.513. Rather, the rules below provide only that certified facilities must make up any outstanding deficit in accordance with § 124.503(b) following withdrawal of certification. *See*, § 124.514(e)(2) below.

The Department disagrees with the comments objecting to the compliance alternative as unsupported by the A.D. Little study. The charge that 90% of the \$7,800 average administrative costs identified in the study were attributable to routine pre-admission screening costs is wrong. The study considered only those costs directly attributable to Hill-Burton regulatory requirements in arriving at the \$7,800 figure. The contention that the study fails to support the policy because the average compliance costs of facilities with small obligations is proportionately less than that of facilities with large obligations is likewise in error. The study found that the average administrative compliance costs for hospitals were \$9,510, for long-term care facilities (nursing homes, TB hospitals, chronic disease hospitals, and

rehabilitation centers), \$4,268, and for all other facilities (public health centers, community mental health/retardation centers, State health laboratories and independent outpatient centers) \$5,009. However, these compliance costs become more significant when compared to base levels. For Fiscal Year 1984 base compliance levels averaged \$155,000 for hospitals, \$49,000 for long-term care facilities, and \$33,000 for all other facilities. Thus, Hill-Burton administrative costs were on average about 6% of the base compliance level for hospitals, 12% of the base compliance level for long-term care facilities and 21% of the base compliance level for "other" facilities, which, on average, have the smallest obligations. Thus, in the Department's view, the study establishes that the compliance costs associated with the regulations weigh disproportionately heavily on facilities with small annual obligations.

The Department disagrees with and has not accepted the remainder of the comments. With regard to the question of whether it has the legal authority to "exempt" these facilities from their assurance obligation, it would agree that it lacks such authority, but it disputes that § 124.514 constitutes an exemption. Rather, it constitutes an alternative compliance standard. It cannot be disputed that the Secretary has discretion, under 42 U.S.C. 300s(3), to prescribe standards of compliance; it likewise cannot be argued that the compliance standards of the 1979 rules are immutable or are the only ones that can effect the statutory purpose. Rather, the Secretary has discretion, under section 300s(3), to determine, based on experience, what those standards should be and to change them as circumstances change. For the reasons discussed above, the Secretary remains convinced that a compliance alternative is needed for facilities with small annual obligations and that the Secretary has the legal authority to establish such an alternative. The Department rejects as completely unfounded the criticism of the compliance obligation on the grounds that it requires no reporting or record-keeping; *see*, § 124.509(b), § 124.510(b), § 124.511(a)(3), § 124.512(c)(3). One commenter noted that "objective" eligibility criteria may be arbitrary. The Department, however, notes that the term "objective" must be construed in terms of the related term "financial criteria," and this is not arbitrary. The Department's experience with the related provision in § 124.513 has indicated little problem in this area. Finally, although the Department agrees

that in a small, often rural community, a \$10,000 Hill-Burton obligation may be significant, it disputes the premise of this criticism, *i.e.*, that certification under this section will deprive the community of uncompensated services. Rather, the compliance alternative is available only to facilities that have a program of "discounted health services." Furthermore, the facilities that are certified under this section continue to be held to a dollar volume of uncompensated (or "discounted") services which they provide, and they must make up deficits if they fail to meet this level. *See*, § 124.514(d) below. Thus, the compliance alternative is structured so that the communities served by such facilities will not lose uncompensated services.

14. Community and Migrant Health Centers Compliance Alternative

Under proposed § 124.503(d), a center funded under either section 329 or section 330 of the PHS Act would be considered to have met its uncompensated services obligation in each year in which it was in compliance with the conditions of its grant relating to provision of services at a discount.

This proposal elicited very little comment. One community health center asked that the provision be made retroactive. Another provider asked that the provision be extended to so-called freestanding National Health Service Corps (NHSC) clinic sites, on the ground that they are likewise required by Federal regulations to provide discounted services. A consumer group objected that the provision was illegal, on the ground that there is no statutory basis for exempting any class of facilities from the obligation.

The Department agrees that the rationale supporting the policy for community and migrant health centers applies equally to certain NHSC sites, at least where such sites are functionally the same as a community or migrant health center, as is the case where the entire medical services of the site are provided by the Corps professionals. It has thus revised the proposed rule to cover certain NHSC clinic sites, but only to the extent the services provided by the NHSC health professional(s) constitute the entirety of the services provided by the facility. While the Department has not accepted the suggestion that the provision be made retroactive, it recognizes that the commenter has raised a valid concern. It has thus revised the provision to include deficit make-up provisions that parallel those applicable under § 124.513. *See*, § 124.515(b) below.

The Department disagrees with the consumer contention that the proposed § 124.503(d) is illegal. As stated in the preamble to the proposed rules, it believes that facilities which are in compliance with the terms of a grant under section 330 or 329 (or an agreement under section 334) of the PHS Act are, in fact, providing a reasonable volume of services to persons unable to pay, and thus should not be required to comply with the conflicting procedural requirements of Subpart F. However, it recognizes that the placement of this provision in § 124.503 in the proposed rules was confusing in this regard. It has thus placed the provisions relating to community and migrant health centers following the other compliance alternatives in a new § 124.515, to make clear that these provisions in fact simply amount to an alternative means of complying with the statutory assurance.

