Bureau of Health Facilities' Increasing Responsibilities in Assuring Medical Care for the Needy and Services Without Discrimination

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THE ADVENT OF A NEW DECADE encourages street corner philosophers. From individual soap boxes, they predict gloom and doom or paint portraits of the coming golden age. The truth always lies somewhere between the extremes. The '80s will bring a changed reality in American economics. That reality is less, rather than more: it is conservation and planning, rather than expansion.

The Bureau of Health Facilities, Health Resources Administration, although a little more than a year old as the 1980s begin, also exists somewhere between the extremes. We are already having to deal with less, rather than more resources, and with the necessary tools of conservation and planning. The Bureau inherited activities started under the familiar Hill-Burton Program. We do not enjoy the popularity of that Program because we are no longer in a position (as Hill-Burton originally was) to fund enormous amounts of new construction for hospitals and other health facilities. Rather, we must implement new regulations that change and strengthen a section of the original Hill-Burton Act that was virtually ignored for 25 years. That section deals with the uncompensated care for the poor and with the community services that facilities agreed to provide in exchange for the financial aid received from the Federal Government. Because of the importance of those regulations, and their impact on the Bureau's work, I will discuss them in detail later.

Another of the Bureau's inherited missions is monitoring the financial viability of facilities which received direct and guaranteed loans under Title VI of the Public Health Service Act (Hill-Burton) and assured loans under the FHA-242 program. In 1969, the Department of Health, Education, and Welfare (DHEW) and the Department of Housing and Urban Development (HUD) signed an agreement which delegated the responsibilities of review to DHEW (and thus, eventually, to this Bureau) for HUD's hospital mortgage insurance program. The program is authorized under Section 242 of the National Housing Act, administered by HUD's Federal Housing Administration (FHA). The 150 FHA-242 projects being monitored by the Bureau represent more than $1.9 billion in guaranteed loans borrowed by medical facilities for construction; 396 direct and guaranteed loan projects awarded primarily under Title VI, but including some awarded under Title XVI of the Public Health Service Act are also being monitored. They represent more than $1.4 billion in value.

In addition to carrying out these inherited duties, we must deal with new requirements in a health care industry that has not fully come to grips with the realities of planning for, and doing with, less. A modest beginning for this new era is the recent congressional passage of a program for conversion and discontinuance of unneeded or excess hospital capacity. Part of the Health Planning and Resources Development

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Amendments of 1979 (Public Law 96–79), the Conversion and Discontinuance Program will be funded in Fiscal Year 1981. National budget constraints will likely mean only limited funds to be used in the demonstration (through matching local and Federal grants) of ways to reduce the number of expensive excess hospital beds. Nevertheless, it is a sign of the times we are entering that cutting back hospital capacity is talked about and argued over. It is a direction which both hospital administrators and community planners should heed. There are numerous estimates of the number of excess hospital beds and a matching number of estimates of the dollars that those empty beds add to the rising costs of health care. Excess hospital beds are estimated to range from 60,000 to 100,000. The Bureau estimates that closing excess capacity would save only about 10 percent of the operating costs of each bed closed. That may not sound like much, but the long-term savings to society, in reduced capital burdens and decreased utilization, will be substantial.

A more immediate directive in planning for the proper use of the nation's resources is also contained in the health planning legislation. The medical facilities section of the State health plans is not a new direction, but it does indicate a new emphasis on facilities as a major element in the health care system.

The original planning legislation (Public Law 93–641) provided for development of separate State medical facility plans (SMFPs) subject to the approval or disapproval of the Secretary, DHEW. In the 1979 legislation Congress recognized that institutional health services—their number, types, condition, personnel, and major equipment—are not separate, but are an integral part of the whole.

In the Bureau's energy program, as well as in facility planning, we are moving toward a holistic concept of health care and the interrelationships that exist. The Health Resources Administration has a broad mandate to identify and work toward solutions of the problems of health care resources. Energy is such a problem, and it will become ever more urgent in the 1980s. When the Bureau of Health Facilities was formed, the energy programs which had been in the Office of the Administrator were elevated to Division status within the Bureau. Through this Division, we operate as a facilitator, bringing health and energy groups together to educate them about present and future problems and provide technical assistance in finding solutions to the dependency of our health care institutions on single sources of fossil fuel and the escalating costs of that fuel.

