

PROVIDER'S GUIDE

to the Hill-Burton
Uncompensated Services
Regulations

This guidance document does not bind the public, except
as authorized by law or incorporated into a contract

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**to the Hill-Burton
Uncompensated Services
Regulations**

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Revised
February 1988

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service
Health Resources and Services Administration
Bureau of Health Resources Development
5600 Fishers Lane
Rockville, Maryland 20857
DHHS Publication No. HRS-MHF 88-1

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FOREWORD

This is a revision of the Provider's Guide issued in January 1984. It incorporates the requirements contained in the revised regulations published on December 3, 1987. The revised regulations became effective on February 1, 1988.

All facilities obligated under the uncompensated services assurance must comply with these revised regulations. However, these regulations provide for compliance alternatives for certain facilities. Therefore, the Provider's Guide is divided into four parts to accommodate facilities obligated under the general rule as well as those certified under one of the compliance alternatives:

- 1) facilities obligated under the general rule;
- 2) facilities eligible for the public facility compliance alternative;
- 3) facilities eligible for the community health center, migrant health center and National Health Service Corps compliance alternative; and
- 4) facilities eligible for the small annual obligation compliance alternative.

Cross references to the regulations are provided wherever regulatory requirements are mentioned.

Hill-Burton facilities are also obligated under the community service assurance, 42 CFR Part 124, Subpart G. This assurance is administered by the Office for Civil Rights. If you have questions concerning the community service assurance, contact the Office for Civil Rights. Their toll free number is: 1-800-942-5577 or, for District of Columbia residents, 245-9180.

If you have questions about the uncompensated services regulations, please contact your Regional Office (listed in Appendix I), State agency (listed in Appendix II), or the Division of Facilities Compliance, Bureau of Health Resources Development, Room 11-19, 5600 Fishers Lane, Rockville, Maryland 20857. The Division's telephone number is: 301-443-5656, or call the Hill-Burton toll free hot line information number: 1-800-638-0742 or, for Maryland residents, 1-800-492-0359.

GLOSSARY

<u>ADJUSTED ANNUAL COMPLIANCE LEVEL</u>	The annual compliance level adjusted by the amount of any deficit required to be made up in that year and by the amount of previously earned excess applied to that year.
<u>AFFIRMATIVE ACTION PLAN</u>	A plan, developed by facilities which had deficits, to enable them to meet their next adjusted annual compliance level.
<u>ALLOCATION PLAN</u>	The method by which a facility intends to distribute uncompensated services.
<u>ALLOWABLE CREDIT</u>	The lesser of a facility's usual charges for services, or the usual charge multiplied by a percentage which equals the total allowable cost as reported in the facility's Medicare Cost Report for the <u>preceding</u> fiscal year divided by the facility's total patient revenues for the year; a factor used to compute the amount of uncompensated services creditable toward a facility's obligation. (This does not apply to facilities certified under the compliance alternatives.)
<u>ANNUAL COMPLIANCE LEVEL</u>	The minimum amount of uncompensated services, in dollars, required to be provided by a facility in a fiscal year, calculated as the lesser of the products of the 10% and 3% methods.
<u>ASSESSMENT</u>	An investigation by the Department of Health and Human Services (HHS) or a State agency of a facility's compliance with the uncompensated services regulations.
<u>BASIC FACILITY REPORT</u>	A document, produced by HHS and sent to facilities, containing data on a facility related to its Hill-Burton uncompensated services obligation.
<u>CATEGORY A</u>	Persons whose family income is not more than the Poverty Income Guidelines, and who are therefore eligible for uncompensated services at no charge.
<u>CATEGORY B</u>	Persons whose family income is greater than the Poverty Income Guidelines, but not more than twice the Guidelines, and who may be eligible for uncompensated services at no charge or in accordance with a schedule of charges specified in the facility's allocation plan.
<u>COMPLAINT</u>	A written allegation, submitted to the Regional Health Administrator of HHS, that a facility failed to comply with the uncompensated services regulations.
<u>COMMUNITY HEALTH CENTER</u>	A facility funded under Section 330 of the Public Health Service Act.

<u>CONDITIONAL DETERMINATION OF ELIGIBILITY</u>	A documented response to a request for uncompensated services, which specifies conditions to be met in order for an individual to receive uncompensated services. A conditional determination of eligibility must be made within specified time frames.
<u>CONSUMER PRICE INDEX (CPI)</u>	The Consumer Price Index for Medical Care, produced by the Bureau of Labor Statistics, used to establish the inflation factor or percentage by which to adjust the annual compliance level under the 10% method, and deficits and excesses.
<u>CORRECTIVE ACTION</u>	Steps to be taken, as required by HHS, to remedy areas of noncompliance.
<u>DEFICIT</u>	The amount by which a facility failed to meet its adjusted annual compliance level of uncompensated services, and which must subsequently be made up.
<u>DENIAL</u>	A negative determination of eligibility containing the reason for denial of uncompensated services.
<u>DETERMINATION OF ELIGIBILITY</u>	A documented response, made within specified time frames, to a request for uncompensated services.
<u>EXCESS</u>	The amount by which a facility exceeded its adjusted annual compliance level of uncompensated services, and which may be used to reduce the facility's dollar obligation in future years.
<u>EXCLUSIONS</u>	Amounts that cannot be included in computing the amount of uncompensated services provided.
<u>FACILITY</u>	An entity that received Federal assistance under Title VI or XVI of the Public Health Service Act, and provided an assurance that it would provide a reasonable volume of services to persons unable to pay.
<u>FACILITY STATUS REPORT</u>	A document, produced by HHS and sent to facilities, containing data on a facility related to its Hill-Burton uncompensated services obligation.
<u>FEDERAL ASSISTANCE</u>	Assistance received by the facility under: Title VI or XVI of the Public Health Service Act; and any assistance supplementary to the Title VI or XVI project received under any one of the following acts: <ul style="list-style-type: none"> • District of Columbia Medical Facilities Construction Act of 1968, 82 Stat. 631 (Pub.L. 90-457) • Public Works Acceleration Act of 1962 (42 USC 2641, et seq.) • Public Works and Economic Development Act of 1965 (42 USC 3121, et seq.) • Appalachian Regional Development Act of 1965, as amended (40 USC App.) • Local Public Works Capital Development and Investment Act of 1976 (Pub.L. 94-369)
<u>FISCAL YEAR</u>	The facility's 12-month accounting year.

<u>HHS</u>	The U.S. Department of Health and Human Services.
<u>INDIVIDUAL NOTICE</u>	A written notice of the availability of uncompensated services, including eligibility criteria, required to be provided to each person seeking services in the facility on behalf of himself or another.
<u>INFLATION FACTOR</u>	A percentage change in the National Consumer Price Index for Medical Care (CPI) used to calculate the annual compliance level under the 10% method, and to adjust deficit and excess amounts.
<u>MIGRANT HEALTH CENTER</u>	A facility funded under Section 329 of the Public Health Service Act.
<u>NATIONAL HEALTH SERVICE CORPS (NHSC) SITE</u>	A facility that has signed a Memorandum of Agreement with the Department under Section 334 of the Public Health Service Act, and where all medical services provided by the facility are provided by the NHSC professional(s).
<u>NURSING HOME</u>	A facility which received Federal assistance for and operates as a "facility for long-term care" as defined at Section 645(h) or Section 1624(6) of the Public Health Service Act.
<u>OPERATING COSTS</u>	The total operating expenses of a facility as set forth in an audited financial statement, minus the amount of reimbursement received or claimed from Medicare or Medicaid, used to calculate the annual compliance level under the 3% method.
<u>PERSONS UNABLE TO PAY</u>	Persons eligible for uncompensated services under Categories A and B, or if certified under one of the compliance alternatives, persons eligible under the facility's program of discounted health services.
<u>POSTED NOTICE</u>	Notices, supplied by HHS in both English and Spanish, of the availability of uncompensated services to be posted in specified areas of the facility.
<u>POSTSERVICE REQUEST</u>	For all facilities, a request for uncompensated services made after receipt of outpatient services, after discharge for inpatient services, or after admission for nursing home services.
<u>POVERTY INCOME GUIDELINES</u>	The income standards, produced by HHS, which are used to establish financial eligibility for uncompensated services.
<u>PRESERVICE REQUEST</u>	For facilities other than nursing homes, a request for uncompensated services made before receipt of outpatient services or before discharge for inpatient services. For nursing homes, a request for uncompensated services made prior to admission.

<u>PUBLIC FACILITY</u>	A facility which is owned and operated by a unit of State or local government or a quasi-public corporation.
<u>PUBLISHED NOTICE</u>	A notice of the availability of uncompensated services including the allocation plan, required to be published by a facility in a local newspaper of general circulation before the beginning of the facility's fiscal year.
<u>QUASI-PUBLIC CORPORATION</u>	A private, nonprofit corporation which has been formally given one or more governmental powers by a general-purpose unit of government to enable it to carry out its work. The formal delegation can be accomplished only by legislative action (e.g., through the State legislature, city or county council).
<u>REQUEST FOR UNCOMPENSATED SERVICES</u>	Any indication by or on behalf of an individual seeking services of the facility of the individual's inability to pay.
<u>SMALL ANNUAL OBLIGATION</u>	A facility with an annual compliance level of no more than \$10,000.
<u>STATE AGENCY</u>	An agency of a State which has entered into an agreement with HHS to assist in monitoring and enforcing the uncompensated services regulations.
<u>SUBSTANTIAL COMPLIANCE</u>	A determination, made by HHS, that a facility substantially complied with the procedural requirements of the regulations and provided uncompensated services to eligible persons who had equal opportunity to apply for those services.
<u>SUBSTANTIAL NONCOMPLIANCE</u>	A determination, made by HHS, that a facility did not substantially comply with the procedural requirements of the regulations which may have resulted in eligible persons not being provided the opportunity to apply and receive uncompensated services.
<u>TEN PERCENT METHOD</u>	Calculation of the annual compliance level by multiplying by 10% the amount of Federal assistance received and still under obligation, and adjusting the product by an inflation factor.
<u>THREE PERCENT METHOD</u>	Calculation of the annual compliance level by multiplying by 3% the facility's operating costs, minus Medicare and Medicaid reimbursement received or claimed.
<u>TRIENNIAL REPORT</u>	The Uncompensated Services Assurance Report, HRSA 710, required to be submitted by facilities at least every 3 years.

PART 1 - GENERAL RULE

INTRODUCTION

WHAT ARE UNCOMPENSATED SERVICES

Uncompensated Services is the term applied to health services made available at no charge or at reduced charges under Titles VI (Hill-Burton) and XVI of the Public Health Service (PHS) Act to persons unable to pay.

WHO MUST PROVIDE THEM

All health facilities which received grants, loans or loan guarantees for construction, modernization, or equipment under Titles VI or XVI of the PHS Act, or any assistance supplementary to the Title VI or XVI assistance, must make uncompensated services available.

WHO IS ELIGIBLE TO RECEIVE THEM

Persons are eligible for uncompensated services if they: 1) are not covered or receive services not covered under a third-party insurer or governmental program; 2) have an annual family income of not more than double the national Poverty Income Guidelines; and 3) request services within a facility's allocation plan.

HOW MUCH SERVICES MUST BE PROVIDED

Facilities are obligated to provide annually a minimum dollar volume of uncompensated services which is the lesser of: 1) 10 percent of the Federal assistance they received, adjusted for inflation; or 2) 3 percent of their annual operating costs, minus Medicare or Medicaid reimbursement.

HOW LONG DOES THE OBLIGATION LAST

Facilities which received grants under Title VI are obligated to provide uncompensated services for 20 years from the date the project was completed (usually the opening date). Facilities which received loans are obligated until the loan is repaid. These periods of obligation may be shortened or lengthened because of the excess and deficit provisions of the regulations. See Chapters IX and X.

Facilities which received grant funds under Title XVI are obligated indefinitely.

HOW ARE THE SERVICES PROVIDED

Uncompensated services must be provided in accordance with the procedural requirements of the uncompensated services regulations, 42 CFR 124.501 et seq.

WHO MONITORS FACILITIES' COMPLIANCE

HHS monitors and enforces the uncompensated services regulations. States may assist HHS with monitoring and enforcement.

HOW TO GET PROGRAM GUIDANCE

HHS sends program information to facilities through Program Policy Notices and Program Information Notes. Some States also provide such materials. Additional guidance is available from the State agencies listed in Appendix 2, from the HHS Regional Offices listed in Appendix 1, and from HHS headquarters (the telephone number is: 301-443-5656, or call the Hill-Burton toll-free hot line information number: 1-800-638-0742; or, for Maryland residents: 1-800-492-0359).

CHAPTER I

OPERATION OF AN UNCOMPENSATED SERVICES PROGRAM

Below is a step-by-step outline for achieving compliance with the new regulations:

- STEP 1 Calculate your annual compliance level and your allowable credit factor before the beginning of your fiscal year.
- STEP 2 Prepare a plan for allocating uncompensated services and publish it in a local newspaper of general circulation before the beginning of your fiscal year.
- STEP 3 Prepare and distribute individual notices to each person seeking services in your facility.
- STEP 4 Post signs provided by HHS about the availability of uncompensated services.
- STEP 5 Make timely determinations of eligibility, provide a copy to the patient promptly, and keep a copy on file. The time frames for making determinations of eligibility are as follows:

Nursing Homes - For requests made prior to admission, within 10 working days of the request, but no later than 2 working days after admission. For requests made after admission, no later than the end of the first full billing cycle following the request.

Other Facilities - For requests made prior to discharge or prior to receipt of outpatient services, within 2 working days following the request. For requests made after discharge or after receipt of outpatient services, no later than the end of the first full billing cycle following the request.

- STEP 6 Maintain separate files of Hill-Burton uncompensated services accounts.

We recommend that you maintain a log or listing of uncompensated services accounts which will enable you to determine the amount of uncompensated services provided at any given time and will assist you in completing your triennial report. A log/list will also save your facility a great deal of time in preparing for an assessment of your Hill-Burton program. See Exhibit 5, page 54, for a sample log.

TIME REQUIREMENTS

1. Before the start of your fiscal year, determine your minimum annual compliance level for the coming fiscal year, and publish a notice of the availability of uncompensated services in a local newspaper of general circulation, including your allocation plan. (The allocation plan can be effective no earlier than 60 days following publication.)
2. Within 60 days after the end of your fiscal year, determine the amount of uncompensated services you provided in the previous fiscal year.
3. Within 90 days after the end of your fiscal year, file the uncompensated services report, HRSA 710, if requested or if you had a deficit in the previous fiscal year. Implement an Affirmative Action Plan, if required.
4. Make determinations of eligibility within the following time frames:
 - Nursing Homes - For requests made prior to admission, within 10 working days of the request, but no later than 2 working days after admission. For requests made after admission, no later than the end of the first full billing cycle following the request.
 - Other Facilities - For requests made prior to discharge, within 2 working days following the request. For requests made after discharge or after receipt of outpatient services, no later than the end of the first full billing cycle following the request.
5. Within 10 working days after being served with a summons or complaint, notify HHS of any legal action alleging noncompliance.
6. Maintain records documenting compliance for 3 years after submission of the triennial report (unless a longer period is required by the Secretary) or 180 days after HHS completes its assessment investigation and issues findings, whichever is less.

CHAPTER II

APPLICABILITY OF THE UNCOMPENSATED SERVICES REGULATIONS

WHO IS SUBJECT TO THE REGULATIONS	Facilities which received Federal assistance under Title VI (Hill-Burton) or Title XVI of the Public Health Service Act, or any assistance supplementary to the Title VI or XVI assistance, are subject to the uncompensated services regulations.	124.501(a)
FOR HOW LONG	Recipients of grants under Title VI are obligated for a period of 20 years from the time construction was completed, which usually means the date services began to be provided ("opening date"). Recipients of loans or loan guarantees with interest subsidies are obligated until the loans are repaid.	124.501(b) (1) (i) 124.501(b) (1) (iii) 124.501(b) (1) (ii)
	These periods of obligation may be shortened or lengthened because of the excess and deficit provisions of the regulations. See Chapters IX and X.	124.503(b) 124.503(c)
	Recipients of grants under Title XVI are obligated indefinitely.	124.501(b) (2)
HOW TO DETERMINE THE "OPENING DATE"	The Basic Facility Reports (BFR) or Facility Status Reports (FSR) sent to you by HHS show the "opening date" for each grant. If you dispute the date shown or any other data on the BFR or FSR, send documentation such as official records, correspondence from State agencies, or newspaper clippings to support your claim to the Division of Facilities Compliance.	