15. State Agencies

Proposed § 124.513 proposed to broaden the types of State agencies with which the Secretary could contract to carry out the assurances program. This proposal attracted no substantive comment and is retained as proposed in the rules below. *See*, § 124.516.

III. Regulatory Flexibility Act and Executive Order 12291

The Regulatory Flexibility Act (5 U.S.C. Ch. 6) requires the Federal Government to anticipate and reduce the impact of rules and paperwork requirements on small businesses. The Secretary certifies that this rule will not have significant economic effect on a substantial number of small entities. Therefore, it does not require a Regulatory Flexibility Analysis.

The Secretary has also determined that this final rule is not a "major rule" as defined under E.O. 12291, because it will not have an annual effect on the economy of \$100 million or more, or otherwise meet the criteria for which a regulatory impact analysis is required.

IV. Information Collection Requirements

Sections 124.504 (a) and (c), 124.507, 124.509 (a) and (b), 124.510 (a) and (b), 124.511(a) 124.513(c), 124.513(d)(2)(ii)(B), and 124.513(d)(2)(iii)(B)(2) of this rule contain information collection requirements which have been approved, under control number 0915-0077 by the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1980.

Sections 124.509(c), 124.514(c), 124.515(b)(2)(ii), and 124.515(b)(3)(ii)(B) of this rule contain new information collection requirements subject to approval by the OMB. We will be

submitting an information collection request to the OMB for approval of these requirements under section 3507 of the Paperwork Reduction Act of 1980 (44 U.S.C. 3507). These requirements will not be effective until the Department obtains OMB approval. When approval is obtained, a notice will be published in *Federal Register* announcing the effective date of these requirements.

V. List of Subjects in 42 CFR Part 124

Grant programs—health, Health facilities, Loan programs—health, Low income persons, Reporting and record-keeping requirements.

Accordingly, the Department of Health and Human Services hereby amends Part 124 of 42 Code of Federal Regulations by revising Subpart F to read as follows:

Dated: August 4, 1987.

Robert E. Windom,
Assistant Secretary for Health.

Approved: October 22, 1987.

Otis R. Bowen,
Secretary.

PART 124—[AMENDED]

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 Notice of availability of uncompensated services.
 - 124.505 Eligibility criteria.
 - 124.506 Allocation of services; plan requirement.
 - 124.507 Written determinations of eligibility.
 - 124.508 Cessation of uncompensated services.
 - 124.509 Reporting requirements.
 - 124.510 Record maintenance requirements.
 - 124.511 Investigation and determination of compliance.
 - 124.512 Enforcement.
 - 124.513 Public facility compliance alternative.
 - 124.514 Compliance alternative for facilities with small annual obligations.
 - 124.515 Compliance alternative for community health centers, migrant health centers and certain National Health Service Corps sites.
 - 124.516 Agreements with state agencies.
- Authority: 42 U.S.C. 216; 42 U.S.C. 300s(3).

Subpart F—Reasonable 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 as otherwise herein provided, 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 and 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—

(a) "Act" means the Public Health Service Act, as amended.

(b) "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, *et seq.*) and

the implementing regulations (42 CFR Part 413) bears to the facility's total patient revenues for the year.

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

(d) "CPI" means the National Consumer Price Index for medical care.

(e) "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.

(f) "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 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.

(g) "Fiscal year" means the facility's fiscal year.

(h) "Nursing home" means a facility which received Federal assistance for and operates as a "facility for long-term care" as defined at, as applicable, section 645(h) or section 1624(6) of the Act.

(i) "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.

(j) "Persons unable to pay" means persons who meet the eligibility criteria set out in § 124.505.

(k) "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.

(l) "Secretary" means the Secretary of Health and Human Services or [his or her] delegatee.

(m) "Uncompensated services" means:

(1) For facilities other than those certified under § 124.513, § 124.514, or § 124.515, health 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. Excluded are services provided more than 96 hours following notification to the facility by a peer review organization that it disapproved the services under section 1155(a)(1) or section 1154(a)(1) of the Social Security Act.

(2) For facilities certified under § 124.513, § 124.514, or § 124.515, services as defined in paragraph (m)(1) of this section and services that are made available to persons unable to pay for them under programs described by the documentation provided under § 124.513(c)(2) or § 124.514(c)(2), as applicable, or pursuant to the terms of the applicable grant or agreement as provided in § 124.515. Excluded are services reimbursed by Medicare, Medicaid or other third party programs, including services for which reimbursement was provided as payment in full, and services provided more than 96 hours following notification to the facility by a peer review organization that it disapproved the services under section 1155(a)(1) of section 1154(a)(1) of the Social Security Act.

§ 124.503 Compliance level.

(a) *Annual compliance level.* Subject to the provisions of this subpart, 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—

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

(2) 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 CPI 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.