Initially, most efforts of the energy programs were devoted solely to health care facilities. These included publications on energy management, surveys of facility consumption and, using funds from the Department of Energy, contract awards for health facilities to demonstrate the use of solar projects for hot water and space heating. However, with the increasingly critical outlook for fossil fuel supplies, the impact of potential fuel shortages, and the need to develop alternative energy sources, it is clear that the ultimate impact will go beyond hospitals and other treatment facilities. There-

fore, the Bureau started a series of energy contingency conferences. From the first conference, the participants developed the concept of a National Alliance for Health and Energy Resources Contingency Planning. That Alliance, first envisioned on September 21, 1979, is now a reality. This non-Federal, voluntary organization was officially formed November 29 and includes representatives from Federal, State, and local government units, as well as provider and health insurance organizations. The Alliance has elected officers (I am honored to serve as its chairperson), established committees and working goals, and scheduled meetings throughout the coming year.

The Bureau's energy programs' staff have been actively cooperating with both the Bureau of Health Planning and the Department of Energy in yet another area. In 1978, Congress passed the National Energy Conservation Policy Act (Public Law 95–619). Among other provisions that act modified the health planning law by adding an 11th national health priority to the goals for national health planning: "The promotion of an effective energy conservation and fuel efficiency program for health service institutions to reduce the rate of growth of demand for energy." The act authorized a matching grant program which, in part, would help hospitals identify and implement energy conservation procedures. The Bureau has conducted a series of regional workshops throughout the nation to explain to local health planners their review responsibilities in this grant program in energy conservation.

The preceding summary of some basic responsibilities indicates the tensions which must be faced in an era of decreasing resources. Other tensions exist in the Bureau's work of implementing the assurance regulations which were published in final form in the May 18, 1979, issue of the Federal Register (*1*). Those tensions relate to the interests of provider, consumer, and government groups—interests which sometimes seem in conflict with one another.

Background

Before detailing the process, which is continuing, of implementing the final regulations, it may be useful to give a short history of the uncompensated care and community service assurances in the United States.

During the first decades of this century, the nation experienced two World Wars and a depression. It was a time of limited resources, particularly hospitals, and the need for hospitals was keenly felt, perhaps because of the burgeoning scientific and medical advances of that era. These advances often depended on technology and expertise that were more adaptable to use within hospital settings than in office practice.

Preceded by studies, commissions, committees, and government involvement through other programs in hospital contruction, the Hospital Survey and Construction Act (Public Law 79–725) was enacted by Congress on August 13, 1946. Co-sponsored by Senator Lister Hill and Senator Harold Burton, the act became widely known as the Hill-Burton Program.

The first Hill-Burton authorization was $75 million for grants-in-aid to the States for planned construction of hospital facilities. From that start, the Program eventually aided more than 12,000 projects involving 7,000 facilities in more than 4,000 communities. The Program eventually disbursed a little more than $4 billion in Federal funds.

From the beginning, Congress indicated that hospitals and health care facilities aided through Hill-Burton had to (*a*) serve all persons residing in the facility's service area without discrimination (the community service assurance) and (*b*) provide a "reasonable volume of services" to persons unable to pay (the uncompensated care assurance).

Those assurances received little regulatory attention for the first quarter century of the act's existence. The first major change occurred in 1963, when the act's "separate but equal" provisions assuring community services were struck down as a result of the *Simkens* v. *Moses* case (*2*). Congress acted in 1964 to delete the clause from the act. On July 22, 1972, the regulations again were changed, partly in response to *Cook* v. *Ochsner Foundation Hospital* (*3*) which had been filed in July 1970 against 10 Hill-Burton aided hospitals in Louisiana. The regulations were changed to stipulate that State Hill-Burton agencies were to administer the compliance of obligated facilities with the assurances specified in the law, set eligibility criteria for persons entitled to uncompensated care, and conduct a monitoring and enforcement program. "Reasonable volume" was defined as being either 3 percent of the obligated facilities' operating costs or 10 percent of the amount of Federal assistance. Or the facility could choose the "open door option" in which it agreed to serve anyone who needed care, regardless of ability to pay. A facility was further obligated to provide this volume of uncompensated care for 20 years in the case of grant recipients or as long as the loan remained unpaid for loans and loan guarantee recipients.

In 1975, the new National Health Planning and Resources Development Act (Public Law 93–641) incorporated the Hill-Burton Program as the new Title XVI of the Public Health Service Act and made other important changes. Monitoring and enforcement of the assurances became the responsibility of the Federal Government, rather than the State Hill-Burton agen-

cies. Facilities which received aid under Title VI (the old Hill-Burton Program) or Title XVI were required to file periodic reports of compliance with the assurances. The new act also allowed individual persons to file complaints with DHEW charging noncompliance by a facility with its assurance obligation.