CHAPTER III

HOW TO CALCULATE YOUR ANNUAL COMPLIANCE LEVEL

WHEN TO START	You should know your compliance level for the coming year when you publish the notice of your facility's uncompensated services obligation so that you can include the amount in the notice, if you choose to do so. See Chapter IV if you choose not to include the amount. Publish the notice before the start of your fiscal year.	124.504(a) (2) 124.504(a)
DETERMINING THE MINIMUM ANNUAL COMPLIANCE LEVEL BY 2 METHODS	The annual compliance level is the minimum amount of uncompensated services a facility must provide in a fiscal year. It is the <u>lesser</u> of 10% of the Federal assistance you received, adjusted for inflation, or 3% of operating costs, minus Medicare and Medicaid reimbursement received (or, if not received, claimed).	124.503
HOW TO START 10% METHOD-GRANTS	Refer to your Basic Facility Report or Facility Status Report provided by HHS, and determine the amount of Federal assistance under obligation. (See Exhibit 3 for instructions on prorating.) Multiply that amount by 10% to compute your Base Compliance Level. The Base Compliance Level must then be adjusted by the percentage change in the National Consumer Price Index (CPI) for medical care between the year in which you received the Federal assistance or 1979, whichever is later, and the latest annual CPI available before the start of your fiscal year. The annual CPI information is sent to you each year by HHS, usually in February or March. Multiply the Base Compliance Level by the percent change in the CPI, and add that amount to the Base Compliance Level. This sum is your Annual Compliance Level under the 10% method.	124.503(a) (2)
EXAMPLE 1	$\$1,000,000$ = Federal Assistance under Obligation 10% = Percentage to be applied 80.9% = CPI (percent change between the 1979 CPI and the 1986 CPI, available in 1987) $\$1,000,000 \times 10\%$ = $\$100,000$ (Base Compliance Level) $\$100,000 \times 80.9\%$ = $\$80,900$ (CPI Adjustment) $\$100,000 + \$80,900$ = $\$180,900$ (Annual Compliance Level)	

**10% METHOD-
LOANS**

The amount of Federal assistance under obligation for facilities which received loans or loan guarantees is based on the cumulative interest subsidy amounts and other payments by HHS. Each interest subsidy amount is adjusted by a change in the CPI between the year in which the Secretary made each payment or 1979, whichever is later, and the most recent year for which a published Index is available. This is different from the May 18, 1979 regulations where the total cumulative interest subsidy amount was adjusted by a single CPI factor based on the year the facility received the loan or 1979, whichever was later. 124.502(f)

Use the interest subsidy figures provided to you by the Department. Use the "CPI Application to 10% Compliance Level for Loan Facilities" portion of the CPI adjustment chart, issued each year as a Program Policy Notice, to determine the CPI adjustment for each interest subsidy payment. Use the column that reflects the beginning of the fiscal year for which you are computing the annual compliance level. See Exhibit 7.

EXAMPLE 2

<u>Payment Year</u>	<u>Change in CPI Between Payment Year and 1986</u>	<u>10% Interest Subsidy</u>	<u>10% Cumulative Int. Subsidy</u>	<u>CPI Adjustment</u>
1979	1.809		39,609	\$ 71,653
1980	1.630	20,605		33,586
1981	1.472	19,900		29,293
1982	1.319	19,390		25,575
1983	1.213	18,846		22,860
1984	1.142	18,265		20,859
1985	1.075	17,646		18,969
1986	1.*	16,986		16,986
1987	1.*	16,282		16,282
1988	1.*	15,531		15,531
1989	1.*	14,731		<u>\$ 14,731</u>

FY 1989 Annual Compliance Level \$286,325

To compute the annual compliance level for this facility's Fiscal Year 1989, beginning February 1, you must multiply each interest subsidy payment by 10 percent and adjust each by a change in the CPI between the year in which the Secretary made each payment or 1979, whichever is later, and the most recent year for which a published Index is available (1986). Take 10 percent of the cumulative interest subsidy amount as of 1979 and adjust it by the change in the CPI between 1979 and 1986 (\$39,609 x 1.809). Then take 10 percent of the interest subsidy paid in 1980 and adjust it by the change in the CPI between 1980 and 1986 (\$20,605 x 1.630). Adjust each subsequent interest subsidy payment, through 1989, by a change in the CPI between the year of the payment and 1986. Sum these yearly adjusted figures to arrive at the FY 1989 annual compliance level, in this case \$286,325.

*NOTE: As of February 1, 1988, the beginning of this facility's FY 1989, there is no published Index available for 1987, 1988, or 1989. Thus, the 1986-1989 interest subsidy amounts have no CPI adjustments when calculating this facility's FY 1989 annual compliance level.

3% METHOD

Next, calculate your Annual Compliance Level under the 3% method. Using the latest audited financial statement available prior to the start of your fiscal year, subtract from the total operating expenses for that year the amount of reimbursement received (or if not received, claimed) in the same year from Medicare and Medicaid. Multiply that amount by 3% to obtain your annual compliance level under the 3% method. (See Exhibit 3 for instructions on prorating.) There is no CPI adjustment to the annual compliance level in the 3% method.

124.503(a)(1)

124.502(i)

EXAMPLE 3

\$800,000 = Operating Expenses
 \$250,000 = Medicare Reimbursements
 \$150,000 = Medicaid Reimbursements
 3% = Percentage to be Applied
 \$800,000 - \$250,000 - \$150,000 = \$400,000 (Operating Costs)
 \$400,000 x 3% = \$12,000 (Annual Compliance Level)

ANNUAL COMPLIANCE LEVEL

Compare the amounts obtained under each method. The lower amount is your Annual Compliance Level for the coming fiscal year.

124.503(a)(1)

ADJUSTED ANNUAL COMPLIANCE LEVEL/DEFICIT

It will be necessary to adjust your annual compliance level if you are required in the coming year to begin making up a deficit from a previous year or years. If this is the case, multiply the amount of the deficit to be made up by the percentage change between the annual CPI available in the year in which the deficit occurred and the latest annual CPI available before the start of your fiscal year. Add this amount to the deficit amount to be made up. This sum, added to your annual compliance level, is your Adjusted Annual Compliance Level for the coming year. See Chapter X to determine the amount of deficit required to be made up in a given year.

124.503(b)

124.503(d)

EXAMPLE 4

\$180,900 = Annual Compliance Level
 \$ 1,000 = Deficit to be made up in coming FY
 7.5% = CPI (Percentage Change)

\$ 1,000 x 7.5% = \$ 75 (Deficit Adjustment)
 \$ 1,000 + \$ 75 = \$ 1,075 (Adjusted Deficit)
 \$180,900 + \$1,075 = \$181,975 (Adjusted Annual Compliance Level)

ADJUSTED ANNUAL COMPLIANCE LEVEL/EXCESS

Conversely, your annual compliance level may be adjusted downward if you have excess uncompensated services from a previous year or years. You may use the excess to reduce your annual compliance level in a subsequent year or years. If you plan to use excess in the coming year, multiply the amount of excess by the percentage change between the annual CPI available at the beginning of the fiscal year in which the excess was earned and the latest annual CPI available before the start of your

124.503(c)

fiscal year. Add this amount to the excess. This sum, subtracted from your annual compliance level, is your Adjusted Annual Compliance Level for the coming year.

EXAMPLE 5

\$180,900 = Annual Compliance Level
\$ 1,000 = Excess From the Previous FY
7.5% = CPI (Percentage Change)

\$ 1,000 x 7.5% = \$ 75 (Excess Adjustment)
\$ 1,000 + \$ 75 = \$ 1,075 (Adjusted Excess)
\$180,900 - \$1,075 = \$179,825 (Adjusted Annual Compliance Level)

If you plan to use excess to reduce your annual compliance level in the coming year, your published notice must contain this explanation. 124.504(a)(3)

FINANCIAL INABILITY

If you anticipate that you will be unable to meet your annual compliance level because of a financial inability to do so, your published notice must contain this explanation. See Chapter IV. 124.504(a)(3)

"ALLOWABLE CREDIT" FACTOR

Facilities which participate in Medicare must use an "allowable credit" factor to determine the amount of uncompensated services they provided during a fiscal year. See also Chapter VII. 124.502(b)

"Allowable credit" is the lesser of a facility's usual charge for services, or the usual charge multiplied by an "allowable credit" factor. The factor is a percentage derived from your Medicare cost report. It is: total allowable costs divided by total patient revenues.

Because the "allowable credit" factor is usually less than 100%, most facilities cannot claim credit for uncompensated services at usual charges; they can claim only a percentage of the usual charges.

To know what amount of services you must provide to meet your uncompensated services dollar obligation at "allowable credit," calculate your "allowable credit" factor before the start of your fiscal year when you determine your compliance level for that year. Use the last Medicare cost report you submitted. If you have not received the audited figures for the cost report, use the figures you claimed.

NOTE: For those States granted a waiver under Section 1886(c) of the Social Security Act, use the payment rate established by the terms of the waiver agreement.

EXAMPLE 6

Facility's fiscal year begins on January 1, 1988.
Facility's last Medicare cost report was submitted on
March 31, 1987; the report was for Fiscal Year 1986.

The facility uses the 1986 Medicare cost report to
calculate its "allowable credit" factor to be
applied to uncompensated services provided in Fiscal
Year 1988.

**CALCULATION
OF
"ALLOWABLE
CREDIT" FACTOR**

(Allowable Patient Care Cost + Hospital Based
Physician Adjustments) divided by Total Patient
Revenues = ____ % (Allowable Credit Factor)

WHERE:

Allowable patient care costs = Medicare Cost Report,
Form 2552, Worksheet A (formerly A-8), Subtotal
Reimbursable Costs, Column 7.

Hospital based physicians adjustments (for patient
care only) = Medicare Cost Report, Form 2552, Supplemental
Worksheet A-8-2 (formerly A-8), all lines covering
hospital based physician costs (for patient care
services only).

Total Patient Revenues = Medicare Cost Report,
Form 2552, Worksheet G-2, Column 3, or from audited
statement of revenue and expense.

When the Total Patient Revenues amount does not
include "Total charges for hospital based physician
patient care services," such charges must be added to
the Total Patient Revenues amount.

CHAPTER IV

HOW TO PREPARE AND PUBLISH AN ALLOCATION PLAN

WHEN

Before the start of your fiscal year, publish notice of your uncompensated services obligation in a local newspaper in your area. The plan can take effect no earlier than 60 days following the date of publication. Therefore, if you wish to implement a new allocation plan at the beginning of your fiscal year, publish at least 60 days before the start of your fiscal year. 124.504(a)

WHAT TO PUBLISH

The published notice must contain four items:

1. The allocation plan you intend to adopt. 124.504(a)(1)
2. The dollar amount of uncompensated services you intend to provide in the coming year OR a statement that you "... will provide uncompensated services to all persons unable to pay who request uncompensated services." This statement means that you do not intend to stop providing uncompensated services during the coming year. 124.504(a)(2)
3. The dollar amount you publish may be equal to, greater or less than your annual compliance level. However, if it is less, you must explain why in the published notice. Only 2 reasons are permissible: a) you plan to use excess earned in a previous year or years to reduce your annual compliance level; OR b) you are financially unable to meet your annual compliance level. See Chapter X for more information about financial inability. 124.504(a)(3)

If you plan to complete your total 20-year dollar obligation in the coming year, or have completed it since the last notice you published, include this information in the current notice.

4. A statement inviting interested parties to comment on the allocation plan. 124.504(a)(4)

ALLOCATION PLAN

You may choose which services you intend to make available as uncompensated services. They need not be limited to the portion of your facility assisted by Hill-Burton funds. The services may be provided in another portion of the facility as long as it is physically connected to the assisted portion. For example, you may have received Hill-Burton funds to construct an outpatient wing. However, you can choose to provide inpatient services in your allocation plan. See Exhibit 6, Program Policy Notice 86-8, dated September 11, 1986. 124.506
124.501(a)

Be sure to specify in your allocation plan, as it is published, the type of services to be made available. Also mention if Category B patients are included, and whether uncompensated services will be provided to them without charge or at a reduced charge. Be specific about the method for reducing charges. For example, include the sliding scale if you use one. If you plan to distribute the services in different periods of the year, specify the method you will use. For example, if you choose to provide 1/4 of your annual dollar obligation each quarter, your published allocation plan must contain this information, including the dollar amount.

124.506(a)

The plan must provide that the facility provides uncompensated services to all persons eligible who request uncompensated services.

You should publish your allocation plan before the start of your fiscal year. The allocation plan can take effect no earlier than 60 days following the date of publication. Therefore, if you wish to implement a new allocation plan at the beginning of your fiscal year, publish a new plan at least 60 days before the start of your fiscal year.

**DID YOU
PUBLISH
ON TIME**

If you failed to publish your allocation plan before the start of your fiscal year, you must provide uncompensated services in accordance with the last allocation plan published in a newspaper of general circulation. If you never published a plan, you must provide uncompensated services to all persons eligible under Categories A and B in all areas of your facility until you stop providing uncompensated services, or until a notice is published and becomes effective.

124.506(b)(1)

**AVOIDING
PROBLEMS**

Publish on time. Until a new plan becomes effective, provide uncompensated services in accordance with the allocation plan you last published. Be sure your individual notice reflects the plan in effect. If you never published a Hill-Burton notice, publish one now. In the interim, however, be sure to provide all services to all persons in Categories A and B, and distribute an individual notice which reflects that plan.

**CHANGING A
PLAN DURING
THE YEAR**

You may change the allocation plan during the fiscal year by publishing the revised plan in a local newspaper of general circulation in your area. The revised plan becomes effective no earlier than 60 days from the date of publication. Be sure to revise the individual notice to reflect the change.

124.505(b)(3)

124.506(c)

MODELS

See Exhibit 1 for samples of published notices.

CHAPTER V

HOW TO NOTIFY PEOPLE AT THE FACILITY

HOW POSTED NOTICES	Post signs provided by HHS conspicuously in your admissions areas, business office, emergency room (if you have one), and in any other areas you believe are appropriate.	124.504 (b) (1)
	The signs are in English and Spanish, and both must be posted at all times that uncompensated services are available.	124.504 (b) 124.508 (a) (3)
	Translate the signs into other languages and post them if 10% or more of the population in your service area (based on Census reports) speaks other than English or Spanish.	124.504 (b) (2)
	Make efforts to communicate the contents of the signs to people you believe may not be able to read them.	124.504 (b) (3)
OTHER SIGNS	If you have met your annual compliance level for the year, or have met your quota for the period specified in your allocation plan, and have decided to stop providing uncompensated services, you may post a notice to that effect. Be sure it also states when uncompensated services will again be available.	124.508 (a) (4)
INDIVIDUAL NOTICE	Prepare and distribute an individual notice to <u>each person</u> who is seeking services on behalf of <u>himself</u> or another. The notice must be provided to <u>everyone</u> even if an individual is over income, is seeking services not covered in your published allocation plan, is covered by insurance, or has not made a request for uncompensated services.	124.504 (c) (1)
	A facility found in noncompliance with the individual notice requirement is subject to losing all of its uncompensated services credit for the period of noncompliance. See Chapter XI.	124.512 (c) (1)
WHAT DOES IT CONTAIN	The individual notice must: <ul style="list-style-type: none">- 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;- set forth the criteria the facility uses for determining eligibility for uncompensated services (be sure to include the income figures from the Poverty Income Guidelines, the types of services covered in your published allocation plan, and the sliding scale or other method used for Category B patients, if applicable);	124.504 (c) (1)

- state where in the facility people can request uncompensated services; and
- state that the facility will make a written determination of eligibility within the specified time frames.

MODELS

See Exhibits 2A and 2B for samples of individual notices.

WHEN

The notice must be provided during periods in which uncompensated services are available. Provide the individual notice before services are received, if possible. When emergencies make this impractical, provide the written individual notice to the patient or next of kin not later than when first presenting a bill.

124.504(c) (2)

Make efforts to communicate the contents of the individual notice to people you believe may not be able to read it.

124.504(c) (3)

**CAN YOU
STOP
PROVIDING
NOTICE**

When uncompensated services are no longer being made available, because you met your quota for the period specified in your allocation plan, for the year, or for your total 20-year period, you may stop providing individual notices. You are also permitted to remove the posted notice for the remainder of that year or period.

124.508(a)

If you wish to stop providing individual written notices and remove posted notices during a fiscal year, records must be maintained on a current basis which will document that your facility has met its compliance level for the year or the period specified in your allocation plan.

Maintaining a log or a listing of uncompensated services will satisfy the requirement for determining the amount of uncompensated services provided at any given time. See Chapter XII.