(b) *Deficits.* If in any fiscal year a facility fails to meet its annual compliance level, it shall provide uncompensated services in an amount sufficient to make up that deficit in subsequent years, and its period of obligation shall be extended until the deficit is made up.

(1) *Types of deficits.* For purposes of determining the timing and amount of any deficit make-up, there are two types of deficits:

(i) *Justifiable deficits.* A justifiable deficit is one in which the facility did not meet its annual compliance level due to either financial inability (as determined under § 124.511(c)) or, although otherwise in compliance with this subpart, a lack of eligible applicants for uncompensated services during the fiscal year.

(ii) *Noncompliance deficits.* A noncompliance deficit is one in which the facility failed to meet its annual compliance level due to noncompliance with this subpart.

(2) *Timing of deficit make-up—(i) Justifiable deficits.* (A) A facility assisted under Title VI of the Act may make up a justifiable deficit at any time during its period of obligation or in the year (or years, if necessary) immediately following its period of obligation.

(B) A facility assisted under Title XVI of the Act is not required to make up a justifiable deficit.

(ii) *Noncompliance deficits.* (A) A facility must begin to make up a noncompliance deficit in the fiscal year following the finding of noncompliance by the Secretary.

(B) A facility which claimed financial inability under § 124.509(a)(2)(iii) and is found by the Secretary, pursuant to § 124.511(c), to have been financially able to provide uncompensated services in the year in which the deficit was incurred shall begin to make up the deficit beginning in the fiscal year following the Secretary's finding.

(C) A facility required to make up a noncompliance deficit but which is determined by the Secretary, pursuant to § 124.511(c), to be financially unable to do so in the year following the Secretary's finding of noncompliance shall make up the deficit in accordance with a schedule set by the Secretary.

(3) *Deficit make-up amount.* (i) The amount of a deficit in any fiscal year is the difference between the facility's annual compliance level for that year and the amount of uncompensated services provided in that year.

(ii) The amount of justifiable deficit must be adjusted by a percentage equal

to the percentage change in the CPI between the CPI available in the fiscal year in which the deficit was incurred and the CPI available in the fiscal year in which it was made up.

(iii) An amount equal to the result of dividing the amount of any noncompliance deficit for a fiscal year by the number of years of obligation remaining and adjusting it by a percentage equal to the percentage change in the CPI between the CPI available in the fiscal year in which the deficit was incurred and the CPI available in the fiscal year in which it was made up shall be added to a facility's annual compliance level for each fiscal year following the fiscal year of the finding of noncompliance.

(4) *Affirmative action plan for precluding future deficits.* Except where a facility reports to the Secretary in accordance with § 124.509(a)(2)(iii) that it was financially unable to provide uncompensated services at the annual compliance level, a facility that fails to meet its annual compliance level in any fiscal year shall, in the following year, develop and implement a plan of action that can reasonably be expected to enable the facility to meet its annual compliance level. Such actions may include special notice to the community through newspaper, radio, and television, or expansion of service to Category B persons. The Secretary may require changes to the plan. Where a facility fails to comply with this section, the Secretary may require it to make up the deficit in the fiscal year following the year in which it was required to institute the plan.

(c) *Excesses.* (1) Except for facilities certified under § 124.513, § 124.514, or § 124.515, if a facility provides in a fiscal year uncompensated services in an amount exceeding its annual compliance level, it may apply the amount of excess 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) *Calculation and adjustment of excess.* (i) The amount of an excess in uncompensated services in any fiscal year is the difference between the amount of uncompensated services the facility provided in that year and the facility's annual compliance level for that year.

(ii) 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 CPI between

the CPI available in the fiscal year in which the facility provided the excess, and the CPI available in the fiscal year in which the facility applies the excess to reduce its annual compliance level or satisfy its remaining obligation.

(3) Except as provided in subparagraph (1) of this paragraph, 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. A facility's remaining obligation is determined as follows:

(i) Where the annual compliance level in such fiscal year is established under paragraph (a)(2) of this section, the remaining obligation is:

(A) For grant assistance, 10 percent of each grant under obligation, multiplied by the number of years remaining in its period of obligation, adjusted as provided for in paragraph (a)(2) of this section, plus any deficits required to be made up and less any unused excesses accrued in prior years; and

(B) For loan assistance, the facility's annual compliance level multiplied by the number of years remaining in the scheduled life of the loan, plus the sum of 10 percent of each yearly cumulative total of additional interest subsidy or other payments (which the Secretary will have made in connection with the guaranteed loan or a direct loan which has been sold) in each subsequent year remaining in the scheduled life of the loan, plus any deficits required to be made up, and less any unused excesses accrued in prior years; or

(ii) Where the annual compliance level in such fiscal year is established under paragraph (a)(1) of this section, the remaining obligation is the average of the facility's annual compliance levels in the previous three years, multiplied by the number of years remaining in its period of obligation, plus any deficits required to be made up under this section, and less any unused excesses accrued in prior years.