The assurance regulations were amended again on October 6, 1975, to require that facilities make determinations of eligibility prior to giving care in providing uncompensated services, post notices of the availability of these services, and keep separate accounts of the amount of uncompensated care provided. (This amendment was to eliminate the hospitals' practice of writing off bad debts to uncompensated care obligation.)

Genesis of Proposed Rules

In *Lugo* v. *Simon,* the plaintiff sought to enforce the Hill-Burton Act requirement that participating States provide adequate hospitals to furnish needed services for persons unable to pay (*4*). The plaintiff also asked that commitments of Hill-Burton aided facilities, the State of Ohio, and the DHEW—to provide a reasonable volume of uncompensated services—be enforced. That case resulted in a stipulation between the plaintiffs and DHEW that the department would issue proposed rules for implementing the assurances program, would have a comment period on those rules, including a public hearing, and would issue the final regulations. The Department issued a notice of proposed rulemaking for both Titles VI and XVI assurances on October 25, 1978. The proposed regulations generated spirited comment. Some of the more controversial proposals follow:

- All obligated facilities be required to meet specified dollar levels of uncompensated service. The effect of that requirement would be to eliminate the "open door option," which had proven difficult to monitor. Rather, facilities would be required to provide uncompensated care in a dollar volume that was the lesser of 3 percent of overall operating costs, minus Medicare and Medicaid reimbursement, or 10 percent of the Federal construction aid received.
- The 10 percent level would be tied to the National Consumer Price Index for Medical Care.
- In line with Title XVI, DHEW would assume responsibility for monitoring and enforcing compliance with the requirements, handling complaints, and conducting investigations. However, States could qualify to share in this responsibility.
- Facilities would help to develop and publish in their areas plans for distributing free or reduced cost services to the poor.
- National financial eligibility standards would replace standards previously set by each State. Under these standards, persons with income below the poverty guidelines established by the Community Services Administration would be eligible for free care, and those with higher incomes, up to twice the amount of the poverty guidelines, would be eligible for free or reduced cost care.
- Facilities would be required to provide a notice of the availability of uncompensated care to all people seeking admittance. The facility must also make a prompt determination of the individual's eligibility for such care if requested. If uncompensated care was denied, the facility would have to provide a statement of reasons for the denial.

During the public comment period (October 26–December 26, 1978) provided for in the proposed regulations, nearly 1,000 provider and consumer organizations and individuals, as well as local and State government bodies, submitted comments. Two days of public hearings were held December 5 and 6, 1978, and additional comments were given in testimony.

Because of the volume and substance of these comments, the Department asked that the court grant additional time before the final regulations were published. Initially, the regulations were to have been published in late March 1979, but with the extension granted by the court, the regulations were published May 18, 1979.

In their final form, the regulations were still considered burdensome by many providers. On June 27, 1979, the American Hospital Association filed suit against the regulations in Chicago Federal Court. According to the AHA, the regulations exceeded statutory authority and congressional intent, changed the burdens of hospitals already under Hill-Burton, thus impairing agreements made when financial assistance was provided.

In its suit, AHA asked for a temporary restraining order, which was denied August 31, and a preliminary injunction, which was denied October 1. Oral arguments were presented January 10, 1980. By the time this paper is published, we may have a determination by the Chicago court.

Some consumer groups have expressed reservations that the final regulations do not go far enough. They contend that during the early years of the Hill-Burton Program providers ignored the law, did not provide sufficient levels of uncompensated care, and are, essentially, getting away without paying the piper.

The consumer-provider tensions over these matters can be illustrated by summarizing comments submitted in response to some of the regulations.

The regulations were to establish a set level of uncompensated services which must be provided, while allowing the obligated facility as much flexibility as possible in choosing how to distribute these services. Setting a dollar amount for all uncompensated care services was the most controversial section of the proposed regulations, since it involved (*a*) eliminating the open door option and (*b*) adding an inflation factor to one compliance option. As expected, this generated the greatest number of comments of any provisions of the proposed rules.

Elimination of Open Door Option

Under the old regulations, the open door option allowed a hospital to fulfill its uncompensated care obligation if the facility stated that it would not turn anyone away simply because they could not afford care.