CHAPTER VI

HOW TO MAKE DETERMINATIONS OF ELIGIBILITY

WHEN	At all times that you are making uncompensated services available, you must make a written determination of eligibility in response to each request for uncompensated services.	124.507 (a)
WHAT IS A "REQUEST"	Consider <u>any indication of an inability to pay</u> as a request for uncompensated services. For example, a general inquiry about assistance or a statement that the person cannot afford to pay should be considered a "request" for uncompensated services. The request may be made by or on behalf of an individual seeking services in the facility.	124.502 (k)
WHEN MAY A REQUEST BE MADE	<p>A request for uncompensated services may be made "at any time." This means that an individual may make a request before, during, or after services are received, including after institution of a collection action against the individual. It also means that a person may make a request more than once for the same services where there is a change in eligibility.</p> <p>For example, if a person was denied uncompensated services because his income exceeded the Poverty Income Guidelines, and three months later the person applies again because his financial circumstances have changed in the interim, the person must be given another determination of eligibility. Use the Poverty Income Guidelines and the allocation plan in effect on the day the most recent request is made. The Poverty Income Guidelines are revised annually, and each revision is sent to you by HHS.</p>	124.502 (k)
IN WRITING	<p>The regulations do not require that requests be in writing. However, you may use an application form for applicants to fill out. Because the regulations do require specific information to be in the determination of eligibility, many facilities have combined an application with the determination. See STEP 7 on page 21 for what the determination of eligibility must contain and Exhibit 4 for a sample format.</p> <p>If you use a written application, be sure there is a space for the date of the request. Be sure you enter the date you received it if it is different from the date signed by the applicant. This is particularly important when applications are returned to you by mail. In addition, be sure you enter the date you made the determination.</p>	124.507 (b)

If you do not use a written application, be sure that your written determination of eligibility contains the required information, including the date of the request, the date the determination was made, and the income and family size of the applicant.

**A TIME
LIMIT**

Complete your determinations of eligibility in writing within the following time frames: 124.507(c)

Nursing Homes - For requests made prior to admission, within 10 working days of the request, but no later than 2 working days after admission. For requests made after admission, no later than the end of the first full billing cycle following the request.

Other Facilities - For requests made prior to discharge or prior to receipt of outpatient services, within 2 working days following the request. For requests made after discharge or after receipt of outpatient services, no later than the end of the first full billing cycle following the request.

Where a determination of eligibility is required by the end of the first full billing cycle following the request, you are precluded from pursuing collection for the services in question prior to making a eligibility determination. 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.

Working days are the facility's working days, generally Monday through Friday, holidays excluded. If you fail to make a determination within the specified time frames, you will be subject to corrective action which could affect the creditability of services toward your uncompensated services dollar obligation. Refer to Chapters VII and XI.

STEP 1

**SERVICES
AVAILABLE**

Determine if the type of services requested are available in your facility. If they are not, determine the patient ineligible, and provide the applicant with a written, dated denial, with the reason for the denial. If the services are available, then:

STEP 2

**COVERED IN
ALLOCATION
PLAN**

Determine if the services requested are covered by your allocation plan. If they are not, determine the patient ineligible, and provide the applicant with a written, dated denial, with the reason for the denial. If the services are covered by your allocation plan, then:

124.505(a)(3)
124.506(a)(1)(i)

STEP 3

Determine if the individual is covered, or receives services covered, under a third-party insurer or governmental program. If the individual is fully covered, determine the patient ineligible, and provide the applicant with a written, dated denial, with the reason for the denial. (See page 20, Conditioning Eligibility, when there is a question as to the existence of third-party coverage.) If the individual is not fully covered under one of these programs or receives services not covered under one of these programs, then:

124.505 (a) (1)

THIRD-PARTY COVERAGE

STEP 4

Obtain from the applicant information on the patient's family income for the 12 months preceding the request for uncompensated services and for the 3 months preceding the request. Use the definition of income in the Poverty Income Guidelines. Food stamps do not count as income. You may use the definition of family in the Guidelines, or adopt your own definition, but apply the definition consistently. Multiply the 3-month figure times 4 and compare the result with the 12-month figure. Use the lesser amount to determine eligibility.

124.505 (a) (2)

124.505 (c)

INCOME

VERIFY INCOME

You are not required to verify income, but you are permitted to do so. If you choose to obtain verification of income, condition the determination of eligibility on income verification, but do the conditional determination within the time frames specified on page 18 ("A Time Limit"), and date it.

You may use any reasonable method to verify information necessary to establish eligibility. Examples of items you may require are:

1. W-2 withholding forms
2. pay stubs
3. income tax returns
4. forms approving or denying unemployment compensation or workmen's compensation
5. oral verification of wage from employer
6. oral verification from public assistance agencies.

AVOIDING PROBLEMS

Bear in mind that items such as W-2 forms and income tax returns may not serve to verify information on income for the three or twelve months preceding the request for uncompensated services; pay stubs would, however, verify income.

If the applicant has none of these documents and you cannot obtain verification from a public assistance agency, you may wish to accept the applicant's signed statement of income to avoid delaying your written determination of eligibility or the provision of services.

If the verification process shows the applicant's claim of income to be untrue, the conditional determination of eligibility may be re-evaluated on this basis.

When a verification procedure is used, it should be applied equally to all requests for uncompensated services. However, in some cases, particularly those in which the patient claims no income, it will not be possible to verify the claim. Therefore, even if a verification procedure is used, it is still within the discretion of the facility to approve a request solely on the basis of the information provided by the applicant.

**CONDITIONING
ELIGIBILITY**

You may condition the provision of uncompensated services on the applicant furnishing any information reasonably necessary to substantiate eligibility. 124.507(b) (2)

Besides conditioning eligibility on verification of income (see above), you may also condition eligibility on a person's applying for local, State, or other third-party assistance programs. If the person is ineligible for third-party assistance, but is eligible for uncompensated services, the person must be provided with uncompensated services.

Eligibility may also be conditioned on the availability of uncompensated services at the time services are to be received.

When a facility makes a favorable determination of eligibility without conditions, the individual is guaranteed the provision of uncompensated services. In the case of a conditional approval, the individual is guaranteed the provision of uncompensated services if the conditions specified in the determination of eligibility are satisfied. If the conditions are not satisfied, the request can then be denied.

Conditional determinations must be made within the time frames specified on page 18 ("A Time Limit").

STEP 5

CATEGORY B

Compare the patient's income and family size to the Poverty Income Guidelines in effect on the day the request is made. If your allocation plan does not include services to Category B patients, SKIP TO STEP 6. If your allocation plan does cover Category B patients, double the Poverty Income Guidelines and compare the figure to the patient's income and family size. If the patient's income is more than twice the Guidelines, determine the patient ineligible for uncompensated 124.506(a) (1) (iv)

services, and provide the applicant with a written, dated statement containing the reason for the denial. If the patient's income is not more than twice the Guidelines, but greater than the published figure in the Guidelines, determine the patient eligible for Category B uncompensated services.* The patient will receive uncompensated services in accordance with the schedule in your published notice.

STEP 6

CATEGORY A

Compare the patient's income and family size to the Poverty Income Guidelines. If the income is more than the Guidelines, and your allocation plan limits services to Category A, determine the patient ineligible, and provide the applicant with a written, dated statement containing the reason for the denial. If the patient's income is not more than the published figure in the Guidelines, determine the patient eligible for Category A uncompensated services without charge.

124.505(a)(2)
124.506(a)(1)(iii)

STEP 7

Each time you determine a patient eligible for uncompensated services, promptly give the applicant a copy of the favorable determination of eligibility, and keep a copy in your files. Be sure the document contains the following information: 1) that services will be provided at no charge or at a specified charge; 2) the date of the request; 3) the date of the determination; 4) the family income of the patient; and 5) the date on which services were or will be provided.

124.507(a)
124.507(b)(1)

CAN YOU
STOP

When uncompensated services are no longer being made available, because you met your quota for the period specified in your allocation plan, for the year, or for your total 20-year period, you may stop making determinations of financial eligibility. That is, you need not do income computations. However, you must provide the individual with a written denial stating that the level of uncompensated services has been met for the specified period. Be sure you have documentation that your quota was met. See Chapters V and XII.

*Some facilities, in their allocation plans, have chosen to limit Category B eligibility to incomes which are less than twice the Guidelines. This is permissible, provided the plan is published. In these cases, Category B eligibility is based on the income limit established in the allocation plan, rather than on twice the Guidelines.

DENIALS

All denials must be in writing to the person who requested uncompensated services, and must state the reason for the denial. You may deny a request for any of the following reasons:

1. Your compliance level has been met for the fiscal year or period specified in your allocation plan, or your total obligation has been met. (No income computations required.)
2. The requested services are not offered in your facility. (No income computations required.)
3. The individual is not eligible under your allocation plan (e.g., the services requested are not included in your allocation plan). (No income computations required.)
4. The individual is fully covered, or receives services fully covered by a third-party insurer or governmental program. (No income computations required.)
5. The eligibility standards under the Poverty Income Guidelines are not met.
6. The individual fails to provide verification of income as required by the facility.
7. The individual does not take reasonable action to obtain third-party coverage, if stated as a condition in your conditional determination of eligibility.

CHAPTER VII

HOW TO DETERMINE THE AMOUNT OF UNCOMPENSATED
SERVICES PROVIDED IN A FISCAL YEAR

WHEN	Within 60 days after the end of your fiscal year, calculate the dollar amount of uncompensated services you provided in that year.	124.510(a) (3)
WHAT IS NOT CREDITABLE TO HILL-BURTON	Some amounts for services provided to eligible patients are creditable toward your uncompensated services dollar obligation, and some are not. To compute the creditable amount of uncompensated services you provided, you must first exclude from each Hill-Burton account those amounts which cannot be counted toward your obligation.	
EXCLUSION	Do not include amounts for services provided where you failed to make a determination of eligibility or where you cannot document that the determination was made.	124.507 (c)
EXCLUSION	Do not include services provided to persons with incomes greater than the Poverty Income Guidelines or, if Category B is included in your allocation plan, greater than twice the Poverty Income Guidelines.	124.505 (a) (2)
EXCLUSION	Do not include services which are not included in your facility's allocation plan.	124.505 (a) (3)
EXCLUSION	Do not include amounts of Medicare deductibles or co-insurance that patients failed to pay. These amounts are recoverable through Medicare allowable bad debts under the presumption of uncollectibility due to medical indigence. See the Medicare Provider's Reimbursement Manual 312.	124.505 (a) (1)
EXCLUSION	Do not include amounts for services for which you received, or expect to receive, reimbursement from third-party insurers or governmental programs, except where the person to whom the facility provides services refused to take reasonable actions necessary to obtain the entitlement.	124.505 (a) (1)
EXAMPLE 1	<p>Patient receives services from the facility in December 1986.</p> <p>Usual charges for the services are \$500.</p> <p>"Allowable credit" factor is 90%.</p> <p>Patient is determined eligible for uncompensated services.</p> <p>A governmental program will pay \$100 for the services. Result: \$100 must be excluded from the amount of qualifying services.</p>	

COMPUTATION

Patient - usual charges	\$ 500
Minus excluded charges	-100
Usual charges of qualifying services	<u>400</u>
Multiplied by "allowable credit" factor	x.90
Allowable credit amount	<u>\$360</u>

EXAMPLE 2

Same facts as above, but patient refuses to take reasonable actions necessary to obtain the entitlement and applying for third-party coverage was not a condition of eligibility. Result: the \$100 entitlement is not excluded.

COMPUTATION

Patient - usual charges	\$ 500
Minus excluded charges	- 0
Usual charges of qualifying services	<u>500</u>
Multiplied by "allowable credit" factor	x.90
Allowable credit amount	<u>\$450</u>

EXCLUSION

Do not include any amount in excess of the payment that the facility has received, or is entitled to receive, from a third-party insurer or under a governmental program where the facility has agreed or is otherwise required to accept this payment as payment in full for the services.

124.505(a)(1)

Many facilities will enter into an agreement with the Federal Government, State or local government or third-party insurer to accept a prospectively or retroactively determined amount as full payment for all services provided to designated beneficiaries. The USUAL CHARGES in excess of this agreed upon amount may not be counted as uncompensated services.

This means that you do not include amounts that make up the difference between reimbursement from Medicaid and the actual cost of services provided to Medicaid patients, even if those patients qualify for uncompensated services because of their income.

EXAMPLE 3

Patient is a recipient of benefits from a local program and the facility is a provider under that program, which requires acceptance of reimbursement as payment in full for the services provided.

Patient receives services at the facility amounting to \$500 at usual charges. The facility is reimbursed by the program in the amount of \$400 as full payment for the services.

The entire \$500 bill is excluded and cannot be counted as uncompensated services because the facility agreed to accept \$400 as full payment for the services.

EXAMPLE 4

Patient is a recipient of benefits from a local program which will cover up to three days of services and the facility is a provider under that program.

Patient receives services at the facility for six days amounting to \$900 at usual charges (\$150 per day).

"Allowable credit" factor is 90%.

The facility is reimbursed by the program in the amount of \$350 as payment in full for three days of services.

The facility must exclude \$450 (\$150 x 3) since it has agreed to accept \$350 as payment in full for three days of services.

COMPUTATION

Patient - usual charges	\$ 900
Minus excluded charges	<u>-450</u>
Usual charges of qualifying services	450
Multiplied by "allowable credit" factor	x 90%
Allowable credit amount	<u>\$405</u>

EXCLUSION

Do not include amounts for services provided to patients more than 96 hours following notification of disapproval of those services by a Peer Review Organization (PRO), under Section 1155(a)(1) or Section 1154(a)(1) of the Social Security Act.

124.502(m)(1)

There will be uncompensated services patients who receive services for a period of time, and then the PRO disapproves of the services. The facility may continue to provide services to the patient for 96 hours after the date of notification by PRO, and the services can be counted as uncompensated services. But any services provided after the 96 hour period may not be counted as uncompensated services.

EXAMPLE 5

Patient admitted to facility on June 1.

Patient determined to be eligible for uncompensated services on June 1.

Patient receives services on June 1, 2, and 3.

PRO disapproves of the services on June 3.

Patient may continue to receive services as uncompensated services on June 4, 5, 6, and 7. Any services provided after June 7 (end of 96 hour period) may not be counted as uncompensated services.

EXCLUSION

Do not include any amounts which would be available under a governmental program (such as Medicare or Medicaid) in which the facility, although eligible to do so, and required by section 124.603(c)(1) of the community service regulations to do so, does not participate.

WHAT IS CREDITABLE TO HILL-BURTON

Include amounts for services provided to eligible patients in accordance with your allocation plan.

124.506 (a) (1)

Include amounts for services for which you did not receive reimbursement because the patient refused to obtain the entitlement, providing that the services are in your allocation plan and the patient is eligible for uncompensated services.

124.505

Include amounts for services not covered by Medicare or Medicaid, providing that the services are in your allocation plan and the patient is eligible for uncompensated services. For example, services provided after Medicare or Medicaid benefits have been exhausted may be applied toward your Hill-Burton obligation. In addition, any services such as a private room or other luxury items, cosmetic or experimental care which may not be covered by Medicare or Medicaid may be applied toward your Hill-Burton obligation.

EXAMPLE 1

Patient is a recipient of benefits from a local program which will cover up to three days of services and the facility is a provider under that program.

Patient receives services at the facility for six days amounting to \$900 at usual charges (\$150 per day).

"Allowable credit" factor is 90%.

The facility is reimbursed by the program in the amount of \$350 as payment in full for three days of services.

The facility may apply toward its Hill-Burton obligation the services provided during the three days not covered by the local program.

COMPUTATION

Patient - usual charges	\$ 900
Minus excluded charges	-450
Usual charges of qualifying services	450
Multiplied by "allowable credit" factor	x.90
Allowable credit amount	\$405

EXAMPLE 2

Patient is a recipient of benefits from a local program which will cover up to three days of services and the facility is a provider under that program.

Patient receives services at the facility for three days at \$150 per day. Patient also receives experimental care, costing an additional \$100, which is not covered by the local program.

"Allowable credit" factor is 90%.

The facility is reimbursed by the program in the amount of \$350 as payment in full for three days of services. However, it receives no reimbursement for the experimental care.

The facility may apply the cost of the experimental care toward its Hill-Burton obligation.

COMPUTATION

Patient - usual charges	\$ 550
Minus excluded charges	-450
Usual charges of qualifying services	100
Multiplied by "allowable credit" factor	x.90
Allowable credit amount	\$ 90

HOW MUCH IS CREDITABLE

In most instances, the dollar amount you may apply toward your Hill-Burton obligation will be less than your usual charges for the services. This is because of the regulatory requirement about "allowable credit," which is related to your participation in Medicare.

124.502(m) (1)

If you do not participate in Medicare, your usual charges for services count toward your Hill-Burton obligation.

"ALLOWABLE CREDIT"

If you participate in Medicare, you must compute your "allowable credit" amount. "Allowable credit" is the lesser of your usual charges for services, or the usual charges multiplied by an "allowable credit" factor. The factor is a percentage derived from your Medicare Cost Report for the preceding fiscal year. See Chapter III.