§ 124.504 Notice of availability of uncompensated services.

(a) *Published notice.* A facility shall publish in a newspaper of general circulation in its area notice of its uncompensated services obligation before the beginning of its fiscal year. The notice shall include:

(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;

(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. 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; and

(4) A statement inviting interested parties to comment on the allocation plan.

(b) *Posted notice.* (1) 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 areas, the business office, and the emergency room.

(2) 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 (b)(1) of this section.

(3) 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.

(c) *Individual written 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, and the date by or period within which the determination will be made.

(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 individual written notice to the 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.

§ 124.505 Eligibility criteria.

(a) A person unable to pay for health services is a person who—

(1) Is not covered, or receives services not covered, under a third-party insurer or governmental program, except where the person is not covered because the facility fails to participate in a program in which it is required to participate by § 124.603(c);

(2) Falls into one of the following categories:

(i) *Category A*—A person whose annual individual or family income, as applicable, is not greater than the current poverty line issued by the Secretary pursuant to 42 U.S.C. 9902 that applies to the individual or family. The facility shall provide uncompensated services to persons in Category A without charge.

(ii) *Category B*—A person whose annual individual or family income, as applicable, is greater than but not more than twice the poverty line issued by the Secretary pursuant to 42 U.S.C. 9902 that applies to the individual or family. 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; and

(3) Requests services within the facility's allocation plan in effect at the time of the request.

(b) For purposes of determining eligibility for uncompensated services, revisions of the poverty line are effective 60 days from the date of their publication in the **Federal Register**.

(c) A person is eligible for uncompensated services if the person's individual or family annual income, as applicable, is at or below the level established under paragraph (a)(2) when calculated by either of the following methods:

(1) Multiplying by four the person's or family's income, as applicable, for the three months preceding the request for uncompensated services;

(2) Using the person's or family's income, as applicable, for the twelve months preceding the request for uncompensated services.

§ 124.506 Allocation of services; plan requirement.

(a)(1) A facility shall provide its uncompensated services in accordance with a plan that sets out the method by which the facility will distribute its uncompensated services among persons unable to pay. The plan must:

(i) State the type of services that will be made available;

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

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

(iv) 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

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

(2) A facility must adopt an allocation plan that meets the requirements of paragraph (a) by publishing the plan in a newspaper of general circulation in its area. The plan may take effect no earlier than 60 days following the date of publication.

(b)(1) If in any fiscal year a facility fails to adopt and publish a plan in accordance with paragraph (a), it shall provide uncompensated services in accordance with the last plan it published in a newspaper of general circulation in its area.

(2) If no plan was previously published in accordance with paragraph (a)(2), the facility must provide uncompensated services without charge to all applicants in Category A and Category B who request service in the facility. This requirement applies until the facility ceases to provide uncompensated services under § 124.508 or until an allocation plan published in accordance with paragraph (a)(2) of this section becomes effective.

(c) A facility may revise its allocation plan during the fiscal year by publishing the revised plan in a newspaper of general circulation in the area it serves. A revised plan may take effect no earlier than 60 days following the date of publication.

§ 124.507 Written determinations of eligibility.

(a) Determinations of eligibility must be in writing, be made in accordance with this section, and a copy of the

determination must be provided to the applicant promptly.

(b) *Content of determinations*—(1) *Favorable determinations.* A determination that an applicant is eligible must indicate:

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

(ii) The date on which services were requested;

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

(iv) The applicant's individual or family income, as applicable, and family size; and

(v) The date on which services were or will be first provided to the applicant.

(2) *Conditional determinations.* (i) As a condition to providing uncompensated services, a facility may:

(A) Require the applicant to furnish any information that is reasonably necessary to substantiate eligibility; and

(B) Require the applicant to apply for any benefits under third party insurer or governmental programs to which he/she is or could be entitled upon application.

(ii) A conditional determination must:

(A) Comply with paragraph (b)(1) of this section; and

(B) State the condition(s) under which the applicant will be found eligible.

(iii) When a facility determines that the condition(s) upon which a conditional determination was made has been met, or will be met, it shall make a favorable determination or denial on the request, as appropriate, in accordance with this section.

(3) *Denials.* A facility must provide to each applicant denied the uncompensated services requested, in whole or in part, a dated statement of the reasons for the denial.

(c) *Timing of determinations*—(1)

Preservice determinations. (i) Facilities other than nursing homes shall make a determination of eligibility within two working days following a request for uncompensated services which is made before receipt of outpatient services or before discharge for inpatient services;

(ii) Nursing homes shall make a determination of eligibility within ten working days, but no later than two working days following the date of admission, following a request for uncompensated services made prior to admission.

(2) *Preservice determinations.* All facilities shall make a determination of eligibility not later than the end of the first full billing cycle following a request for uncompensated services which is made after receipt of outpatient services, discharge for inpatient

services, or admission for nursing home services.

§ 124.508 Cessation of uncompensated services.