Almost all providers opposed eliminating the open door option. They maintained, for example, that only this option would truly address the needs of individual communities. Some communities, providers said, do not have enough poverty-level people to enable the obligated hospital to reach the 3 or 10 percent option levels. The spokesman for one general hospital in Nebraska said that, in 1976 and 1977, its bad debts and charity care combined would not have met the 3 percent compliance level. Other providers argued that the need for uncompensated care fluctuates from year to year, based on employment conditions, for example, or that residents of certain areas would resent and refuse care they saw as "charity." Only the open door option, these providers argued, would meet such community needs.

Some provider commenters cited those facilities—such as public-general hospitals and facilities required by State or local law to provide service to all—that would suffer undue paperwork and reporting problems without the open door option when, in fact, they must always maintain an open door.

Other provider commenters advocated that if, as the Department contended, the problem with open door facilities was one of monitoring compliance, the regulations address proper reporting mechanisms which would allow monitoring.

Some consumers sided with providers and were against eliminating the open door. They agreed that open door was the best mechanism for providing care to the poor and believed that other requirements in the new regulations, such as record-keeping and written determination of eligibility, would provide the needed proof of compliance with the open door option.

However, a large number of consumers urged that the open door option be eliminated. They said it had long been used by hospitals that wanted to evade their responsibilities. One commenter backed this observation by referring to the unaudited reports of a group of Rhode Island hospitals, in which only 7 out of 40 open door facilities reporting would have met either the 3 or 10 percent level of uncompensated care.

Department's Decision

The final regulations eliminated the open door option. The Department and Bureau officials continue to believe that having a clear dollar standard against which facility performance can be measured will simplify monitoring and administration, gain public confidence that a "reasonable volume" of services has in fact been made available, and will result in facilities shouldering relatively equal minimum obligations to serve the medically indigent.

There will be some instances where community need may not be great enough to meet the 3 or 10 percent level but, as provided in the final regulations, the total minimum level would then simply be spread out over a longer period of compliance (for Title VI facilities) so that, ultimately, the dollar volume would be provided. The charity hospitals could meet the total dollar volume in a shorter period.

Provision is made in the regulations for communities where the demand has been below compliance level. The hospital is required to develop an affirmative action plan to reach those publics that may qualify for uncompensated care. For public hospitals and others required by local law to serve as open door facilities, the regulations would require more expense if the open door option had been retained. Under the regulations, a facility has to give each incoming patient notice of the availability of the uncompensated care program, until the yearly level of care is met. Therefore, a facility which operated under open door would have had to provide such notices throughout the year—at substantial expense.

Inflation Factor

The proposed regulations recommended that the 10 percent option be modified by hinging it to an inflation factor—specifically the Consumer Price Index (CPI) for medical care. (The 3 percent option would automatically increase with inflation since it is related to operating costs). The rationale for this modification was to insure that the real value of services to be provided would remain constant.

During the comment period, providers generally objected to the modification, charging that the result would be a 200 percent return on the original Federal aid received by the facility. This, they said, was an im-

possible burden on facilities, would, in itself, be inflationary, and, further, that the CPI is not an appropriate measure of inflation.

Consumers generally supported the inflation factor, even suggesting in some instances that it be made retroactive to 1972 since they felt failure to do so "condemned consumers to appreciate less than half of the Hill-Burton entitlement."

After reviewing these comments, the Department staff continued to hold that the inflation factor is appropriate since it will keep the value of the uncompensated services constant in relation to the economy, and thus it will insure that the indigent are not deprived of services because of inflation. However, making this inflation factor retroactive to 1972 would make facilities subject to a suddenly increased obligation for which they have had no opportunity to plan.

In the analysis of the impact of these regulations, the Department estimates that, if all obligated facilities were to use the 10 percent option, in 1980 $395 million in care would be provided to the medically indigent. This amount would increase to $537 million in 1984. However, if hospitals had been providing the required levels of uncompensated care all along, these figures would not represent new costs. The Department will reassess its position on the inflation factor before it results in truly *added* costs of $100 million, or more, annually.

Deficits and Excesses in Compliance

The proposed regulations required facilities to make up deficits in the volume of uncompensated care in the following year, unless the Secretary extended the period of makeup. Providers opposed this provision vigorously, as did some State planning agencies. Additionally, providers pointed out that, to be fair, if deficit makeup is required, credit should also be given for excess levels of uncompensated care provided. Consumers favored the deficit makeup; indeed many argued that facilities that were in the 3 or 10 percent option should be required to make up deficits incurred since 1972. The reason, stated by one consumer, was that facilities had been on notice since 1972 that they were required by law to provide these levels of care without charge, and failing to apply the makeup factor would let many facilities avoid their obligation altogether. Consumers suggested sanctions, including makeup of all deficits before any review of a proposed use of Federal funds by a facility is conducted by the HSA or State planning agency.