124.502(b)

**CALCULATION
OF "ALLOWABLE
CREDIT"
AMOUNT**

The "Allowable credit" amount is the lesser of Line a or Line b, below:

a. Usual charges for the services \$ _____

b. Usual charges for the services x %
("allowable credit" factor) \$ _____

"Allowable credit" amount (lesser amount of
Line a or b above) \$ _____

**AMOUNT OF
UNCOMPEN-
SATED
SERVICES**

After you have computed your "allowable credit" amount, you must subtract from that amount any payments you received from or on behalf of Category B patients. The difference is the amount of uncompensated services you may apply toward your Hill-Burton dollar obligation.

124.502 (m)

CHAPTER VIII

WHAT TO DO ONCE YOU HAVE MET YOUR COMPLIANCE LEVEL FOR
THE FISCAL YEAR OR PERIOD SPECIFIED IN YOUR ALLOCATION PLAN

**PROVIDE
EXCESS**

You may continue providing uncompensated services to persons unable to pay. The amount in excess of the annual compliance level may be used to reduce the annual compliance level in a future year or years. Services provided during the period of excess must meet the same regulatory requirements as services provided before the annual compliance level is met. For example, you must continue to make timely determinations of eligibility and provide individual notices. See Chapter IX.

124.503(c)(1)

**CEASE
PROVIDING
UNCOMPENSATED
SERVICES**

If you have maintained records which document that you have met your compliance level for the year or for the period specified in your allocation plan, you may stop providing uncompensated services for the remainder of that year or period.

124.508(a)(1)

During the period of time for which you are not providing uncompensated services, you may:

1. Cease providing individual notices;
2. Remove the posted notices;
3. Post an additional notice stating that your facility has satisfied its obligation for the fiscal year or appropriate period and when additional uncompensated services will be available; and
4. Stop making determinations of financial eligibility (although you are still required to make written denials stating that your compliance level has been met for the specified period).

124.508(a)(2)

124.508(a)(3)

124.508(a)(4)

CHAPTER IX

HOW TO APPLY EXCESS TO REDUCE
YOUR ANNUAL COMPLIANCE LEVEL IN FUTURE YEARS

EXCESS	You have an excess if the amount of uncompensated services you provided in a fiscal year is more than your adjusted annual compliance level for that year. See Chapter VII.	124.503(c)(2)
WHEN TO CALCULATE	Within 60 days after the end of a fiscal year, you must determine the amount of uncompensated services you provided in that year. If the amount is less than your adjusted annual compliance level, see Chapter X.	124.510(a)(3) 124.503(b)
CREDITABLE EXCESS	Excess is creditable toward your uncompensated services obligation only if the services in excess of your adjusted annual compliance level are provided in accordance with the regulations.	124.503(c)(1)
USING EXCESS	Excess which is creditable may be used to reduce your annual compliance level in the coming year or in future years. You decide when to use it.	124.503(c)(1)
"BUYING OUT" EARLY	Excess may be used by Title VI-assisted facilities to complete their total 20-year dollar obligation early. The regulations provide formulas for calculating the amount of uncompensated services required to satisfy the remainder of your obligation. Which formula to use depends on the type of assistance received and the method used for computing your annual compliance level in the buy out year. Where the annual compliance level in the buy out year has been calculated under the 10 percent method, compute the buy out amount as follows:	124.503(c)(2)
10 PERCENT METHOD GRANTS	For grant assistance, multiply the annual compliance level (as adjusted by CPI) in the buy out year by the number of years remaining in your 20-year obligation. If you want to know whether the amount of uncompensated services you provided in the <u>previous</u> year will satisfy the remainder of your obligation, do not include the previous year (buy out year) in determining the number of years remaining. If you want to know the amount of uncompensated services to provide in the <u>current</u> year to satisfy the remainder of your obligation, include the current year (buy out year) in determining the number of years remaining. Prorate the portion of the final year under obligation, if necessary (see Exhibit 3). Add any deficits from prior years to be made up, and subtract any excess to be used. Be sure to adjust deficits and excesses by the appropriate CPI. Excess uncompensated services	124.503(c)(3)(i)(A)

provided in the buy out year receive no CPI adjustment.
See Chapters II and III.

EXAMPLE 1

A facility with a fiscal year beginning July 1, 1987, wants to provide sufficient uncompensated services in that year to satisfy its 20-year obligation.

Where: 7/22/70 = Opening Date for Grant
 3 years, 21 days = Length of Time Remaining in Grant (Including Buy Out Year)
 \$180,900 = Annual Compliance Level (\$100,000 Base Compliance Level Adjusted by 80.9% CPI)
 \$ 1,075 = Adjusted Excess (\$1,000 from the Previous Year Adjusted by 7.5% CPI)

Then: \$180,900 x 3 = \$542,700 (Obligation for 3 Years)
 (\$180,900/365) x 21 = \$10,408 (Obligation for 21 days)
 \$542,700 + \$10,408 = \$553,108 (Remaining Obligation)
 \$553,108 - \$ 1,075 = \$552,033 (Amount to be Provided in FY 88 to Buy Out)

10 PERCENT METHOD

For loan assistance: Step 1) Multiply your facility's annual compliance level (adjusted by the appropriate CPIs) by the number of years remaining in the scheduled life of the loan. See Chapters II and III. 124.503(c)(3)(i)(B)

LOANS

EXAMPLE 2a

A facility with a fiscal year beginning February 1, 1988, wants to provide sufficient uncompensated services in that year to satisfy its 20-year obligation.

Where: \$286,325 = FY 1989 Annual Compliance Level
 3 = Number of Years Remaining in Life of Loan (Including FY 1989)

Then: \$286,325 x 3 = \$858,975

Step 2) Add to that amount the sum of 10 percent of each yearly cumulative total of additional interest subsidy or other payments (no CPI adjustment) in each subsequent year remaining in the scheduled life of the loan. Do not include the interest subsidy amounts from the current year or prior years, as they are already included in the annual compliance level.

EXAMPLE 2b

<u>Subsequent Years</u>	<u>10% Int. Subsidy</u>	<u>10% Cumulative Int. Subsidy</u>
1990	\$14,000	\$14,000
1991	\$13,000	<u>\$27,000</u>

Total Cum. Amt. of Add'l Int. Subsidy \$41,000

Step 3) Add any deficits from prior years to be made up, and subtract any excesses to be used. Be sure to adjust deficits and excesses by the appropriate CPI. Excess uncompensated services provided in the buy out year receive no CPI adjustment. See Chapter III.

EXAMPLE 2c

Where: \$1,000 = Excess from Previous FY
7.5% = CPI Adjustment

Then: $(\$1,000 \times .075) + \$1,000 = \$1,075$ (Adjusted Excess)

EXAMPLE 2d

The buy out amount is: Step 1 + Step 2 - Step 3 (for excess amounts) or + Step 3 (for deficit amounts).

Where: \$858,975 = Annual Compliance Level x
Remaining Years
\$ 41,000 = Total Cumulative Amount of
Additional Interest Subsidy
\$ 1,075 = Adjusted Excess

Then: $\$858,975 + \$41,000 - \$1,075 = \$898,900$ (Amount to be Provided in FY 89 to Buy Out)

3 PERCENT
METHOD

GRANTS AND/
OR LOANS

Where the annual compliance level in the buy out year is calculated under the 3 percent method, compute the buy out amount (for grant and loan assistance) as follows: Step 1) Add the annual compliance levels for the buy out year (under the 3 percent method) and the two previous years (whether computed under the 3 percent or 10 percent method) and divide by three.

Step 2) Multiply this average amount by the number of years remaining in your period of obligation. Do not include the buy out year in determining the number of years remaining in the period of obligation. (For grant assistance, see Exhibit 3 for instructions on prorating).

Step 3) If you want to know the amount of uncompensated services to provide in the coming year to satisfy the remainder of your obligation, add the annual compliance level for the buy out year. (If you are determining whether the amount of services provided in the previous year will satisfy the remainder of your obligation, skip Step 3.)

Step 4) Add any deficits to be made up from prior years and subtract any excesses to be applied. Be sure to adjust deficits and excesses by the appropriate factor. Excess uncompensated services provided in the buy out year receive no CPI adjustment. See Chapters II and III.

EXAMPLE 3

A facility with a fiscal year beginning July 1, 1987, wants to provide sufficient uncompensated services in that year to satisfy its 20-year obligation.

**EXAMPLE 3
CONTINUED**

Where: \$100,000 = Annual Compliance Level in Buy Out
Year Computed Under 3% Method
\$ 90,000 = Annual Compliance Level in Year
Prior to Buy Out Year
\$ 80,000 = Annual Compliance Level 2 Years
Prior to Buy Out Year
\$ 90,000 = Average Annual Compliance Level
7/1/91 = Opening Date for Grant
3 = Years Remaining in Grant (Excluding
Buy Out Year)
\$ 1,075 Adjusted Excess (\$1,000 from FY 87
adjusted by 7.5% CPI)

Then: $(\$90,000 \times 3) + \$100,000 = \$370,000$ (Remaining
Obligation)
 $\$370,000 - \$1,075 = \$368,925$ (Amount to be
Provided in FY 88 to Buy Out)

**ADJUSTING
EXCESS**

Excess is adjusted by the CPI inflation factor. 124.503(c)(2)(ii)
(Excess uncompensated services provided in the buy
out year receive no CPI adjustment.) Take this into
account when deciding to use it. See Chapter III for
more information about the inflation adjustment and
an example of the calculation.

**PUBLISHED
NOTICE**

When you plan to use excess, be sure your published 124.504(a)(3)
notice includes information about the amount of
excess you plan to use to reduce your annual
compliance level. See Chapter IV.

CHAPTER X

HOW TO DEAL WITH A DEFICIT IN
MEETING YOUR ANNUAL COMPLIANCE LEVEL

DEFICIT	You have a deficit if the amount of uncompensated services you provided in a fiscal year is less than your adjusted annual compliance level for that year. See Chapter VII.	124.503 (c) (3) (i)
WHEN TO CALCULATE	Within 60 days after the end of a fiscal year, you must determine the amount of uncompensated services you provided in that year. If the amount is more than your adjusted annual compliance level, see Chapter IX.	124.510 (a) (3) 124.503 (c)
FILE A DEFICIT REPORT	If the amount is less than your adjusted annual compliance level, file an Uncompensated Services Assurance Report, HRSA 710, within 90 days after the end of your fiscal year. Be sure to indicate the reason for the deficit.	124.509 (a) (1) (ii) (A) 124.509 (a) (1) (iii)
TYPE OF DEFICIT	There are two types of deficits, justifiable deficits and noncompliance deficits.	
JUSTIFIABLE	A justifiable deficit is due to either financial inability to provide uncompensated services at the facility's adjusted annual compliance level, or a lack of eligible applicants requesting uncompensated services during the fiscal year.	124.503 (b) (1) (i)
NONCOMPLIANCE	A noncompliance deficit is one which results from failure to comply with the uncompensated services regulations. For example, a deficit caused by a failure to make determinations of eligibility or provide individual notice would be considered a noncompliance deficit.	124.503 (b) (1) (ii)
DEFICIT MAKE-UP REQUIREMENTS	The requirements for making up a deficit differ, depending on the type of deficit incurred and the type of Federal assistance you received.	
TITLE VI	Facilities which received assistance under Title VI of the PHS Act (and any assistance supplementary to that project) always have to make up deficits. Title VI facilities may make up a justifiable deficit at any time during their period of obligation or in the year or years immediately following their obligation.	124.502 (f) 124.503 (b) (2) (i) (A)
	Title VI facilities must begin to make up deficits due to noncompliance in the year following the Secretary's finding of noncompliance. The amount of noncompliance deficit to be made up each year is determined as follows: Divide the amount of the	124.503 (b) (2) (ii) (A) 124.503 (b) (3) (ii)

noncompliance deficit by the number of years of obligation remaining. This amount, adjusted by a change in the CPI between the CPI available in the fiscal year in which the deficit was incurred and the CPI available in the year in which the deficit was made up, is added to the annual compliance level for each fiscal year following the finding of noncompliance.

124.503(b)(3)(iii)

EXAMPLE

Where: \$1,000 = Deficit
10 = Years Remaining in Obligation

Then: $\$1,000/10 = \100 (Base Amount of Deficit to be Added to Each Remaining Year)

\$100, adjusted by the appropriate CPI factor, is the amount to be added to the annual compliance level for each remaining year in the facility's obligation.

Note: Any noncompliance deficits found after the 18th year of obligation must be made up entirely in the year following the finding of noncompliance.

TITLE XVI

Recipients of Title XVI assistance (and any assistance supplementary to that project) are not required to make up justifiable deficits. They must make up a deficit only if the deficit was due to noncompliance with the regulations. Title XVI facilities with a noncompliance deficit must make up the entire deficit, as adjusted by the inflation factor, in the year following the Department's finding of noncompliance.

124.503(b)(2)

**TITLE VI
AND XVI**

Facilities which received assistance under both Titles VI and XVI must make up deficits according to the Title VI requirements as long as the Title VI assistance remains under obligation. See Chapter II.

**WHICH
TITLE**

Refer to your Basic Facility Report or Facility Status Report provided by the Department. It identifies the type of assistance you received.

**AFFIRMATIVE
ACTION PLAN**

Submit an Affirmative Action Plan with your report, HRSA 710, for each year in which you have a deficit, unless your facility reports that the deficit was due to financial inability to provide uncompensated services at the annual compliance level.

124.503(b)(4)

Your facility should implement the Affirmative Action Plan immediately. The purpose of the Affirmative Action Plan is to increase the probability that you will meet your adjusted annual compliance level next time. Refer to section 124.503(b)(4), which gives specific approaches you may choose to include in your plan. The Department, after reviewing your plan, may require changes in it. Keep the plan, or revised plan, in effect until you meet your adjusted annual compliance level.

**CONTENTS
OF PLAN**

The Affirmative Action Plan you submit to the Secretary should contain the following information:

1. Identification of facility
2. Fiscal year in which the deficit occurred
3. Compliance level for the year in which the deficit occurred
4. Amount of uncompensated services provided in that year
5. Amount of the deficit
6. Reasons for the deficit
7. Action to be taken to meet the facility's compliance level.

**DEFICIT DUE
TO FINANCIAL
INABILITY**

If the reason for the deficit was financial inability to meet your adjusted annual compliance level, you may request a deferment of the deficit make-up requirement. Submit the necessary documentation when you send the report, HRSA 710, to the Department. Refer to Program Policy Notice 89-1, December 1, 1989, for guidance about the documentation needed. If you claim financial inability, you are not required to implement an Affirmative Action Plan at this time.

If the Department agrees with your claim of financial inability, the deficit is considered a justifiable one. If you are a Title VI facility, you may make up this justifiable deficit at any time during your period of obligation or in the year or years immediately following your obligation. See Chapter III for more information about the inflation adjustment and an example of the calculation. If you are a Title XVI facility, you are not required to make up this justifiable deficit.

If the Department disagrees with your claim, the deficit is considered to be a noncompliance deficit and must be made up in accordance with the requirements outlined on pages 35-36. See Chapter III for more information about the inflation adjustment and example of the calculation. You must now submit and implement an Affirmative Action Plan.

FINANCIALLY
UNABLE TO
MAKE UP A
NONCOMPLIANCE
DEFICIT NEXT
YEAR

If you are required to make up all or a portion of a noncompliance deficit next year and you are financially unable to do so, you may request a deferment of part or all of the deficit to a future year or years. Submit the necessary documentation when you send the report, HRSa 710, to the Department. Refer to Program Policy Notice 89-1, December 1, 1989, for guidance about submitting a claim.

124.509(a)(2)(iii)
124.511(c)

If the Department agrees with your claim, you must make up the deficit, as adjusted by the inflation factor, in accordance with a schedule set by the Department. See Chapter III for more information about the inflation adjustment and an example of the calculation.

124.503(b)(2)(ii)(C)

If the Department disagrees with your claim, you must make up the deficit in accordance with the procedures outlined on pages 35-36. See Chapter III for more information about the inflation adjustment and an example of the calculation.

124.503(b)(2)(ii)
124.503(b)(4)

CHAPTER XI

COMPLIANCE

HHS will periodically investigate and assess each facility to determine compliance with the uncompensated services regulations. This includes certifying the amount of uncompensated services you provided as well as identifying areas of noncompliance and prescribing corrective action as necessary. 124.511(b)

A facility which substantially complies with the procedural requirements of the rule will receive full credit for the uncompensated services it reports. On the other hand, a facility which systematically fails to comply with procedural regulatory requirements will be subject to losing credit for the entire year, despite the presence of otherwise creditable accounts. 124.512(b), (c)

SUBSTANTIAL COMPLIANCE

The determination of substantial compliance is based on 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 the determination are:

1. Did the facility have in place procedures that complied with the regulations and systematically follow them?

The facility should have procedures in place for meeting the regulatory requirements. For example, the facility should have a system for providing an individual notice to each person seeking services in the facility and for making determinations of eligibility within the proper time frames.