(a) *Facilities not certified under § 124.513, 124.514, or § 124.515.* Where a facility, other than a facility certified under § 124.513, § 124.514, or § 124.515, has maintained the records required by § 124.510(a) and determines based thereon that it has met its annual compliance level for the fiscal year or the appropriate level for the period specified in its allocation plan, it may, for the remainder of that year or period:

(1) Cease providing uncompensated services;

(2) Cease providing individual notices in accordance with § 124.504(c);

(3) Remove the posted notices required by § 124.504(b); and

(4) 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.

(b) *Facilities certified under § 124.514.* Where a facility certified under

§ 124.514 has maintained the records required by § 124.510(c) and determines based thereon that it has met its compliance level, under § 124.514(d), for the fiscal year, it may, for the remainder of the fiscal year:

(1) Cease providing uncompensated services; and

(2) Discontinue providing notice pursuant to § 124.514(b)(2).

§ 124.509 Reporting requirements.

(a) *Facilities not certified under § 124.513, 124.514, or § 124.515*—(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.

(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)(1)(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 § 124.504(a) was published, and the name of the newspaper that printed the notice;

(iii) If the amount of uncompensated services provided by the facility 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 provide documentation prescribed by the Secretary;

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

(v) Other information that the Secretary prescribes.

(3) *Institution of suit.* Not later than 10 days after being served with a summons or complaint the facility shall notify the HHS Regional Health Administrator¹ for the Region 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.

(b) *Facilities certified under § 124.513.* A facility certified under § 124.513 shall comply with paragraph (a)(3) of this section and shall submit within 90 days after the close of its fiscal year, as appropriate:

(1) A certification, signed by the responsible official of the facility, that there has been no material change in the factors upon which the certification was based; or

(2) A certification, signed by the responsible official of the facility and supported by appropriate documentation, that there has been a material change in the factors upon which the certification was based.

(c) *Facilities certified under § 124.514.* A facility certified under § 124.514 shall comply with paragraph (a)(3) of this section and shall submit within 90 days after the close of its fiscal year, as appropriate:

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

(1)(i) A certification, signed by the responsible official of the facility, that there has been no material change in the factors upon which the certification was based; or

(ii) A certification, signed by the responsible official of the facility and supported by appropriate documentation, that there has been a material change in the factors upon which the certification was based; and

(2) A certification, signed by the responsible official of the facility, of the amount of uncompensated services provided in the previous fiscal year.

(d) *Facilities certified under § 124.515.* A facility certified under § 124.514 shall submit such reports as are required by the terms of its grant under section 329 or 330 or by its agreement under section 334 of the Act, as applicable, at such intervals as the Secretary may require.

§ 124.510 Record maintenance requirements.

(a) *Facilities not certified under § 124.513, § 124.514, or § 124.515.* (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 § 124.509(a) was obtained;

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

(iii) Copies of written determinations of eligibility under § 124.507.

(2) A facility shall retain the records maintained pursuant to paragraph (a)(1) for three years after submission of the report required by § 124.509(a)(1), except where a longer period is required by the Secretary, or until 180 days following the close of the Secretary's assessment investigation under § 124.511(b), whichever is less.

(3) A facility shall, within 60 days of the end of each fiscal year, determine 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 on request. If a report is or will be filed under § 124.509(a)(1), a facility may respond to a request by providing a copy of the report to the requester.

(b) *Facilities certified under § 124.513 or § 124.514.* A facility certified under § 124.513 or § 124.514 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 applicable requirements of this subpart in any fiscal year, including those documents submitted to the Secretary under § 124.513(c) or § 124.514(c). A facility shall maintain these records for three years, except where a longer period is required as a result of an investigation by the Secretary. In such cases, records must be kept until 180 days following the close of the Secretary's assessment investigation under § 124.511(b).

(Approved by the Office of Management and Budget under OMB control number 0195-0103 with respect to § 124.513.)

(c) *Facilities certified under § 124.515.* A facility certified under § 124.515 shall maintain the records required by its grant under section 329 or section 330 or its agreement under section 334 of the Act, as applicable, for such period of time as the grant agreement may require.

§ 124.511 Investigation and determination of compliance.

(a) *Complaints.* A complaint that facility is out of compliance with the requirements of this subpart may be filed with the Secretary by any person.

(1) A complaint is considered to be filed with the Secretary on the date the following information is received in the Office of the HHS Regional Health Administrator for the Region in which the facility is located:

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

(ii) The name and location of the facility;

(iii) The date or approximate date on which the event occurred; and

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

(2) 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, including a facility certified under § 124.513, § 124.514, or § 124.515, shall provide to the Secretary on request any documents, records and other information concerning its operation that relate to the requirements of this subpart. A facility will be presumed to be out of compliance with its assurances unless it supplies documentation sufficient to show compliance with applicable provisions of this subpart.

(4) Section 1627 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/she will be unable to issue a decision on a complaint or otherwise take appropriate action within the six month period, the Secretary 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) *Assessments.* The Secretary periodically investigates and assesses facilities to ascertain compliance with the requirements of this subpart, including certification of the amount of uncompensated services provided in a fiscal year or years, and provides guidance and prescribes corrective action to correct noncompliance.