The final regulations, in response to these comments, retained the deficit makeup provision, but added credit for excess uncompensated care services provided; thus the Department reinforced its position that facilities are obligated to provide a set dollar volume of services.

Posted Notices

The proposed regulations provided that notices be posted in appropriate places in an obligated facility, informing the public of the availability of uncompensated care. Further, such notices were to be bilingual in those communities with a bilingual population, and they were to outline the procedure for filing with DHEW complaints of noncompliance against the facility.

In the final regulations, the Department responded to a number of specific suggestions on language change and assumed the cost of printing and mailing signs. Responding to comments, the Department also provided signs to obligated facilities on the community service assurance. The Bureau printed and distributed more than 80,000 signs by late August 1979. Facilities must post signs in business and admissions offices and emergency rooms. One sign is a notice of "availability of medical care for those who cannot afford to pay" and the other sign states that "this facility is legally obligated to serve the community."

Because of the wording of the final regulations, facilities are legally bound to display both English and Spanish versions of the sign whether or not there is a Spanish-speaking population in the area. Proposed changes in this language have been discussed with various interest groups, but the regulations have not yet been altered.

Individual Notices

The regulations proposed in October 1978 required that each person seeking service in an obligated facility receive an individual written notice of the availability of uncompensated services, criteria of eligibility for the service, the facility's allocation plan, and the availability of prompt eligibility determination. These notices were to be given before the patient was served except in emergency cases, when they could be provided no later than the patient's first bill for services.

Providers objected in the comment period saying, among other things, that the notices would encourage fraudulent applications from some patients and antagonize others who do not want "charity." But the most common objection was cost. Providers asked for exceptions since, according to one provider association; the majority of the 123 million patients cared for each year in Title VI-obligated facilities are already covered by insurance and thus would be ineligible for uncompensated care.

Consumers generally favored giving notices to individual patients, but suggested numerous refinements—for example, multilingual notices.

The requirement for individual notices is part of the final regulations. This is consistent with a legal decision stemming from *Newsom* v. *Professional Adjustment Service* (*5*), which suggested that such notices are required. The expense of individual notices is ameliorated by requiring that notices be given out only until the facility has met its yearly obligation level.

Eligibility Determinations

Eligibility determinations are those criteria to be applied to decide if an individual is truly eligible, because of income level, to receive uncompensated services.

A 1974 court decision, *Corum* v. *Beth Israel Medical Center* (*6*), struck down previous regulations on eligibility. The court disallowed the practice of hospitals deciding after services were given (and a bill sent to the patient) that the patient was eligible for care without charge. The patient has the right to know, said the court, whether or not he or she will be receiving such care before assuming liability for the bills.

The proposed regulations followed this reasoning and required that, in order for a hospital to count services under its uncompensated care obligation, a determination of eligibility must be made "promptly on request." The hospital must give a copy of the determination to the patient and, if free care was denied, give a written explanation to the patient.

In general, both consumers and providers supported the shift from "prior" determination to that made "on request." However, in response to many comments, the regulations now define "request" as any indication of inability to pay for service. "Promptly" is defined as 2 working days. The hospital may verify the information provided in a patient's request for free care. However, a hospital does not have to determine eligibility if it has provided its annual obligated level of free care. Reasons for denial must be given to the patient, including, for example, that the hospital has already met its annual requirement for uncompensated services.

Uncompensated care is viewed as a last resort payment program and should be used only for those not eligible for any other form of health payment. Thus, hospitals may require that a patient applying for uncompensated care, who is eligible for service under other programs such as Medicaid or Medicare, must apply for those benefits. The patient may, however, request uncompensated care before or "at any time" after services have been provided.

Reporting and Record Maintenance

The proposed regulations required facilities to submit annual reports on compliance and certain financial data no later than 60 days after the end of their fiscal year. Facilities were required to maintain records for 5 years.

Providers pointed out that Medicare cost reports are completed 90 days after the close of the fiscal year, and they requested that the two reporting requirements be synchronized; the final regulations allowed the annual reports to be submitted at the same time as Medicare cost reports. Also, convinced that annual reporting was a true burden to obligated facilities, the Department changed the regulations to require reporting only every 3 years, on a staggered basis to be determined by the Department. However, the Department may require that the facility report more often if there is a possibility of noncompliance. Also, when a facility does not meet its obligated level of uncompensated services, it must file a report.

