

# *Program Policy Notice No. 13-04*

- ◆ U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
- ◆ Health Resources and Services Administration
- ◆ Healthcare Systems Bureau

February 14, 2013

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To: Nursing Homes Obligated Under the General Hill-Burton Uncompensated Services Regulations

Subject: Guidance for Nursing Homes

The following guidance is provided to illustrate ways in which nursing homes can substantially reduce their deficits and increase the amount of uncompensated services credit:

1. **Reduce your deficit by calculating the annual compliance level under the 3 percent method.**

The annual compliance level is equal to the lesser of 10 percent of the Federal assistance received, adjusted for inflation, or 3 percent of operating costs, minus Medicare and Medicaid reimbursement. Nursing homes generally benefit by using the 3 percent method. **In fact, a nursing home that provided 3 percent documentation had its deficit reduced from over \$2,000,000 to about \$200,000.**

If your uncompensated services deficit is based in whole or in part on the 10 percent method, use the attached form to determine whether the 3 percent method produces a smaller annual compliance level for any years within your facility's period of obligation. Should the 3 percent method result in a lower annual compliance level, provide the documentation (Medicare/Medicaid cost reports and audited financial statements specified on the attached form) so that the obligation status can be revised.

2. **Request uncompensated services on behalf of patients.**

A facility need not wait for a patient to initiate a Hill-Burton request. A facility may request uncompensated services on behalf of an individual as long as it has specific knowledge of the individual's total income at the time of the request. The application/determination of eligibility form must include the date of the request, the date of the determination, family size/income information, dates of services, and the amount of free or reduced cost care provided. The patient does not need to sign the application. **A request may cover outstanding balances only, or it may cover outstanding balances as well as services you provide for up to the next 12 months.**

**3. Review existing accounts with outstanding balances.**

Facilities often have accounts for which they have not pursued payment from individuals or for which they have been unsuccessful in collecting payments. We suggest you review open accounts and determine whether any are for Hill-Burton eligible patients. You may ask the patients or family members for current income information, and apply for Hill-Burton services on their behalf. **Any amounts for services which are owed and are legally collectable under State law from the patient may be applied toward the facility's uncompensated services obligation, as long as the patient is currently eligible and the services are included in the facility's current Hill-Burton published allocation plan.**

You may consider deceased individuals for eligibility under the Hill-Burton program. In determining whether a deceased individual qualifies, eligibility is based on the family's income at the time of the request. **However, where the family includes only the deceased individual, financial eligibility is based on the decedent's income for the 3 months or 12 months preceding the death, using the poverty guidelines applicable at the time of death.** For purposes of determining family size, the deceased patient is included as a family member.

**4. Expand your allocation plan to include services to persons with incomes up to triple the poverty level (Category C).**

You may be able to increase the amount of Hill-Burton credit by increasing financial eligibility to include persons with incomes up to three times the poverty level. In many nursing homes, the only individuals who meet the Category A and B income-eligibility requirements for receipt of uncompensated services are also covered by their State's Medicaid program; hence, they are by definition ineligible for uncompensated services. By including Category C individuals, the pool of Hill-Burton eligible individuals may be greatly increased so that a nursing home can provide free or below cost health services and satisfy its uncompensated services obligation.

**5. Identify services which are not covered by Medicaid.**

Because many patients in nursing homes are covered by Medicaid, nursing homes may benefit by identifying services not covered by Medicaid which may be eligible for Hill-Burton credit. Examples of services not covered by Medicaid may include: bed-hold days, occupational therapy, physical therapy, speech therapy, eye examinations, glasses, hearing aids, dentures, podiatry, certain drugs, transportation, admission kits, and activity supplies. You should review your State's Medicaid Plan for a specific list of noncovered services.

**6. Provide services in another facility which is part of the same corporate entity and health service area.**

Where a facility is part of a single corporation which includes one or more health care sites located within the same health service area, the facility may request approval to provide Hill-Burton uncompensated services in the other site(s). (See Program Policy Notice No. 91-01.)

For example, a nursing home may request approval to provide uncompensated services in a hospital that is part of the same corporation and health service area. If approved, uncompensated services provided at the hospital, in accordance with the regulatory requirements, may be credited toward the nursing home's Hill-Burton obligation.

**7. File a financial inability claim when you cannot afford to meet your annual compliance level.**

If you feel that your facility is financially unable to meet its adjusted annual compliance level, you may file a financial inability claim with the Department of Health and Human Services. If the Department, after reviewing the claim, finds that the facility is financially unable to meet the annual compliance level, the Department will establish a deferment schedule for the facility to make up that deficit. If the Department finds that the facility is financially able, an affirmative action plan will be required at that time. To determine if filing a financial inability claim is appropriate for your facility, please see Program Policy Notice No. 95-07.

**8. Consider eligibility for one of the compliance alternatives.**

There are three compliance alternatives. Two are designed to accommodate facilities that provide substantial amounts of free care, but are unable to qualify for Hill-Burton credit due to failure to meet certain regulatory requirements. The two alternatives are the public facility compliance alternative (for publicly owned and operated facilities) and the charitable facility compliance alternative (for public and non-profit facilities). The third alternative is the unrestricted availability compliance alternative, which was designed to accommodate Title VI facilities that operate fully expanded allocation plans, but have chronic deficits. Qualifying for one of these alternatives allows you to:

- convert your obligation which is based on dollars to time;
- absolve prior deficit years;
- operate your own discounted health services program, defining both program and financial eligibility criteria (limited to the public and charitable alternatives); and
- reduce record keeping and many other regulatory requirements applicable to non-alternative facilities (limited to public and charitable alternatives).

For further information or assistance regarding items discussed above, or if you need a copy of the Program Policy Notices referred to above, please contact the Division of Poison Control and Healthcare Facilities, Healthcare Systems Bureau, Health Resources and Services Administration, Parklawn Building, 5600 Fishers Lane, Room 10-105, Rockville, Maryland 20857; telephone (301) 443-5656.

*for Linda Tidwell*

Joyce G. Somsak  
Associate Administrator

**CALCULATION FOR DETERMINING  
ANNUAL COMPLIANCE LEVELS UNDER THE 3 PERCENT METHOD**

FACILITY: \_\_\_\_\_

I.D. NUMBER: \_\_\_\_\_

CITY & STATE: \_\_\_\_\_

Fiscal Year			
Information Year*			
1. Total Operating Expense (A specific line item in Facility's Audited Financial Statement)			
2. Medicare Reimbursement**			
3. Medicaid Reimbursement (Worksheets E-3/E-5, Part III, total cost reimbursable to provider)			
4. Total Operating Cost 1 – (2 + 3)			
5. 3 Percent Obligation 4 x .03			

\*Information to be obtained from facility's Audited Financial Statement and Medicare and Medicaid Cost Reports for two years before the reporting year (i.e., for 2012 reporting year, use data from FY 2010).

\*\* Use Medicare Worksheets E Part A; E Part B; E-2; E-3 Part I; E-3 Part II; and E-3 Part III, total cost reimbursable to provider. In addition, there may be certain costs reimbursed by Medicare which are not reflected on the Medicare Cost Report. These amounts can be found in the Provider Statistics and Reimbursement Report.