(1) Compliance after February 1, 1988.

(i) The Secretary may certify that a facility has substantially complied with its assurance for a fiscal year or years, and such certification shall establish that the facility provided the amount of uncompensated services certified for the period covered by the certification.

(ii) A certification of substantial compliance shall be based on the amount properly claimed by the facility pursuant to § 124.509(a), utilizing procedures determined by the Secretary to be sufficient to establish that the facility has substantially complied with its assurance for the period covered by the certification. The procedures will include examination of individual account data to the extent deemed necessary by the Secretary.

(iii) A certification of substantial compliance will be made where the Secretary determines that, for the period covered by the certification, the facility provided uncompensated services to establish persons who had equal opportunity to apply therefor. In making this determination, the Secretary will consider, in descending order of importance, whether—

(A) Corrective action prescribed pursuant to § 124.512(b) has been taken by the facility;

(B) Any compliance with the requirements of this subpart may be remedied by corrective action under § 124.512(b);

(C) The facility had procedures in place that complied with the requirements of §§ 124.504(c), 124.505, 124.507, 124.509, 124.510, 124.513(b)(2), 124.514(b)(2), and 124.515, as applicable.

and systematically correctly followed such procedures.

(2) *Compliance prior to February 1, 1988.* The Secretary will determine the amount of creditable services provided prior to the effective date of these rules using the compliance standards applicable under the rules as promulgated on May 18, 1979, based on procedures determined by the Secretary to be sufficient to establish that the facility provided such amounts of uncompensated services in the period(s) being assessed.

(c) *Determinations of Financial inability.* In determining whether a facility was or is financially able to meet its annual compliance level, the Secretary will consider any comments submitted by interested parties. In making this determination, the Secretary will consider factors such as:

- (1) The ratio of revenues to expenses;
- (2) The occupancy rate;
- (3) The ratio of current assets to current liabilities;
- (4) The average cost per patient day;
- (5) The number of days of operating expenses in accounts payable;
- (6) The number of days of revenues in accounts receivable;
- (7) The sinking fund (or depreciation fund) balance;
- (8) The debt coverage ratio; and
- (9) The availability of restricted or unrestricted funds (such as an endowment) available for charitable use.

§ 124.512 Enforcement.

(a) If the Secretary finds, based on his/her investigation under § 124.511, that a facility did not comply with the requirements of this subpart, the Secretary 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.

(b) A facility, including a facility certified under § 124.513 or § 124.514, 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, including:

- (1) Provision of uncompensated services to applicants improperly denied;
 - (2) Repayment of amounts improperly collected from persons eligible to receive uncompensated services; and
 - (3) Other corrective actions prescribed by the Secretary.
- (c) The Secretary may disallow all of the uncompensated services claimed in

a fiscal year where the Secretary finds that the facility was in substantial noncompliance with its assurance because it failed to:

- (1) Have a system for providing notice to eligible persons as required by § 124.504(c), § 124.513(b)(2) or § 124.514(b)(2), as applicable;
 - (2) Comply with the applicable reporting requirements of § 124.509;
 - (3) Have a system for maintaining records of uncompensated services provided in accordance with § 124.510; or
 - (4) Take corrective action prescribed pursuant to paragraph (b) of this section.
- (d) In the absence of a finding of substantial compliance or substantial noncompliance in a fiscal year, the Secretary may disallow uncompensated services claimed by a facility in that fiscal year to the extent that the Secretary finds that such services are not documented as uncompensated services under § 124.510 or are subject to disallowance under § 124.513(d) or § 124.514(d), as applicable.

§ 124.513 Public facility compliance alternative.

(a) *Effect of certification.* The Secretary may certify a facility which meets the requirements of paragraphs (b) and (c) of this section as a "public facility". A facility which is so certified is not required to comply with this subpart except as otherwise herein provided.

(b) *Criteria for qualification.* A public facility may qualify for certification under this section if all of the following criteria are met:

(1) It is a facility which is owned and operated by a unit of State or local government or a quasi-public corporation as defined at 42 CFR 124.2(m).

(2) It provides health services without charge or at a substantially reduced rate to persons who are determined by the facility to qualify therefore under a program of discounted health services. A "program of discounted health services" must provide for financial and other objective eligibility criteria and procedures, including notice prior to nonemergency service, that assure effective opportunity for all persons to apply for and obtain a determination of eligibility for such services, including a determination prior to service where requested; *provided that*, such criteria and procedures are not required where the facility makes all services available to all persons at no or nominal charge.

(3)(i) It received, for the three most recent fiscal years, at least 10 percent of its total operating revenue (net patient revenue plus other operating revenue,

exclusive of any amounts received, or if not received, claimed, as reimbursement under Titles XVIII and XIX of the Social Security Act) from State and local tax appropriations or other State and local government revenues, or from a quasi-public corporation as defined at 42 CFR 124.2(m), to cover operating deficits attributable to the provision of discounted services; or

(ii) If provided, in each of the three most recent fiscal years, uncompensated services under this subpart or under programs described by the documentation provided under § 124.513(c)(2) in an amount not less than twice the annual compliance level computed under § 124.503(a).