Within 10 days of receiving a legal complaint of noncompliance, the facility must report the complaint to the Department. Providers argued that this provision was too burdensome. However, the Department does not believe that it causes an undue burden, and further, considers it a necessary requirement to help the Department fulfill its responsibility for enforcing the regulations.

Records of compliance are to be available to the public. The Department believes that assisted facilities should be accountable to the community in their fulfillment of the assurances and that interested members of the public, working closely with facilities, can be helpful in assuring compliance without Federal intervention. However, hospitals are cautioned that identification of individual patients should be avoided.

Enforcement

As mentioned, the 1974 Health Planning Act changed responsibility for monitoring and enforcement provisions of the Hill-Burton Program from the States to the Department. The proposed regulations took the new law into account. The regulations also stipulated that the Department could enter into an agreement with the State planning agency (SHPDA) in which the State would then assist the Department by carrying out agreed upon monitoring and enforcement responsibilities. However, the Department retained ultimate responsibility.

Providers, arguing that State-level administration is more appropriate since both needs and resources are better known at that level, were against the change from State to Federal administration. This same theme was repeated by consumer groups, particularly those from States which had demonstrated positive involvement with the assurance program. A California consumer

group against the change pointed out that resources for frequent on-site visits and financial audits are necessary and questioned whether necessary Federal resources exist. A Massachusetts commentator pointed out that a few State agencies have started active enforcement of the assurances and, for indigent patients in such States, a change in Federal control resulting in delays and procedural complexities would represent a serious step backward.

However, consumers who regarded their State's enforcement of Hill-Burton assurances as lax generally supported the transfer of responsibility to the Federal Government. A Georgia legal aid society, for example, recommended that before a State agency be allowed to contract with the Department to administer the assurances, it must furnish satisfactory documentation of adequate past enforcement and monitoring efforts.

The final regulations, as already noted, conform with statutory requirements and thus transfer the responsibility for the assurances from the States to the Department. Overall, the States did not satisfactorily enforce the assurances, and those few that did are encouraged to enter into an agreement with the Department to continue their enforcement activities. States entering into agreements may go beyond the scope of these regulations, which are minimum requirements. For example, a State which has agreed to enforce the assurances program may develop more stringent legal sanctions against facilities that fail to comply.

State Agreements

The Bureau is particularly anxious, considering our limited workforce, to encourage those States able to take over monitoring and enforcement functions to sign agreements with the Department. In September 1979, we sponsored three national meetings with State agencies for initial discussions on their potential role in compliance activities. A model State agreement was drafted and presented to the 47 State agency representatives who chose to attend. The agreement outlined the following functions which a State may choose to assume for the Federal Government: monitoring for compliance, investigation of complaints regarding noncompliance and making initial determinations in those cases for the Secretary, applying State legal sanctions against facilities which are out of compliance, and reviewing facilities' affirmative action plans and reporting forms.

A number of States have filed preliminary agreements with the Department, and others have expressed an interest in drafting agreements. We hope to involve as many as possible of those States that have the interest and resources for implementing the requirements of the law.

At a series of four national meetings held in December 1979, representatives from DHEW Regional Offices, State planning agencies, and consumer and provider organizations were invited to discuss with the Bureau staff the model State agreement, and the materials that had been developed to aid the facilities and State agencies that might sign agreements, in complying with the requirements of the new regulations. These materials had been developed with the aid of Regional Office and State agency people and had been commented on by both consumer and provider representatives. The materials include a provider's guide (*7*) which gives the basic framework for obligated facilities to comply with the assurance requirements; an assessment manual, outlining policies and procedures for assessing facilities, which will be mailed to all obligated facilities (this manual is intended for Regional Office staff as well as those State agencies which sign agreements); and a consumer brochure, oriented to the medically indigent, that explains their rights under the uncompensated care and community service assurances.

The December meetings were attended by representatives from 31 State agencies. Consumer groups and providers were widely represented. Each meeting lasted 2 days, and included workshops which were small group discussions of the manuals in detail. These meetings were extremely valuable to the Bureau because of the questions raised by both providers and consumers on areas of the regulations which need clarification. For example, one concern which surfaced at all the meetings was the definition of "at any time" in reference to patients asking for uncompensated services. Specifically, the Bureau was asked to define the parameters for dealing with requests for eligibility determinations after the service has been given. Under the wording now in the regulation, "at any time" could mean that a patient could ask for a determination years after care had been received.