2. Can any violations be remedied by corrective action?

Where a remedy is available which results in uncompensated services being provided to qualified individuals, the facility will receive credit for those services. For example, where a facility erroneously provides an individual with uncompensated services at a reduced charge when the person was eligible for services at no charge, it can remedy that error by ceasing collection on the amount erroneously charged and/or refunding patient payments improperly collected. However, there are some areas of noncompliance which cannot be remedied adequately and will result in the total loss of uncompensated services credit, such as failure to provide individual notice or to make determinations of eligibility (see Substantial Noncompliance).

3. Has the facility implemented corrective action previously prescribed?

If your facility was found in noncompliance with certain aspects of the regulations and was directed to take corrective action, it must do so in order to receive uncompensated services credit for the period of time covered by the corrective action.

**SUBSTANTIAL
NONCOMPLIANCE**

Facilities found to be in substantial noncompliance are subject to receiving no credit for the period of noncompliance. 124.512(c)

The following areas of noncompliance may result in the disallowance of all of the uncompensated services claimed during that time:

1. Failure to have a system in place for providing individual notice to each person seeking services in the facility;
2. Failure to submit a report when requested to do so by the Department;
3. Failure to maintain records which document compliance with the regulations, such as determinations of eligibility; and
4. Failure to take corrective action prescribed by the Department.

**PARTIAL
CREDIT**

Partial credit may be given when there is neither substantial compliance nor substantial noncompliance. For example, where an assessment finds that your claim includes amounts for services provided to ineligible persons according to your allocation plan, the ineligible accounts may be disallowed. 124.512(d)

CHAPTER XII

HOW TO REPORT AND KEEP RECORDS

REPORTING

WHEN TRIENNIAL	At least once every three years, you will be asked by HHS to complete and submit an Uncompensated Services Assurance Report (HRSA 710, formerly HRA 275). The report is due within 90 days following the end of your fiscal year, unless a longer period is approved by the Secretary for good cause.	124.509(a)(1)(iii)
ANNUAL	If you have a deficit in meeting your adjusted annual compliance level, submit a report for that deficit year. See Chapter X. A copy of the reporting form appears in Appendix 4. The report is due within 90 days after the close of the fiscal year, unless a longer period is approved by the Secretary for good cause.	124.509(a)(1)(ii)(A) 124.509(a)(1)(iii)
	If a facility is found in noncompliance with the reporting requirement, it will be subject to losing all uncompensated services credit for the period that was to be covered by the report.	124.512(c)(2)
ATTACHMENTS	Be sure that copies of your published and individual notices are attached for each fiscal year covered in the report.	
INSTITUTION OF SUIT	If legal action is brought against your facility alleging noncompliance with the regulations, notify the appropriate Regional Health Administrator of HHS within 10 working days after you receive a summons or a complaint. The addresses of the HHS Regional Offices appear in Appendix 1.	124.509(a)(3)

RECORDKEEPING

WHAT RECORDS	The uncompensated services records you maintain establish the basis for the data you provide in the Uncompensated Services Assurances Report (HRSA 710).	124.510(a)(1)(i)
	Failure to maintain records of uncompensated services provided may result in the disallowance of accounts.	124.512(c)(3)
	Keep the uncompensated services accounts segregated from other patient accounts.	124.510(a)(1)(ii)
	Be sure you keep copies of determinations of eligibility, both approvals and denials. See Chapter VI for information about the content of the determinations.	124.510(a)(1)(ii)

**MAINTAINING
A LOG/LIST**

If your facility wishes to stop providing individual written notices, stop making eligibility determinations, and remove posted notices during a fiscal year, records must be maintained on a current basis which will document that your facility has met its compliance level for the year or the period specified in your allocation plan. In addition, within 60 days of the end of each fiscal year, you must determine the amount of uncompensated services you provided in that fiscal year.

124.508(a)
124.510(a)(3)

Maintaining a log or listing of uncompensated services accounts will satisfy these requirements for determining the amount of uncompensated services provided at any given time. A log/list will facilitate facility tracking of accounts and preparation for assessments conducted by HHS. Exhibit 5 illustrates how such current records could be maintained.

**ACCESS
TO
RECORDS**

The records which document your compliance must be made available for public inspection, consistent with personal privacy. Confidential patient medical information need not be provided or made available. If copies of inspected materials are requested by organizations other than HHS or State agencies, you may apply a reasonable charge to these requests. Records must be provided to HHS or State agencies on request. You may initially respond to a request for compliance information by making available for inspection a copy of your triennial report, HRSA 710.

124.510(a)(1)

**RECORD
MAINTENANCE**

Keep records for at least 3 years after submission of your triennial report (unless the Department requests that the records be kept longer), or for 180 days following the close of an assessment investigation, whichever is less. The investigation is considered closed after HHS issues its findings.

124.510(b)(1)(iii)

CHAPTER XIII

HOW TO GET READY FOR AN ASSESSMENT

PURPOSE OF ASSESSMENT	Assessments are conducted by HHS or State agencies to determine a facility's compliance with the uncompensated services regulations. A <u>close-out assessment</u> is scheduled to investigate a facility's claim that it has completed its 20-year obligation. Assessments may also be scheduled without a close-out claim having been made. These are termed <u>triennial assessments</u> , because they usually cover the period included in a facility's most recent triennial report (HRSA 710).
RESULT	Assessments result in findings issued by HHS to the facilities on their compliance with the rules. Where noncompliance is observed, technical assistance is provided and corrective actions may be prescribed in the letter of findings to bring facilities into compliance. The findings also certify the dollar amount of uncompensated services creditable to the facilities' obligation in each fiscal year assessed. Where assessments conclude that facilities have completed their 20-year obligation, a letter of certification is sent to those facilities.
PREPARATION	As far in advance as possible, HHS will contact you to set up a mutually acceptable time for the assessment. At this time, HHS may also ask questions and request materials about your uncompensated services program to facilitate the assessment process.
WHAT TO HAVE AVAILABLE	<p>You should have already completed and submitted to your State agency or HHS an Uncompensated Services Assurance Report, HRSA 710. If the report does not cover all the fiscal years to be assessed, you will be asked to complete a report for those years.</p> <p>Of particular importance are the attachments to the reports, namely your published notices, individual notices, and Affirmative Action Plans (if any) for each fiscal year.</p>
POLICIES AND PROCEDURES	<p>HHS will ask you for copies of any written policies or procedures your facility may have developed for your uncompensated services program, such as directives to the facility staff or special notices to patients.</p> <p>You will also be asked about your facility's procedure for processing requests for uncompensated services and for making determinations of eligibility in response to requests. Copies of any forms you use may be requested also.</p>

RECORDS

Much of the time needed for the assessment will be used by HHS to review your uncompensated services accounts to establish the dollar amount creditable toward your obligation. HHS will ask how your records are kept and if a log or list, such as that illustrated in Exhibit 4, is maintained. If you have a log/list of uncompensated services accounts, or can construct one, HHS may ask for a copy to expedite the process when the assessment is conducted.

Other documents related to uncompensated services accounts that HHS will review are applications, determinations of eligibility (approvals and denials), billings, zero balance sheets, evidence of third-party or patient payments, evidence of resolution of conditionally approved requests, and evidence of disapproval of services by a Peer Review Organization, if applicable. HHS will also request a copy of any special codes used in your system of recordkeeping, such as symbols to denote insurance coverage, types of service, and so on.

**FACILITY
STAFF**

HHS will ask you to identify the person on the staff of the facility who is most familiar with your uncompensated services program, particularly the application and determination of eligibility process and records maintenance.

The materials provided to HHS before the assessment will make the process proceed more quickly at the time of the assessment.

EXHIBIT 1-A - PUBLISHED NOTICE

NOTICE OF
AVAILABILITY OF
HILL-BURTON
UNCOMPENSATED SERVICES

John Doe Hospital of Baltimore, Maryland, will make available from March 1, 1988 to February 28, 1989 \$139,286 of Hill-Burton uncompensated services allocated 25% for each Calendar Quarter. Inpatient services will be available on a first request, first served basis to eligible persons who are unable to pay for hospital services until this hospital's quarterly compliance level is met.

Amount of uncompensated services the facility intends to make available in the fiscal year
Method for distributing services during different times of the year
Type of services available

Eligibility for uncompensated services will be limited to persons whose family income is not more than the current poverty income guidelines (Category A) established by the Department of Health and Human Services. This notice is published in accordance with 42 CFR 124.504 Notice of Availability of Uncompensated Services. We invite interested parties to comment on this allocation plan.

Services limited to Category A patients

Inviting interested parties to comment

Published in the Baltimore Sun, Baltimore, Maryland, January 1, 1988.

Published before start of facility's fiscal year with effective date at least 60 days from publication date

EXHIBIT 1-B - PUBLISHED NOTICE

NOTICE OF
AVAILABILITY OF
HILL-BURTON
UNCOMPENSATED SERVICES

John Doe Hospital of Baltimore,
Maryland, will make available from

July 1, 1988 to June 30, 1989 at least
\$139,286 of Hill-Burton uncompensated
services. All services of the

Amount of uncompensated
services the facility intends
to make available in the
fiscal year

facility will be available on a first
request, first served basis to eligible
persons who are unable to pay for
hospital services until this hospital's
annual compliance level is met.

Eligibility for free care will be
limited to persons whose family income
is not more than the current poverty
income guidelines (Category A)

established by the Department of
Health and Human Services. Persons

whose family income is above but less
than double the poverty income
guidelines (Category B) will be
considered for reduced cost care in
accordance with the schedule below.

Whether persons in Category B
will be provided uncompensated
services

Persons whose income is greater than
the guidelines but not more than 1 1/4
times the guidelines will be eligible
for a 75% reduction from the usual
charges. Persons whose income is
greater than the guidelines but not
more than 1 1/2 times the guidelines
will be eligible for a 50% reduction
from the usual charges. Persons whose
income is greater than 1 1/2 times the
guidelines but less than double the
guidelines will be eligible for a 25%
reduction from the usual charges.

Method used for reducing
charges to persons eligible
under Category B

We invite interested parties to
comment on this allocation plan.

Inviting interested parties
to comment

This notice is published in
accordance with 42 CFR 124.504 Notice
of Availability of Uncompensated
Services and will become effective on

August 1, 1988.

*Effective no earlier than 60
days from publication

Published in the Baltimore Sun,
Baltimore, Maryland, June 1, 1988.

Before the start of the
facility's fiscal year

*Since the plan cannot be effective any earlier than 60 days from publication,
the facility must provide services in accordance with the previously
published plan until the effective date. If no plan has ever been published,
the facility must provide all services to all persons in Categories A and B
until a published plan becomes effective.

EXHIBIT 1-C - PUBLISHED NOTICE

NOTICE OF
AVAILABILITY OF
HILL-BURTON
UNCOMPENSATED SERVICES

John Doe Hospital of Baltimore, Maryland, will provide from March 1, 1988 to February 28, 1989 \$120,000 of Hill-Burton uncompensated services to all eligible persons unable to pay who request those services.

Amount of uncompensated services the facility intends to make available

This amount is less than our annual compliance level due to the application of excess credit from previous years to Fiscal Year 1989. All services of the

Explanation for amount being less than annual compliance level

facility will be available as uncompensated services. Eligibility for uncompensated services will be limited to persons whose family income is not more than the current poverty income guidelines (Category A) established by the Department of Health and Human Services. This notice is published in accordance with 42 CFR 124.504 Notice of Availability of Uncompensated Services and will

*Effective no earlier than 60 days from publication date

become effective April 1, 1988.

We invite interested parties to comment on this allocation plan.

Inviting interested parties to comment

Published in the Baltimore Sun, Baltimore, Maryland, January 25, 1988.

Before the start of the facility's fiscal year

*Since the plan cannot be effective any earlier than 60 days from publication, the facility must provide services in accordance with the previously published plan until the effective date. If no plan has ever been published, the facility must provide all services to all persons in Categories A and B until a published plan becomes effective.

EXHIBIT 1-D - PUBLISHED NOTICE

NOTICE OF
AVAILABILITY OF
HILL-BURTON
UNCOMPENSATED SERVICES

John Doe Hospital of Baltimore, Maryland, will provide from March 1, 1988 to February 28, 1989 uncompensated services to all eligible persons unable to pay who request those services. All services of the facility will be available as uncompensated services. Eligibility for uncompensated services will be limited to persons whose family income is not more than Category A of the current poverty income guidelines established by the Department of Health and Human Services. This notice is published in accordance with 42 CFR 124.504 Notice of Availability of Uncompensated Services. We invite interested parties to comment on this allocation plan.

Amount of uncompensated services the facility intends to make available is not included. Therefore, notice must include a statement that the facility will provide uncompensated services to all persons unable to pay who request uncompensated services.

Inviting interested parties to comment

Published in the Baltimore Sun, Baltimore, Maryland, January 1, 1988.

Published before the start of facility's fiscal year with effective date at least 60 days from publication date

EXHIBIT 2-A - INDIVIDUAL NOTICE

NOTICE OF AVAILABILITY OF UNCOMPENSATED SERVICES

(Name of facility) is required by law to give a reasonable amount of its services without charge to eligible persons who cannot afford to pay for care.

Uncompensated services are limited to (listing of restrictions on types of services as found in your published allocation plan).

To be eligible to receive uncompensated services, your family income must be at or below the following levels:

(Use this table if only Category A persons are provided uncompensated services under your published allocation plan.)

<u>Size of Family</u>	<u>Poverty Guideline*</u>
1	5,500
2	7,400
3	9,300
4	11,200
5	13,100
6	15,000
for each additional family member add	1,900

(Use this table if both Category A and B persons are provided uncompensated services without charge under your published allocation plan.)

<u>Size of Family</u>	<u>Poverty Guideline*</u>
1	11,000
2	14,800
3	18,600
4	22,400
5	26,200
6	30,000
for each additional family member add	3,800

(*These figures are the 1987 Poverty Income Guidelines for all States except Alaska and Hawaii. Alaska and Hawaii guidelines may be found in Federal Register Vol. 52, No. 34, February 20, 1987, page 5340. The Poverty Income Guidelines are revised annually.)

If you think you may be eligible for uncompensated services, you may request them at (location within the facility where requests are to be made). (Name of facility) will make a written conditional or final determination of your eligibility for uncompensated services as follows: (For facilities other than nursing homes): Within 2 working days following a preservice request; or by the end of the first full billing cycle following a postservice request. (For nursing homes): Within 10 working days, but no later than 2 days after admission following a preservice request; or by the end of the first full billing cycle following a postservice request.

EXHIBIT 2-B - INDIVIDUAL NOTICE

NOTICE OF AVAILABILITY OF UNCOMPENSATED SERVICES

(Name of facility) is required by law to give a reasonable amount of its services without charge or at a reduced charge to eligible persons who cannot afford to pay for care. Uncompensated services are limited to (restrictions on types of services as found in your allocation plan).

To be eligible for uncompensated services, your family income must be at or below the following levels:

<u>Size of Family</u>	Without Charge	At Reduced Charge
	<u>Poverty Guideline*</u>	<u>Poverty Guideline*</u>
1	5,500	11,000
2	7,400	14,800
3	9,300	18,600
4	11,200	22,400
5	13,100	26,200
6	15,000	30,000
for each additional family member add	1,900	3,800

(A facility may prescribe its own method of reducing charges. A facility may either explain the method it uses, e.g.

Persons eligible for reduced charge services will be responsible for one-half (1/2) the charges for the services provided.

or may illustrate the method as with a sliding scale, e.g.

<u>Size of Family</u>	<u>Greater than</u>		<u>Greater than</u>		<u>Greater than</u>	
	<u>Up to</u>	<u>Up to</u>	<u>Up to</u>	<u>Up to</u>	<u>Up to</u>	<u>Up to</u>
1	5,500	7,150	7,150	8,250	8,250	11,000
2	7,400	9,652	9,620	11,100	11,100	14,800
3	9,300	12,090	12,090	13,950	13,950	18,600
4	11,200	14,560	14,560	16,800	16,800	22,400
patient share of usual charge	30%		50%		70%	

These are only suggestions. The actual method of reduction is at the facility's discretion, except that the charge must be less than the allowable credit for those services).

If you think you may be eligible for uncompensated services, you may request them at (location within facility where requests are to be made). (Name of facility) will make a written conditional or final determination of your eligibility for uncompensated services as follows:

(For facilities other than nursing homes): Within 2 working days following a preservice request; or by the end of the first full billing cycle following a postservice request.

(For nursing homes): Within 10 working days, but no later than 2 ^{working} days after admission following a preservice request; or by the end of the first full billing cycle following a postservice request.

EXHIBIT 3

INSTRUCTIONS FOR PRORATING

For the purpose of calculating the obligation of a Title VI facility which received grant assistance, the date of construction completion (day, month, year) will constitute the beginning of the obligation period. The obligation will terminate exactly 20 years later. For example, the obligation for construction completed on March 6, 1965 would terminate on March 5, 1985.