(c) *Procedures for certification.* To be certified under this section, a facility must submit to the Secretary, in addition to other materials that the Secretary may from time to time require, copies of the following:

(1) Audited financial statements or official State or local government documents (such as annual reports or budget documents), for the three most recent fiscal years, sufficient to show that the facility meets the criteria in paragraph (b)(3)(i) or (ii).

(2) A complete description of its program(s) of discounted health services, including charging and collection policies of the facility, and eligibility criteria and notice and determination procedures used under its program(s) of discounted services.

(Approved by the Office of Management and Budget under OMB control number 0915-0103.)

(d) *Period of effectiveness.* (1) A certification by the Secretary under this section remains in effect until withdrawn. The Secretary may disallow credit under this subpart when the Secretary determines that there has been a material change in any factor upon which certification was based or substantial noncompliance with this subpart. The Secretary may withdraw certification where the change or noncompliance has not been adequately remedied or otherwise continues.

(2) *Deficits—(i) Title VI-assisted facilities with assessed deficits.* Where a facility assisted under Title VI of the Act has been assessed as having a deficit under § 124.503(b) that has not been made up prior to certification under this section, the facility may make up that deficit by either—

(A) Demonstrating to the Secretary's satisfaction, that it met the requirements of paragraph (b) of this section for each year in which a deficit was assessed; or

(B) Providing an additional period of service under this section on the basis of one (or portion of a) year of certification of each year (or portion of a year) of deficit assessed. The period of obligation applicable to the facility under § 124.501(b) shall be extended until the deficit is made up in accordance with the preceding sentence.

(ii) *Title VI-assisted facilities which have not been assessed.* Where any period of compliance under this subpart of a facility assisted under Title VI of the Act has not been assessed, the facility will be presumed to have no allowable credit for such period. The facility may either—

(A) Make up such deficit in accordance with paragraph (d)(2)(i) of this section; or

(B) Submit an independent certified audit, conducted in accordance with procedures specified by the Secretary, of the facility's records maintained pursuant to § 124.510. If the audit establishes to the Secretary's satisfaction that no, or a lesser, deficit exists for the period in question, the facility will receive credit for the period so justified. Any deficit which the Secretary determines still remains must be made up in accordance with paragraph (d)(2)(i) of this section.

(iii) *Title XVI-assisted facilities.* (A) A facility assisted under Title XVI of the Act which has an assessed deficit which was not made up prior to certification under this section shall make up that deficit in accordance with paragraph (d)(2)(i)(A) of this section. If it cannot make the showing required by that paragraph, it shall make up the deficit when its certification under this section is withdrawn.

(B) A facility assisted under Title XVI of the Act whose compliance with this subpart has not been completely assessed will be presumed to have no allowable credit for the unassessed period. The facility may make up the deficit by—

(1) Following the procedure of subparagraph (d)(2)(iii)(A) of this section; or

(2) Submitting an independent certified audit, conducted in accordance with procedures specified by the Secretary, of the facility's records maintained pursuant to § 124.510. If the audit establishes to the Secretary's satisfaction that no, or a lesser, deficit exists for the period in question, the facility will receive credit for the period so justified. Any deficit which the Secretary determines still remains must be made up in accordance with paragraph (d)(2)(iii)(A) of this section.

§ 124.514 Compliance alternative for facilities with small annual obligations.

(a) *Effect of certification.* The Secretary may certify a facility which meets the requirements of paragraphs (b) and (c) of this section as a "facility with a small annual obligation." A facility which is so certified is not required to comply with this subpart except as otherwise herein provided.

(b) *Criteria for qualification.* A facility may qualify for certification under this section if all of the following criteria are met:

(1)(i) *Title VI-assisted facilities.* (A) For the facility's fiscal year in which this section becomes effective, the level, computed under § 124.503(c) (3), divided by the number of years remaining in its period of obligation (including an additional year or portion of a year for each year or portion of a year in which a deficit was incurred and has not been made up), is not more than \$10,000;

(B) For a subsequent fiscal year, the level computed under subparagraph (A) of this paragraph, is at or less than \$10,000, adjusted by a percentage equal to the percentage change in the CPI available in the year in which this section becomes effective and the most recent year for which a published index is available.

(ii) *Title XVI-assisted facilities.* (A) For the facility's fiscal year in which this section becomes effective, the level under § 124.503(a), plus the amount of any noncompliance deficits which have not been made up, is at or less than \$10,000.

(B) For a subsequent fiscal year, the level, computed under subparagraph (A) of this paragraph, is at or less than \$10,000, adjusted as provided in paragraph (b) (i) (B) of this section.