These and other equally important questions will be addressed by the Bureau through policy issuances that will be transmitted to all obligated facilities, as well as to consumer advocates, State agencies, and of course, the Regional Offices.

Other enforcement tools given to the Bureau in the new regulations include early dismissal of complaints filed by individual persons against noncomplying facilities. Early dismissal (no sooner than 45 days after receipt of the complaint) allows suits to be filed in court for a determination there. Complaints will be dismissed early at the discretion of the Bureau or at the request of the complainant, but the choice of options will always be based on enforcement priorities of the Depart-

ment. In other words, this discretionary choice will allow the Bureau to concentrate resources on a complaint which might be of great significance and far reaching consequences in certain compliance issues. The Bureau, through the Department, can ask the Attorney General to bring action for specific performance against a noncomplying facility.

Service to the Community

Many of the changes in the final regulations on the community service assurance obligations were intended to clarify or to make explicit what was already implicit in the old regulations.

The new community service and uncompensated care regulations are summarized on page 173.

Although the duration of obligation for community services was not changed, this factor did receive comment. The obligation to provide a community service without discrimination in accepting patients is not time-limited for either Title VI- or XVI-aided facilities. The complaint by some providers that this is an unreasonable burden has been answered by the courts. A 20-year limitation on this assurance was struck down in *Cook* v. *Ochsner Foundation Hospital* (*3*) and in *Lugo* v. *Simon* (*4*).

Both consumers and providers commented on the need to define the "service areas" of obligated facilities. In the final regulations "service area" is defined as that approved in the most recent Hill-Burton plan approved by the Secretary of DHEW for the State where the particular facility is located. Because some plans have not been updated since the early 1970s, each facility is given the opportunity to propose, for the Secretary's approval, a service area that differs from that in the most recent Hill-Burton plan if the facility can show that the Hill-Burton area no longer applies.

The regulations now specifically state that facilities may not discriminate in providing services on the grounds of race, creed, color, or national origin, and further, "on any ground unrelated to an individual's need for the service or the availability of the needed service in the facility." This wording essentially prohibits admissions practices that have the effect of excluding persons residing in the service area. It prohibits any pattern of providing care that would have the same exclusionary effect. For example, the regulations would require obligated hospitals to insure that Medicaid and Medicare patients will be treated.

As might be expected, providers generally argued that this regulation of admissions procedures is not appropriate or proper; consumers in general supported these proposals.

The Department responded, in the final regulations, that facilities assisted with Federal funds have agreed to make their services available to all persons in the service area and that this agreement is not fulfilled when methods of admission are used to prevent such persons from taking advantage of available services. However, the final regulations do not ban the use of preadmission deposits—only those which can be viewed as exclusionary.

The Department also disagreed with providers' assertion that hospitals do not have authority over their medical staff. In fact, the Department stated in the analysis section of the final regulations that "We are aware of no courts that have taken a contrary view, and in fact, the case law relating to termination of physician staff privileges very clearly supports the hospital's right to impose reasonable conditions on staff privileges."

The regulations do allow a facility to deny services to those who cannot pay. This is not a contradiction. Not all U.S. facilities received Hill-Burton aid, and further, the uncompensated care provisions apply only to facilities which received aid after September 1959. Also, once the annual obligation level is met, a facility is not required to give uncompensated care. However, Department officials do not believe that the facility is living up to its community service obligations if it denies emergency service (when it has that capability) simply because the patient cannot establish an ability to pay. Thus, a facility having emergency capability which denies emergency care is in violation of the community service obligation. Of course, once treatment is rendered and the patient stabilized, the facility may transfer the patient. Also, the facility may bill for services rendered in such cases.

One other change in the final rules for community services has been to define "resides." This change was specifically intended to make it clear to obligated facilities that migrant workers and others who reside in the service area of Title VI-assisted facilities may not be denied services on the ground that these workers are not permanent residents.

Conclusion

Within the limitations of existing resources, we are developing tools to implement these regulations. This is a top Bureau priority, for we know that through the assurances program a basic human right will be extended to people otherwise unable to afford medical care.

References

1. Medical facility construction and modernization; requirements for provision of services to persons unable to pay and community service by assisted health facilities. Federal Register, Vol. 44, No. 98, pp. 29372–29410, May 18, 1979.
2. *Simkins* v. *Moses H. Cone Memorial Hospital,* 323 F. 2d 959 (4 Cir. 1963), cert. den. 376 U.S. 938 (1964).