If only the month and year of completion of construction are available, consider the opening date to be the last day of the month. For example, if construction was completed in March 1965, the opening date would be March 31, 1965. Therefore, the obligation would run through March 30, 1985.

Where a grant expires during a fiscal year, calculate the number of days the project was under obligation for that fiscal year. For example, a facility has a January 1 fiscal year start date. The obligation for construction completed March 6, 1965 terminates on March 5, 1985. Therefore, counting the number of days from the beginning of the fiscal year (January 1, 1985) until the termination date (March 5, 1985), the project was under obligation for 64 days.

To arrive at the base compliance level for that project, using the 10 percent method, divide the grant amount by 365 (366 if the prorated period includes February 29) which will give you a daily rate. Then multiply the daily rate by the number of days the project was under obligation, in this case, 64. Add this amount to all other grants and loan interest subsidy amounts under obligation, and multiply by 10 percent. This will be the base compliance level under the 10 percent method. Do not prorate cumulative interest subsidy amounts for the final year of a loan.

Where the 3 percent method is used and there is only one grant (or multiple grants having the same expiration date) remaining under obligation, divide the amount calculated under the 3 percent method by 365 (366 if the prorated period includes February 29) which will give you a daily rate. Then multiply the daily rate by the number of days the facility was under obligation. This will be the base compliance level, as well as the annual compliance level, under the 3 percent method.

You may find the proration chart, on the next page, helpful in calculating the number of days remaining in the final year of a grant.

To determine the number of days remaining in a grant, first go to the table which corresponds to the facility's fiscal year. Next, determine the last full month the grant is under obligation and add the number which appears next to it to the number of days under obligation in the last partial month. For example, a facility with a fiscal year beginning July 1, 1986 received a grant with a February 15, 1967 opening date. Using the July 1 through June 30 table, determine the last full month (January) and add the number of days which appears next to it (215) to the number of days under obligation in the last month (14). Therefore, the number of days under obligation is 215 + 14, or 229. (If the prorated period includes February 29, add 1 to the number of days derived by using the proration chart.)

PRORATION CHART
(Cumulative Number of Days by Fiscal Year)

January 1 - December 31

January	31
February	59
March	90
April	120
May	151
June	181
July	212
August	243
September	273
October	304
November	334
December	365

February 1 - January 31

February	28
March	59
April	89
May	120
June	150
July	181
August	212
September	242
October	273
November	303
December	334
January	365

March 1 - February 28

March	31
April	61
May	92
June	122
July	153
August	184
September	214
October	245
November	275
December	306
January	337
February	365

April 1 - March 31

April	30
May	61
June	91
July	122
August	153
September	183
October	214
November	244
December	275
January	306
February	334
March	365

May 1 - April 30

May	31
June	61
July	92
August	123
September	153
October	184
November	214
December	245
January	276
February	304
March	335
April	365

June 1 - May 31

June	30
July	61
August	92
September	122
October	153
November	183
December	214
January	245
February	273
March	304
April	334
May	365

July 1 - June 30

July	31
August	62
September	92
October	123
November	153
December	184
January	215
February	243
March	274
April	304
May	335
June	365

August 1 - July 31

August	31
September	61
October	92
November	122
December	153
January	184
February	212
March	243
April	273
May	304
June	334
July	365

September 1 - August 31

September	30
October	61
November	91
December	122
January	153
February	181
March	212
April	242
May	273
June	303
July	334
August	365

October 1 - September 30

October	31
November	61
December	92
January	123
February	151
March	182
April	212
May	243
June	273
July	304
August	335
September	365

November 1 - October 31

November	30
December	61
January	92
February	120
March	151
April	181
May	212
June	242
July	273
August	304
September	334
October	365

December 1 - November 30

December	31
January	62
February	90
March	121
April	151
May	182
June	212
July	243
August	274
September	304
October	335
November	365

EXHIBIT 4 - APPLICATION/DETERMINATION OF ELIGIBILITY

JOHN DOE HOSPITAL
BALTIMORE, MARYLAND

Application for Hill-Burton Assistance

Name: Last First M.I.

--	--	--

Address: Street City/State Zip Code

--	--	--

Social Security Number Home Phone Employer

--	--	--

	Last 12 Months	Last 3 Months x 4	Family Size
Patient's Gross Income			
Other Family Income			
Total Family Income			

Type of Service Rendered/Requested

Date(s) of Service

I certify that the above information is true and accurate to the best of my knowledge. Further, I will make application for any assistance (Medicaid, Medicare, Insurance, etc.) which may be available for payment of my hospital charge, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges. If any information I have given proves to be untrue, I understand that the hospital may re-evaluate my financial status and take whatever action becomes appropriate.

Date of Request _____ Applicant's Signature _____

ELIGIBILITY DETERMINATION (For Office Use Only)

Date Application Received

Income Verified: Yes _____ No _____

Type of Verification: _____

The applicant is approved ___/conditionally approved___ for care at no charge___ or a reduction of ___% of allowable charges under Category B of the Poverty Income Guidelines. Amount provided as uncompensated services is _____. Condition(s) if applicable:

The applicant's request for free or reduced charge services has been denied for the following reasons(s):

Date of Conditional Determination _____ Date of Final Determination _____

Date Applicant Notified _____ Approved by _____

Program Policy Notice

Number 86-8 (OHF)

- U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

- Public Health Service

- Health Resources and Services Administration

- Bureau of Health Maintenance Organizations and Resources Development

- Office of Health Facilities

To: Facilities Obligated Under the Uncompensated Services Assurance (HILL-BURTON)
Regional Health Administrators, PHS
Regions I-X
Attention: Directors, DHRD
State Agencies with Agreements

SEP 11 1986

Subject: Annual Compliance Level Using the 3 Percent Method

I. ISSUE

How to determine, under the Hill-Burton program, what portion(s) of a health care structure should be used to calculate the annual compliance level using the 3 percent method.

II. DECISION

- A. Where a construction project assisted with Hill-Burton funds resulted in a freestanding structure and discrete operating entity, that entity is the "facility" within the meaning of the uncompensated services regulations, and the 3 percent method for calculating the annual compliance level is based on the operating costs of that discrete entity alone.
- B. Where a construction project assisted with Hill-Burton funds resulted in a discrete operating entity which was not physically separate from another health care structure, three criteria must be met in order for that discrete operating entity to be considered the "facility" within the meaning of the uncompensated services regulations. The three criteria are described in Section III. Criteria, below. If the criteria are met, then the 3 percent method for calculating the annual compliance level can be based on the operating costs of that discrete operating entity alone. However, if the annual compliance level is based on the operating costs of the discrete operating entity alone, the provision of uncompensated services must be limited to the discrete operating entity. Otherwise, services provided elsewhere in the larger health care structure would not be creditable toward the "facility's" uncompensated services obligation because they were not provided in the "facility."

If any one of the criteria is not met, the entire health care structure is considered the "facility," and the 3 percent method for calculating the annual compliance level is based on the operating costs of the entire health care structure.

III. CRITERIA

Three criteria must be met in order to consider the discrete operating entity as the "facility" and to base the operating costs on that discrete operating entity alone. The criteria are:

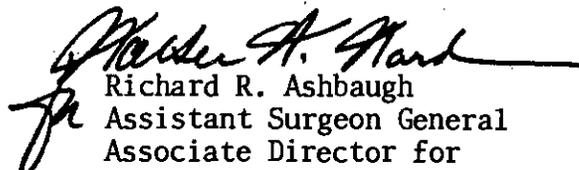
1. The discrete operating entity is one of the categories of "facilities" assisted under the Hill-Burton Act. They are: General Hospital, Tuberculosis Hospital, Mental Hospital or Unit, Chronic Disease Hospital, Public Health Center, Rehabilitation Center, Community Mental Health Center or Facility for the Mentally Retarded, State Health Department Laboratory, Outpatient Facility, or Nursing Home;
2. The construction project assisted with Hill-Burton funds was treated as a distinct and separate "facility" for purposes of Title VI funding and is a different category of operational entity from the larger health care structure; and
3. The "facility" has audited financial statements which set out the operating costs of the discrete entity, as required by section 124.503(a)(1) of the regulations. (Formerly 124.503(a)(1)(i))

Where more than one construction project was assisted with Hill-Burton funds and resulted in more than one discrete operating entity, apply the criteria separately to each project. For each project meeting the criteria, calculate the annual compliance level using the lesser of 10 percent of the Federal assistance received for that project or 3 percent of the operating costs of that discrete operating entity alone.

When calculating the annual compliance level for the remaining projects which did not meet the criteria, use only the Federal assistance for those projects or the operating costs for the remaining health care structure.

IV. ADDITIONAL INFORMATION

If you have any questions, please contact: Office of Health Facilities, Division of Facilities Compliance, 5600 Fishers Lane, Room 11-25, Rockville, Maryland 20857, 301 443-5656.


Richard R. Ashbaugh
Assistant Surgeon General
Associate Director for
Health Facilities

Program Policy Notice

Number 88-2 (OHF)

- U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
- Public Health Service
- Health Resources and Services Administration
- Bureau of Maternal and Child Health and Resources Development
- Office of Health Facilities

March 7, 1988

To: Facilities Obligated Under the Uncompensated Services Assurance (HILL-BURTON)
Regional Health Administrators, PHS
Regions I-X
Attention: Directors, DHRD
State Agencies with Agreements

Subject: Consumer Price Index (CPI) for Medical Care: 1987 Index and Percent Change

DATE THIS CPI BECOMES EFFECTIVE FOR HILL-BURTON FACILITIES: MARCH 12, 1988

This notice provides guidance to facilities obligated to provide uncompensated services in accordance with the requirements of the Hill-Burton program. The adjustments included in this notice are to be used in calculating the adjusted annual compliance levels using the 10 percent method and in adjusting compliance deficits or excesses from the past year to the current year.

The latest adjustments are based on the yearly average Consumer Price Index for medical care in 1987 which was recently issued by the U.S. Department of Labor, Bureau of Labor Statistics, and on the CPI in prior years. The 1987 CPI for medical care is 462.2. A description of the calculations for both the annual compliance level and the adjusted excesses and deficits follows. Examples of these calculations and the tables from which to obtain the appropriate adjustments are also included.

COMPUTATION OF ANNUAL COMPLIANCE LEVEL

Computation of the percent change in the CPI for medical care between 1987 and the base year of 1979 is as follows:

Index Point Change

1987 Yearly Average Index	462.2
1979 Base Year Index	-239.7
	<u>222.5</u>

Percent Change

Index Point Change	222.5	=	.9283
Base Year Index	239.7		
Percent Change			92.8

- A. Facility with Grant Assistance - A facility with a fiscal year beginning on or after March 12, but before the 1988 annual CPI becomes available in 1989, uses the 92.8 percent change when calculating the annual compliance level. Application of the percent change to computation of annual compliance levels under the 10 percent method is illustrated below:

Example:

All Federal Grant Assistance Under Obligation = \$500,000.

Federal Assistance Under Obligation x 10% = Base Level

\$500,000 x 10% = \$50,000 (Base Level)

Base Level + (Base Level x Percent Change in CPI) = Annual Compliance Level

\$50,000 + (\$50,000 x 92.8%) = \$96,400 (Annual Compliance Level)

- B. Facility with Loan Assistance - To compute the annual compliance level for a fiscal year beginning on or after March 12, 1988, multiply each interest subsidy payment by 10 percent and adjust each by a change in the CPI between the year in which the Secretary made each payment or 1979, whichever is later, and the most recent year for which a published index is available, 1987. Use the last column of the CPI Application to 10% Compliance Level for Loan Facilities table to determine the percentage change. The first number in the column, 92.8 percent, is the change between 1979 and 1987. Take 10 percent of the cumulative interest subsidy amount through 1979 and adjust it by 92.8 percent. The second number, 73.8 percent, is the change between 1980 and 1987. Take 10 percent of the annual interest subsidy paid in 1980 and adjust it by 73.8 percent. Adjust each subsequent annual interest subsidy payment, through 1986, by a change in the CPI between the year of the payment and 1987. In calculating the annual compliance level for Fiscal Year 1989, interest subsidy payments made in Fiscal Years 1987, 1988, and 1989 have no CPI adjustment. Sum these yearly figures to arrive at the annual compliance level. (For an example of the calculations, see page 8 of the February 1988 Provider's Guide to the Hill-Burton Uncompensated Services Regulations.)

COMPUTATION FOR ADJUSTING AN EXCESS OR DEFICIT

Computation of the percent change in the CPI for medical care between 1987 and 1986 is as follows:

<u>Index Point Change</u>	
1987 Yearly Average Index	462.2
1986 Yearly Average Index	-433.5
	28.7
<u>Percent Change</u>	
Index Point Change	28.7
1986 Yearly Average Index	433.5
	= .066
Percent Change	6.6

Excess Adjustment

Adjustment of excess amounts earned in a fiscal year beginning March 12, 1987 through March 11, 1988, to be applied to the following fiscal year, is illustrated below:

Example:

Annual Compliance Level for FY 1989, Beginning July 1, 1988 = \$96,400

Excess Uncompensated Services Provided in FY 1988 = \$1,000

Excess Uncompensated Services + (Excess Uncompensated Services x Percent Change in CPI) = Adjusted Excess

\$1,000 + (\$1,000 x 6.6%) = \$1,066 (Adjusted Excess)

Annual Compliance Level - Adjusted Excess = Adjusted Annual Compliance Level

\$96,400 - \$1,066 = \$95,334 (Adjusted Annual Compliance Level)

Deficit Adjustment

Adjustment of deficits incurred in a fiscal year beginning March 12, 1987 through March 11, 1988, to be made up in the following fiscal year, is illustrated below:

Example:

Annual Compliance Level for FY 1989, Beginning July 1, 1988 = \$96,400

Deficit Amount from FY 1988 to be made up in FY 1989 = \$1,000

Deficit + (Deficit x Percent Change in CPI) = Adjusted Deficit

\$1,000 + (\$1,000 x 6.6%) = \$1,066 (Adjusted Deficit)

Annual Compliance Level + Adjusted Deficit = Adjusted Annual Compliance Level

\$96,400 + \$1,066 = \$97,466 (Adjusted Annual Compliance Level)

If you have any further questions, please contact: Office of Health Facilities, Division of Facilities Compliance, 5600 Fishers Lane, Room 11-25, Rockville, Maryland 20857, 301 443-5656.


Richard R. Ashbaugh
Director
Office of Health Facilities

CPI ADJUSTMENT TABLES

CPI APPLICATION TO 10% COMPLIANCE LEVEL FOR GRANT FACILITIES WITH FISCAL YEARS BEGINNING:

<u>THROUGH</u>	<u>USE</u>
May 18, 1979	May 19, 1981
May 20, 1981	May 11, 1982
May 12, 1982	May 13, 1983
May 14, 1983	May 11, 1984
May 12, 1984	May 11, 1985
May 12, 1985	May 11, 1986
May 12, 1986	May 11, 1987
May 12, 1987	March 11, 1988
March 12, 1988	March 11, 1989
	No adjustment
	10.9%
	22.9%
	37.1%
	49.1%
	58.3%
	68.2%
	80.9%
	92.8%

CPI APPLICATION TO 10% COMPLIANCE LEVEL FOR LOAN FACILITIES AND
CPI APPLICATION TO EXCESS AND DEFICIT

<u>Applied to year beginning:</u>											
	5/18/79- 3/19/81	3/20/81- 3/11/82	3/12/82- 3/13/83	3/14/83- 3/11/84	3/12/84- 3/11/85	3/12/85- 3/11/86	3/12/86- 3/11/87	3/12/87- 3/11/88	3/12/88- 3/11/89		
5/18/79- 3/19/81	0	10.9%	22.9%	37.1%	49.1%	58.3%	68.2%	80.9%	92.8%		
3/20/81- 3/11/82	-	-	10.8%	23.6%	34.4%	42.7%	51.6%	63.0%	73.8%		
3/12/82- 3/13/83	-	-	-	11.6%	21.3%	28.9%	36.9%	47.2%	57.0%		
3/14/83- 3/11/84	-	-	-	-	8.7%	15.5%	22.6%	31.9%	40.6%		
3/12/84- 3/11/85	-	-	-	-	-	6.2%	12.8%	21.3%	29.4%		
3/12/85- 3/11/86	-	-	-	-	-	-	6.2%	14.2%	21.8%		
3/12/86- 3/11/87	-	-	-	-	-	-	-	7.5%	14.7%		
3/12/87- 3/11/88	-	-	-	-	-	-	-	-	6.6%		

Earned in year beginning:

PART TWO -- PUBLIC FACILITY COMPLIANCE ALTERNATIVE

INTRODUCTION

WHAT IS THE PUBLIC FACILITY COMPLIANCE ALTERNATIVE	The Public Facility Compliance Alternative (PFCA) is a substitute method by which publicly-owned facilities which meet certain qualifications can fulfill their Hill-Burton uncompensated services obligation.
WHAT ARE UNCOMPENSATED SERVICES	Uncompensated services, for the purpose of facilities certified under the compliance alternative, is the term applied to health services made available at no charge or at reduced charges in accordance with your facility's program of discounted health services.
WHO MUST PROVIDE THEM	All health facilities which received grants, loans or loan guarantees for construction, modernization, or equipment under Titles VI or XVI of the PHS Act, or any assistance supplementary to the Title VI or XVI assistance, must make uncompensated services available.
WHO IS ELIGIBLE TO RECEIVE THEM	Persons are eligible for uncompensated services if they: 1) are not covered or receive services not covered under a third-party insurer or governmental program; and 2) meet the criteria specified under your facility's program of discounted health services.
HOW LONG DOES THE OBLIGATION LAST	Facilities which received grants under Title VI are obligated to provide uncompensated services for 20 years from the date the project was completed. Facilities which received loans are obligated until the loan is repaid. The period of obligation for these facilities may be lengthened due to deficits incurred. Facilities which received funds under Title XVI are obligated indefinitely.
HOW ARE THE SERVICES PROVIDED	Uncompensated services must be provided in accordance with the procedures and policies established by your facility, and approved by HHS. Your program for providing free or discounted services must include objective eligibility criteria and procedures for notifying potential applicants.
WHO MONITORS FACILITIES' COMPLIANCE	HHS monitors and enforces the uncompensated services regulations. States may assist HHS with monitoring and enforcement.