(2) It provides health services without charge or at a substantially reduced rate to persons who are determined by the facility to qualify therefor under a program of discounted health services. A "program of discounted health services" must provide for financial and other objective eligibility criteria and procedures, including notice prior to nonemergency service, that assure effective opportunity for all persons to apply for and obtain a determination of eligibility for such services, including a determination prior to service where requested; *provided that*, such criteria and procedures are not required where the facility makes all services available to all persons at no or nominal charge.

(c) *Procedures for certification.* To be certified under this section, a facility must submit to the Secretary, in addition to other materials that the Secretary may from time to time require, a complete description of its program(s) of

discounted health services, including charging and collection policies of the facility, and eligibility criteria and notice and determination procedures used under its program(s) of discounted services.

(d) *Period of effectiveness.* A certification by the Secretary under this section remains in effect until withdrawn. During the period in which such certification is in effect, the facility must provide uncompensated services in an amount not less than the level applicable under paragraph (b)(1) of this section for each fiscal year. The Secretary may disallow credit under this subpart when the Secretary determines that there has been a material change in any factor upon which certification was based or substantial noncompliance with this subpart. The Secretary may withdraw certification where the change or noncompliance cannot be or has not been adequately remedied on noncompliance otherwise continues.

(e) *Deficits.* (1) Where the compliance level of a facility assisted under Title VI of the Act is computed under paragraph (b)(1)(i)(A) of this section as including additional year(s) or a portion of a year, the facility's period of obligation under this subpart shall be extended by such additional period, until certification is withdrawn.

(2) Where a facility has been assessed as having a deficit under § 124.503(b) that has not been made up prior to withdrawal of certification under this section or fails to provide services as required by paragraph (d) of this section, the facility must make up the deficit in accordance with § 124.503(b) following withdrawal of certification.

§ 124.515 Compliance alternative for community health centers, migrant health centers and certain National Health Service Corps sites.

(a) *Period of effectiveness.* For each fiscal year for which a facility that receives a grant to operate a community health center under section 330 of the Act or a migrant health center under section 329 of the Act is in substantial compliance with the terms and conditions of such grant relating to the provision of services at a discount, the facility shall be certified as having met its annual compliance level in accordance with requirements of this subpart and shall not be required otherwise to comply with the requirements of this subpart for that fiscal year. This provision also applies to any facility that has signed a memorandum of agreement with the Secretary under section 334 of the Act if the services provided by the National

Health Service Corps professional(s) assigned pursuant to that agreement constitute all of the medical services provided by the facility.

(b) *Deficits*—(1) *Title VI-assisted facilities with assessed deficits*. Where a facility assisted under Title VI of the Act has been assessed as having a deficit under § 124.503(b) that has not been made up prior to certification under this section, the facility may make up that deficit by either—

(i) Demonstrating to the Secretary's satisfaction that it met the requirements of paragraph (a) of this section for each year in which a deficit was assessed; or

(ii) Providing an additional period of service under this section on the basis of one (or portion of a) year of certification for each year (or portion of a year) of deficit assessed. The period of obligation applicable to the facility under § 124.501(b) shall be extended until the deficit is made up in accordance with the preceding sentence.

(2) *Title VI-assisted facilities which have not been assessed*. Where any period of compliance under this subpart of a facility assisted under Title VI of the Act has not been assessed, the facility will be presumed to have no allowable credit for such period. The facility may either—

(i) Make up such deficit in accordance with paragraph (b)(1) of this section; or

(ii) Submit an independent certified audit, conducted in accordance with procedures specified by the Secretary, of the facility's records maintained pursuant to § 124.510. If the audit establishes to the Secretary's satisfaction that no, or a lesser, deficit exists for the period in question, the

facility will receive credit for the period so justified. Any deficit which the Secretary determines still remains must be made up in accordance with paragraph (b)(1) of this section.

(3) *Title XVI-assisted facilities*. (i) A facility assisted under Title XVI of the Act which has an assessed deficit which was not made up prior to certification under this section shall make up that deficit in accordance with paragraph (b)(1)(i) of this section. If it cannot make the showing required by that paragraph, it shall make up the deficit when it is no longer certified under this section.

(ii) A facility assisted under Title XVI of the Act whose compliance with this subpart has not been completely assessed will be presumed to have no allowable credit for the unassessed period. The facility may make up the deficit by—

(A) Following the procedure of paragraph (b)(3)(i) of this section; or

(B) Submitting an independent certified audit, conducted in accordance with procedures specified by the Secretary, of the facility's records maintained pursuant to § 124.510. If the audit establishes to the Secretary's satisfaction that no, or a lesser, deficit exists for the period in question, the facility will receive credit for the period so justified. Any deficit which the Secretary determines still remains must be made up in accordance with paragraph (b)(3)(i) of this section.

§ 124.516 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, the Secretary may enter into an agreement with an agency of a State to assist 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 any assistance the Secretary requests in any one or more of the following areas, as set out in the agreement:

(1) Investigation of complaints regarding noncompliance;

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

(3) Review of reports submitted under § 124.509, including affirmative action plans;

(4) 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 the Secretary's initiative; and

(5) 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) 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.

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