3. *Cook* v. *Ochsner Foundation Hospital,* Civil No. 70–1969 (E.D. La. filed March 13, 1975)
4. *Lugo v. Simon,* 426 F. Supp. 28 (N.D. Ohio 1976)
5. *Newsom* v. *Professional Adjustment Service, Inc.,* 453 F. Supp. 401 (M.D. Tenn. 1978)
6. *Corum* v. *Beth Israel Medical Center* 373 F. Supp. 550 (S.D.N.Y. 1974)
7. Provider's guide to regulations, uncompensated care and community service assurances; guidance to aid facility compliance with its uncompensated care and community service obligations under Hill-Burton and other Federal financial assistance programs. Bureau of Health Facilities, Department of Health, Education, and Welfare, Hyattsville, Md., December 1979.

Summary of Final Regulations for Assisted Health Care Facilities

These rules affect 5,000 facilities obligated by the uncompensated care requirements and 7,000 obligated by the community service requirements of Title VI of the Public Health Service Act (formerly Hill-Burton) and Title XVI of the act (Public Law 93-641 and amendments). They substantially change the assurance program.

Uncompensated Care

Facilities which received aid under Title VI were required to provide uncompensated care for 20 years. The final rules affect only the time remaining in that 20-year period. Title XVI-aided facilities must provide uncompensated care throughout their existence.

A facility must provide a dollar volume of uncompensated care equal, annually, to 3 percent of its operating costs (less Medicare and Medicaid reimbursement) or 10 percent of the amount of aid it received—whichever amount is smaller. The 10 percent figure will be adjusted each year, using the percentage change in the Consumer Price Index for medical care.

If a Title VI facility does not provide this level of uncompensated care (for any reason) in a given year, it will be required to make up the deficit in following years. However, a facility which provides more than the required level may have the excess credited to its obligation in future years. This provision means that a facility may fulfill its obligation in less than 20 years.

If a facility does not meet the minimum level of uncompensated care because of demonstrated low demand in the community, an affirmative action program will be required. Through this program, the facility will inform those needing services of its availability.

If a facility, for financial reasons, cannot provide the volume of uncompensated services required, it may apply to the Secretary of Health, Education, and Welfare for a deferral of all or a portion of the services it is required to provide.

Title XVI-aided facilities will be required to make up deficits only if the deficits are caused by noncompliance with the regulations.

Facilities must publish plans for allocating uncompensated services. These plans must take account of community needs and thus must be sent to the local health systems agency which may advise. However, final decisions are up to the facility's managers.

Facilities must publish, post, and provide each incoming patient with a notice of the availability of the uncompensated care program. Once a yearly level is met, the facility no longer has to give each admitted patient such notices or provide uncompensated services.

Persons unable to pay may request and can obtain a determination of their eligibility for uncompensated care before services are provided, or after collection action has been taken by the hospital.

The Community Services Administration poverty guidelines will be used to determine eligibility.

Hospitals are required to provide compliance reports every 3 years, although the Secretary may determine a need for such reports more frequently. The facility must report each year it does not provide the full level of uncompensated services.

Hospitals must keep financial records which clearly show the difference between uncompensated services and expenses such as bad debts and other write-offs.

Individuals may continue to file complaints against a facility for noncompliance with the assurances. These complaints may, however, be dismissed by the Secretary if a decision cannot be reached on a timely basis. Complainants may ask, after 45 days have passed, that their complaint receive early dismissal so they may file in court.

Community Services

Facilities must provide services without discrimination.

Facilities (with some exceptions such as specialized service facilities like alcohol treatment centers) must serve all those who live or work in their service area.

Facilities must participate, if qualified, in major governmental and third-party reimbursement programs.

They must not use admission policies which would effectively bar those who otherwise would be eligible for uncompensated care. An example of such a policy is requiring preadmission deposits of the medically indigent. Another example, specifically mentioned in the regulations, is the practice of some physicians with staff privileges refusing to treat Medicare and Medicaid patients. Should a facility not admit Medicare and Medicaid patients, because no staff physicians will treat them, it will be considered in noncompliance with the community service regulations.

The regulations specifically prohibit facilities which have emergency treatment capability from denying such treatment to any person needing it because he or she cannot pay for it.

State planning agencies may assist the Department of Health, Education, and Welfare in its monitoring and enforcement activities under the assurance program.