**HOW TO GET
PROGRAM
GUIDANCE**

HHS sends program information to facilities through Program Policy Notices. Some States also provide such materials. Additional guidance is available from the State agencies listed in Appendix 2, from the HHS Regional Offices listed in Appendix 1, and from HHS headquarters (the telephone number is: 301-443-5656, or call the Hill-Burton toll-free hot line information number: 1-800-638-0742; or, for Maryland residents: 1-800-492-0359).

CHAPTER I

HOW TO DETERMINE IF YOU QUALIFY FOR CERTIFICATION UNDER THE PUBLIC FACILITY COMPLIANCE ALTERNATIVE

CRITERIA FOR QUALIFICATION

There are three criteria for eligibility for the public facility compliance alternative. See Exhibit 1 for guidance.

124.513(b)

1. Your facility must be owned and operated by a unit of State or local government, or a quasi-public corporation.

124.513(b)(1)

A quasi-public corporation is a private, nonprofit corporation which has been formally given one or more governmental powers by legislative action through State legislature, city or county council.

2. Your facility must provide health services without charge or at a substantially reduced charge to individuals who qualify for your program of discounted health services. You must establish financial and other criteria for determining eligibility for your facility's uncompensated services program. In addition to income, the financial criteria may include assets and liabilities. Other criteria may include residency requirements and specific types of services which will be made available at no or reduced charge. You are not required to use the eligibility criteria specified in section 124.505(a)(2), although you may do so.

124.513(b)(2)

An acceptable program of discounted health services must also include procedures, such as providing notice prior to nonemergency services, which will ensure that all persons have an equal opportunity to apply for and obtain a determination of eligibility for services. The procedures must permit providing a determination of eligibility, where requested, before receiving services.

If your facility makes all services available to all persons at no or nominal charge, your program of discounted health services need not include the procedures specified in this section.

3. Your facility:

124.513(b)(3)(i)

- a) received an average of at least 10 percent of its operating revenue from State or local government over the previous 3 fiscal years to support its uncompensated services program. See Exhibit 3 for guidance; or

b) provided in each of the 3 most recent fiscal 124.513(b)(3)(ii)
years, uncompensated services in an amount not
less than twice its annual compliance level
computed under section 124.503(a) of the
regulations.

If you meet the above qualifications, see
Chapter II for instructions on how to apply
for the compliance alternative.

CHAPTER II

HOW TO APPLY FOR THE PUBLIC FACILITY COMPLIANCE ALTERNATIVE

If you feel your facility qualifies for certification under the public facility compliance alternative, provide the following documentation to your regional office. Refer to Exhibit #2, pages 1 and 2, for guidance. 124.513 (b)

1. Documentation to substantiate that the facility is owned and operated by a unit of State or local government, or a quasi-public corporation. In instances where the required information is in a larger document, please note where it can be found. 124.513 (b) (1)
 - a. If a quasi-public corporation operates your facility, a copy of the legislative documentation which establishes the basis for the functions your facility performs.
 - b. If your facility is operated under a management contract, a copy of the management contract, if applicable. Do not submit a copy if your facility has received prior approval by the Department to operate your program under the current lease agreement or management contract.
2. Documentation about your "program of discounted health services." 124.513 (b) (2)
 - a. If your facility operates a no or nominal charge program, which provides all services to all people at no or nominal charge, submit a complete description of the program, including charging and collection policies and procedures, and a copy of the citation from the statute, regulation, or other governmental authority which requires that services be provided at no or nominal charge.
 - b. If your facility provides health services at a substantially reduced rate, submit a complete description of your program, including charging and collection policies and procedures, eligibility criteria (income plus any other criteria), procedures used to notify people about your program, procedures used for determining patient eligibility, and a copy of the citation from the statute, regulation, or other governmental authority which requires that services be provided at a substantially reduced rate.

3. Documentation to substantiate that your facility qualifies under the 10 percent criterion. 124.513(b)(3)(i)

Audited financial statements or official State or local government documents, such as annual reports or budget documents, for the 3 most recent fiscal years.

4. Documentation to substantiate that your facility qualifies under twice the annual compliance method (2 x ACL). 124.513(b)(3)(ii)

Audited financial statements which shows that your facility provided at least 2 x ACL under your own discounted health services program.

CHAPTER III

OPERATION OF AN UNCOMPENSATED SERVICES PROGRAM UNDER THE PUBLIC
FACILITY COMPLIANCE ALTERNATIVE

**PROGRAM OF
DISCOUNTED
HEALTH
SERVICES**

Once your facility is certified under the public facility compliance alternative, your facility is obligated to provide uncompensated services in accordance with the program of discounted health services approved by the Department.

**PERIOD OF
OBLIGATION**

In general, facilities which received grants under Title VI are obligated to provide uncompensated services for 20 years from the date the project was completed. Title VI facilities which received loans are obligated until the loan is repaid. Facilities which received Title XVI assistance are obligated indefinitely.

However, the period of obligation may be extended for Title VI facilities as a result of deficits incurred. For example, there are 5 years remaining in your grant. You also have an outstanding deficit, as of the time of certification, equal to 2 years' annual compliance level. Therefore, the obligation would be extended by 2 years for a remaining period of obligation of 7 years.

**PERIOD OF
CERTIFICATION**

Certification under the compliance alternative is effective until withdrawn by the Department.

**WITHDRAWAL OF
CERTIFICATION**

Withdrawal of certification may occur for the following reasons:

124.513(d)(1)

1. a material change upon which certification was based (see Chapter III, page 69); and
2. substantial noncompliance with the alternative (see Chapter V, page 76).

Where certification is withdrawn, a facility will be subject to the requirements of the general rule.

CERTIFICATION
UNDER 2 x ACL

**PERIOD OF
OBLIGATION**

If your facility was certified under the 2 x ACL method and you did not provide discounted health services at least equal to that amount, the period of obligation will be extended by one year for each year the specified level of uncompensated services was not provided.

**LEVEL OF
UNCOMPEN-
SATED
SERVICES**

If your facility was certified under the 2 x ACL method, you must provide discounted health services in each subsequent fiscal year at least equal to twice the annual compliance level.

EXCESS

Under the public facility compliance alternative, uncompensated services provided in excess of a facility's annual compliance level cannot be used to reduce the annual compliance level in a future year or to complete the obligation in fewer years.

DEFICITS

If you did not provide discounted health services equal to at least twice your annual compliance level, you have a deficit. Therefore, an additional year will be added to your obligation period. Continued failure to meet the criteria for certification may result in withdrawal of certification.

CERTIFICATION
UNDER 10 PERCENT

**PERIOD OF
OBLIGATION**

If your facility was certified under the 10 percent criterion and you did not receive, during the previous 3 years, an average of at least 10 percent of your operating revenue from State or local government, an additional year may be added to your obligation. Continued failure to meet the criteria for certification may result in withdrawal of certification. (See Exhibit 3 for guidance on how to determine the amount of State and local funding received.)

**LEVEL OF
UNCOMPENSATED
SERVICES**

If your facility was certified under the 10 percent method, you do not have an annual compliance level.

REPORTING

WHEN Within 90 days after the close of your fiscal year, you must submit to the regional office, the following: 124.509(c)

- WHAT**
1. A certification, signed by the responsible official of your 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. If your program was changed, you must send information, including the date the change occurred, about the revised program. A material change would include the following:
 - a. Your facility is no longer publicly owned and operated;
 - b. Initial certification was based on a no or nominal charge program but your facility is not currently operating such a program;
 - c. Initial certification was based on a program of discounted health services but your facility is not currently operating such a program; and
 - d. Certification was based on the 2 x ACL method or the 10 percent method but you did not operate your program in accordance with the plan submitted for approval.

Where the facility changes its program of discounted health services and the Department approves the changes, your facility can continue operating under the new program. However, if the Department finds the new program to be unacceptable, it will specify required changes and will extend your facility's obligation to compensate for the length of time the facility operated an unacceptable program.

No form will be provided for your report. The report is simply a statement certifying that there has or has not been a material change in the factors upon which initial certification was based.

COMPLAINTS

Your facility remains subject to the complaint provisions of the regulations which permit individuals to file complaints concerning a facility's noncompliance with the regulatory requirements. If a complaint is filed against your facility, the decision will be based on whether your facility was operating in accordance with the program of discounted health services you described and the Department approved.

124.511(a)

The vast majority of complaints filed against facilities in the past were from individuals who alleged that they were not notified of the uncompensated services program. Therefore, it is important that you provide notice to individuals in accordance with your approved program.

**INSTITUTION
OF SUIT**

If legal action is brought against your facility alleging noncompliance with the regulations, notify the appropriate Regional Health Administrator of HHS within 10 working days after you receive a summons or complaint. The addresses of the HHS regional offices appear in Appendix 1.

RECORDKEEPING**WHAT
RECORDS**

The uncompensated services records you maintain establish the basis for the data you provide in your annual certification. The following records must be maintained:

124.510(b)

1. Copies of the documentation used for certification.
2. Documentation to substantiate patient eligibility in accordance with your program of discounted health services.
3. Facilities certified under the 2 x ACL method must maintain, on a current basis, documentation to substantiate that your facility met the annual compliance level for the year or for the period specified in your program of discounted health services.

**ACCESS
TO
RECORDS**

The records which document your compliance must be made available for public inspection, consistent with personal privacy. Confidential patient medical information need not be provided or made available. If copies of inspected materials are requested by organizations other than HHS or State agencies, you may apply a reasonable charge to these requests. Records must be provided to HHS or State agencies on request.

**RECORD
MAINTENANCE**

Keep records for at least 3 years following submission of your annual certification letter, except where a longer period is required as a result of an assessment investigation. In such a case, keep records for 180 days following the close of an investigation. An investigation is considered closed after HHS issues its findings.

CHAPTER IV

HOW TO MAKE UP DEFICITS INCURRED FOR YEARS PRIOR TO CERTIFICATION
UNDER THE PUBLIC FACILITY COMPLIANCE ALTERNATIVE

ASSESSED
FACILITIES

124.513(d) (2) (i)

TITLE VI A facility assisted with Title VI funds can:
a) submit documentation, similar to that provided at the time of initial certification, to substantiate that your facility was in compliance at the time of certification; or b) have an additional year(s) or portion of a year added to your period of obligation for each assessed deficit year or portion of a year.

TITLE XVI A facility assisted with Title XVI funds can:
a) submit documentation, similar to that provided at the time of initial certification, to substantiate that your facility was in compliance at the time of certification; or b) if documentation cannot be provided, you will have to make up the deficit when certification is withdrawn.

UNASSESSED
FACILITIES

124.513(d) (2) (ii)

TITLE VI
FACILITIES A facility assisted with Title VI funds can:
a) follow the same procedures stated above for Title VI assessed facilities; or b) submit an independent certified audit to establish the amount of uncompensated services provided. The audit must be conducted in accordance with established policies and procedures, and will be reviewed by the Department. If the audit finds, to the Department's satisfaction, that no or a lesser deficit exists, the facility will receive credit for those amounts.

TITLE XVI
FACILITIES A facility assisted with Title XVI funds can:
a) submit documentation, similar to that provided at the time of initial certification, to substantiate that your facility was in compliance at the time of certification; or b) submit an independent certified audit to establish the amount of uncompensated services provided. The audit must be conducted in accordance with established policies and procedures, and will be reviewed by the Department. If the audit finds, to the Department's satisfaction, that no or a lesser deficit exists, the facility will receive credit for those amounts. Any deficit which still remains must be made up when certification is withdrawn.

CHAPTER V

COMPLIANCE UNDER THE PUBLIC FACILITY COMPLIANCE ALTERNATIVE

HHS will investigate complaints against facilities to determine compliance with the uncompensated services regulations. 124.511(b)

This includes reviewing records to see if eligible persons, who qualified under your program of discounted health services, were provided those services. The investigation will also include identifying areas of noncompliance and prescribing corrective action. 124.512(b), (c)

SUBSTANTIAL COMPLIANCE

The determination of substantial compliance is based on 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 the determination are:

1. Did the facility systematically follow the program of discounted health services approved by HHS?

For example, if your program of discounted health services includes providing notice of your uncompensated services program to each person upon admission, then it must do so in order to receive uncompensated services credit.

2. Can any violations be remedied by corrective action?

Where a facility erroneously provides an individual with uncompensated services at a reduced charge when the person was eligible for services at no charge, it can remedy that error by ceasing collection on the amount erroneously charged and/or refunding patient payments improperly collected. However, there are some violations which cannot be remedied, such as failure to submit your annual certification, which may result in additional years being added to your uncompensated services obligation. (See Substantial Noncompliance).

3. Has the facility implemented corrective action previously prescribed?

If your facility was found in noncompliance with certain aspects of the regulations and was directed to take corrective action, it must do so in order to be eligible to continue to operate under the public facility compliance alternative.

**SUBSTANTIAL
NONCOMPLIANCE**

Facilities found to be in substantial noncompliance are subject to having an additional year(s) added to their obligation period.

124.512(c)

The following areas of noncompliance may result in additional years being added to your uncompensated services obligation:

1. Failure to provide notice in accordance with your program of discounted health services approved by the Department;
2. Failure to submit your annual certification;
3. Failure to maintain records of uncompensated services provided under your program of discounted health services; and
4. Failure to take corrective action prescribed by the Department.

**WITHDRAWAL OF
CERTIFICATION**

A pattern of substantial noncompliance may result in withdrawal of certification under the public facility compliance alternative.

124.513(d)

Where certification is withdrawn, a facility will be subject to the requirements of the general regulations.

EXHIBIT 1

FACILITY CERTIFICATION CHECKLIST

To be used by the facility to determine if it qualifies for the compliance alternative.

YES NO

1. Ownership

Is the facility publicly (or quasi-publicly) owned?
(A quasi-public facility is defined as a private nonprofit corporation which has been formally given one or more governmental powers by a general-purpose unit of government to enable it to carry out its work.)

If "yes," proceed to question #2.

If "no," the facility is ineligible for the public facility compliance alternative.

2. Control

Is the facility operated by its ownership?

If "yes," proceed to #3.

If "no," documentation must be provided as stated on DOCUMENTATION list.

3. Description of discounted health services program

a. Does the facility make all services available to everyone at no or nominal charge?

If "yes," proceed to #4.

If "no," proceed to #3b.

b. Did the facility have a program of discounted health services for each of the 3 most recent fiscal years, and is it still operating such a program?

If "yes," answer the following questions:

i. Does the discounted health services program have objective eligibility procedures?

ii. Is notice provided to enable equal opportunity for application?

iii. Are determinations of eligibility made, including preservice where requested?

YES

NO

If the answer to any of the above questions (3b.i through 3b.iii) is "no," the facility is ineligible for the public facility compliance alternative. If the answer to all of the above questions is "yes," proceed to #4.

4. Public funding support

Has a State or local government provided an average of at least 10% of the facility's funding (exclusive of Medicare/Medicaid reimbursement) for the 3 most recent fiscal years? _____

If "yes," the facility may be eligible for certification. Please send the required documentation, and we will process your application.

If "no," proceed to #5.

5. Level of Services

Did the facility provide in each of the 3 most recent fiscal years, health services at no or nominal charge or at a discount in an amount not less than twice the annual compliance level under the Hill-Burton program? _____

If "yes," the facility may be eligible for certification. Please send the required documentation, and we will process your application.

If "no," the facility is not eligible for certification under the compliance alternative.

If you apply for certification under the compliance alternative, you must continue to operate the facility's Hill-Burton program as required in the past, until such time as you are certified under the public facility alternative.

EXHIBIT 2

DOCUMENTATION

(If after reviewing the facility certification checklist the facility believes that it will qualify for the compliance alternative, it should provide the documentation described below. In instances where the required information is in a larger document, the facility should note where it can be found. Numbers correspond to items on Facility Certification Checklist.)

- 1) Evidence of public/quasi-public ownership.
- 2) Copy of management contract or lease, if applicable (unless the facility has the prior approval of the Hill-Burton waiver/recovery program to operate under such lease or management contract).
- 3) Description of indigent care program.
 - a. For facilities that charge no or nominal fees to all people for all services, please provide the following:
 - i. Description of program;
 - ii. Charging and collection policies and procedures; and
 - iii. Citation from statute, regulation, or other governmental authority which requires that the facility provide all services to all people at no or nominal charge.
 - b. For facilities that have a program of discounted health services, please provide the following:
 - i. Description of program;
 - ii. Charging and collection policies and procedures;
 - iii. Eligibility criteria (income plus any other criteria);
 - iv. Procedures used to notify people about the availability of the discounted health services program; and
 - v. Procedures for determining patient eligibility.

The above information may be provided by submitting copies of patient brochures, procedural manuals, annual reports, etc. Please highlight or note where the required information is included.

- 4) Annotated audited financial statements or budget documents for the 3 most recent fiscal years, which include the following information:
- i. Total operating revenue;
 - ii. Medicare and Medicaid reimbursement (either received or claimed);
 - iii. Sources and amounts of government revenue (excluding capital appropriations, Medicare and Medicaid reimbursement or contractual allowances, and other expenses not related to support of the facility's discounted health program); and
 - iv. Dollar amount of care provided under its indigent care program (for #5 on checklist). Please explain if this is not assigned a line item on your audited financial statement. Do not include bad debts, contractual allowances, employee discounts, etc.

EXHIBIT 3

FORMAT FOR DETERMINING AMOUNT OF STATE AND LOCAL FUNDING RECEIVED

If the 10 percent method is to be used for recertification, lines 1 through 19 below should be completed for the 3 most recent fiscal years.

	FY _____	FY _____	FY _____
1. Facility's Total Revenues	_____	_____	_____
2. (-) Revenues for Non-Patient Care Programs	_____	_____	_____
3. (-) Revenues for Capital Expenditures	_____	_____	_____
4. (-) Medicare Reimbursements	_____	_____	_____
5. (-) Medicaid Reimbursements	_____	_____	_____
6. (-) Any Direct Federal Grants	_____	_____	_____
7. (=) Revenues for Patient Care Programs	_____	_____	_____
8. State and Local Funds for Indigent Patient Care Programs	_____	_____	_____
9. % State and Local funds for Indigent Patient Care Programs (Line 8 Divided by Line 7)	_____	_____	_____

If the percentage of governmental support is below 10 percent for one or more of the three years, add total government support (line 8) for the three years, add total operating revenue (line 1) for the three years, and divide total support by total revenue.

Percent Government Support Dollars for 3 Fiscal Years

Fiscal Year _____	Government Support \$ _____	Operating Revenue \$ _____
Fiscal Year _____	Government Support \$ _____	Operating Revenue \$ _____
Fiscal Year _____	Government Support \$ _____	Operating Revenue \$ _____
	TOTAL SUPPORT \$ _____	TOTAL REVENUE \$ _____

3-Year Average of Government Support _____ %
(Total Government Dollars/Total Operating Revenue)

PART THREE - COMMUNITY HEALTH CENTER, MIGRANT HEALTH CENTER AND
NATIONAL HEALTH SERVICE CORPS SITE COMPLIANCE ALTERNATIVE

INTRODUCTION

**WHAT IS THE
COMPLIANCE
ALTERNATIVE**

The compliance alternative is a substitute method by which community health centers, migrant health centers and certain National Health Service Corps sites which are in compliance with the conditions of their grant under Section 330 or 329 or agreement under Section 334 of the Public Health Service Act can fulfill their Hill-Burton obligations.

**CRITERIA FOR
QUALIFICATION**

You may be certified under the compliance alternative if your facility:

1. 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; or
2. Has signed an agreement with the Secretary under Section 334 of the Act and the services provided by the National Health Service Corps professional(s) constitute all of the medical services provided by the facility.

CHAPTER I

HOW TO APPLY FOR CERTIFICATION UNDER THE
COMMUNITY HEALTH CENTER, MIGRANT HEALTH CENTER,
AND NATIONAL HEALTH SERVICE CORPS COMPLIANCE ALTERNATIVE

**NOTIFY
REGIONAL
OFFICE**

If your facility meets one of the above criteria, notify your HHS Regional Office listed in Appendix 1. Identify all fiscal years, beginning with Fiscal Year 1980, for which your facility was a grant recipient under Section 330 or 329 of the Act, or in the case of National Health Service Corps sites, had a memorandum of agreement under Section 334 of the Act.

**EFFECT OF
CERTIFICATION**

A facility certified under the compliance alternative is not required to comply with the uncompensated services regulations. It will be certified as having met its annual compliance level for each year in which it is in compliance with the conditions of its grant under Section 330 or 329 or its agreement under Section 334 or the Act relating to the provision of services at a discount.

**PERIOD OF
CERTIFICATION**

Certification under the compliance alternative is effective until withdrawn by the Department.

**WITHDRAWAL OF
CERTIFICATION**

If your facility loses its grant support or no longer has an agreement with the Secretary, advise your regional office immediately. Certification will be withdrawn and your facility will automatically become subject to the requirements of the uncompensated services regulations for the remainder of your obligation.

CHAPTER II

HOW TO MAKE UP DEFICITS INCURRED BEFORE CERTIFICATION
UNDER THE COMMUNITY HEALTH CENTER, MIGRANT HEALTH CENTER, AND
NATIONAL HEALTH SERVICE CORPS SITE COMPLIANCE ALTERNATIVE

- TITLE VI
ASSESSED
DEFICIT** Where a Title VI assisted facility has been assessed as having a deficit which has not been made up prior to certification, it can make up that deficit by: 124.515(b) (1)
1. demonstrating that it received grant assistance under Section 330 or 329 of the Act, or had a memorandum of agreement with the Secretary under Section 334 of the Act, for each year in which there was an assessed deficit; or
 2. adding, to the period of obligation, a year (or portion of a year) for each year (or portion of a year) of deficit assessed.
- UNASSESSED
DEFICIT** A Title VI assisted facility whose compliance has not been completely assessed prior to certification under this compliance alternative will be presumed to have no credit for the unassessed period. A facility can make up that deficit by: 124.515(b) (2)
1. demonstrating that it received grant assistance under Section 330 or 329 of the Act, or had a memorandum of agreement with the Secretary under Section 334 of the Act, for each year in which there was an assessed deficit;
 2. adding, to the period of obligation, a year (or portion of a year) for each year (or portion of a year) of deficit assessed; or
 3. submitting an independent certified audit to establish the amount of uncompensated services provided. The audit must be conducted in accordance with Department policies and procedures. If the audit finds, to the Department's satisfaction, that no or a lesser deficit exists, the facility will receive credit for that period. Any deficit which still remains must be made up in accordance with number 1 or 2 above.
- If you wish to have an independent audit, contact your regional office, listed in Appendix 1, to obtain an Audit Guide which contains instructions for independent auditors conducting uncompensated services assessments.

TITLE XVI

**ASSESSED
DEFICIT**

Where a Title XVI assisted facility has been assessed as having a deficit which has not been made up prior to certification, it can make up that deficit by demonstrating that it received grant assistance under Section 330 or 329 of the Act, or had a memorandum of agreement with the Secretary under Section 334 of the Act, for each year in which there was an assessed deficit.

124.515(b) (3) (i)

**UNASSESSED
DEFICIT**

A Title XVI assisted facility whose compliance has not been completely assessed prior to certification under this compliance alternative will be presumed to have no credit for the unassessed period. A facility can make up that deficit by:

124.515(b) (3) (ii)

1. demonstrating that it received grant assistance under Section 330 or 329 of the Act, or had a memorandum of agreement with the Secretary under Section 334 of the Act, for each year in which there was an assessed deficit; or
2. submitting an independent certified audit to establish the amount of uncompensated services provided. The audit must be conducted in accordance with Department policies and procedures. If the audit finds, to the Department's satisfaction, that no or a lesser deficit exists, the facility will receive credit for that period.

Any deficit that still remains must be made up when the facility is no longer certified under the compliance alternative.

PART FOUR - SMALL ANNUAL OBLIGATION COMPLIANCE ALTERNATIVE

INTRODUCTION

WHAT IS THE
SMALL ANNUAL
OBLIGATION
COMPLIANCE
ALTERNATIVE

The small annual obligation compliance alternative is a substitute method by which facilities with annual obligations of \$10,000 or less and which operate a program of discounted health services can fulfill their Hill-Burton obligations.

WHAT ARE
UNCOMPEN-
SATED
SERVICES

Uncompensated services, for the purpose of facilities certified under the compliance alternative, is the term applied to health services made available at no charge or at reduced charges in accordance with your facility's program of discounted health services.

WHO MUST
PROVIDE
THEM

All health facilities which received grants, loans or loan guarantees for construction, modernization, or equipment under Titles VI or XVI of the PHS Act, or any assistance supplementary to the Title VI or XVI assistance, must make uncompensated services available.

WHO IS
ELIGIBLE
TO RECEIVE
THEM

Persons are eligible for uncompensated services if they:
1) are not covered or receive services not covered under a third-party insurer or governmental program;
and 2) meet the criteria specified under your facility's program of discounted health services.

HOW MUCH
SERVICES
MUST BE
PROVIDED

Facilities are obligated to provide annually a minimum dollar volume of uncompensated services which is the lesser of: 1) 10 percent of the Federal assistance they received, adjusted for inflation; or 2) 3 percent of their annual operating costs, minus Medicare or Medicaid reimbursement.

HOW LONG
DOES THE
OBLIGATION
LAST

Facilities which received grants under Title VI are obligated to provide uncompensated services for 20 years from the date the project was completed. Facilities which received loans are obligated until the loan is repaid. The period of obligation may be lengthened due to deficits incurred.

Facilities which received funds under Title XVI are obligated indefinitely.

HOW ARE
THE SERVICES
PROVIDED

Uncompensated services must be provided in accordance with the procedures and policies established by your facility, and approved by HHS. Your program for providing free or discounted services must include objective eligibility criteria and procedures for notifying potential applicants.

WHO MONITORS
FACILITIES'
COMPLIANCE

HHS monitors and enforces the uncompensated services regulations. States may assist HHS with monitoring and enforcement.

**HOW TO GET
PROGRAM
INFORMATION**

HHS sends program information to facilities through Program Policy Notices. Additional guidance is available from the HHS Regional Offices listed in Appendix 1 and from HHS headquarters (the telephone number is: 301-443-5656, or call the Hill-Burton toll-free hot line information number: 1-800-638-0742; or, for Maryland residents: 1-800-492-0359).

**REGULATORY
COMPLIANCE**

Following is a step-by-step guide to the regulatory requirements, with cross references to the appropriate regulations sections and discussion on the effects of noncompliance.

CHAPTER I

HOW TO DETERMINE IF YOU QUALIFY FOR CERTIFICATION UNDER
THE SMALL ANNUAL OBLIGATION COMPLIANCE ALTERNATIVE

- CRITERIA FOR QUALIFICATION
- There are two criteria for eligibility for the small annual obligation compliance alternative: 124.514(b)
1. Your facility's annual compliance level must be no more than \$10,000 in the fiscal year in which the regulations become effective, February 1, 1988 (for any subsequent year, the \$10,000 limit for eligibility will be adjusted by the change in the CPI available in the year you are applying for the compliance alternative); and 124.514(b) (1)
 2. Your facility must provide health services without charge or at a substantially reduced charge to individuals who qualify for your facility's program of discounted health services. You must establish financial and other objective criteria for determining eligibility for your facility's uncompensated services program. In addition to income, the financial criteria may include consideration of assets and liabilities. Other criteria may include residency requirements and specific types of services which will be made available at no or reduced charge. You are not required to use the eligibility criteria specified in section 124.505(a) (2), although you may do so. 124.514(b) (2)

An acceptable program of discounted health services must also specify procedures, including the provision of notice prior to nonemergency services, which will ensure that all persons have an equal opportunity to apply for and obtain a determination of eligibility for services. In the case of a preservice request, the procedures must include providing a determination of eligibility before receiving services, where requested.

If your facility makes all services available to all persons at no or a nominal charge, your program of discounted health services need not include the criteria and procedures specified in 2 above.

\$10,000 or
LESS

The method for determining whether your facility meets the \$10,000 or less criterion depends on whether your facility received Title VI or Title XVI assistance. Following is the step-by-step process for determining if your facility meets this criterion. If you need further assistance, contact your HHS Regional Office listed in Appendix 1, or HHS headquarters (the telephone number is: 301-443-5656, or call the Hill-Burton toll-free hot line information number: 1-800-638-0742; or, for Maryland residents: 1-800-492-0359).

TITLE VI

Your facility meets the \$10,000 criterion if: the level, computed under the buy out formula, divided by the number of whole and partial years remaining in your 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.

Step 1

Calculate your facility's remaining obligation as described in Part One - Chapter IX, "Buying Out Early." Use amounts certified by the Department as a result of an assessment. However, there will likely be some unassessed years preceding your application for certification under the small annual obligation compliance alternative. If this is the case, use the amounts of uncompensated services reported on the Uncompensated Services Assurance Report (HRSR 710) for years unassessed by the Department. Where reported figures are used, the obligation must be recalculated once the Department has conducted an assessment and certified amounts creditable toward the obligation.

124.514(b)(1)(i)(A)

Example:

Where: \$ 4,975 = FY 1988 Base Compliance Level (1/1/88)
\$ 9,000 = FY 1988 Annual Compliance Level
(\$4,975 x 1.809 CPI Factor)
5 = Number of Years Remaining in Grant
\$ 800 = Deficit as of End of FY 1987
.075 = CPI Adjustment to be Applied to Deficit

Then: \$ 9,000 x 5 = \$45,000
\$45,000 + (\$800 x 1.075) = \$45,860 (Remaining Obligation)

Step 2

Determine the number of years remaining in your facility's period of obligation (the number of years remaining in your grant or loan plus the number of deficit years). a) If you have multiple grants or loans, determine the number of years until the last grant expires or the last loan payment is due. b) In addition, if you have a deficit which has not been made up, add an additional year or portion of a year proportionate to the amount of remaining deficit. To do this, calculate the remaining deficit as of the year prior to the year for which you are applying for the compliance alternative. Divide (use 2 decimal places) the remaining deficit by the adjusted annual compliance level (including prior year deficits) for that year. The number of years remaining in your period of obligation = a + b.

Example:

Where a facility's fiscal year begins January 1, 1988 and the opening date of its grant was January 1, 1973 (the 20-year obligation, therefore, runs through December 31, 1992), there are 5 years remaining in the grant.

In addition, as of the end of Fiscal Year 1987, the facility had a deficit of \$800. The adjusted annual compliance level for Fiscal Year 1987 was \$9,500. Divide the \$800 deficit by the \$9,500 annual compliance level, which equals .09 deficit years.

Add the 5 years remaining in your grant to the .09 deficit years for a remaining period of obligation of 5.09 years. This means that your obligation, under the compliance alternative, is 5.09 years, or 5 years and 1 month (round to the nearest month).

Step 3

Divide the amount of remaining obligation (Step 1) by the number of years remaining in the period of obligation (Step 2). For example, \$45,860 divided by 5.09 equals \$9,010.

If the amount computed in Step 3 above is \$10,000 or less (in the fiscal year in which the regulations become effective), and you have a program of discounted health services, you may be eligible for certification under the small annual obligation compliance alternative. See Chapter II, "How to Apply for the Small Annual Obligation Compliance Alternative."

For subsequent fiscal years, the \$10,000 limit for eligibility will be adjusted by the change in the CPI between the CPI available in the facility's fiscal year the regulations become effective and the CPI available in the fiscal year for which you are applying for the compliance alternative. For example, suppose you are applying for the alternative in your fiscal year beginning January 1, 1989. If the difference between the CPI available in the fiscal year in which the regulations became effective (Fiscal Year 1988 for a January 1 fiscal year start date) and the CPI available for your Fiscal Year 1989 is 6.6 percent, then the \$10,000 limit for eligibility would increase to \$10,660 (\$10,000 + \$660).

124.514(b)(1)(i)(B)

TITLE XVI

For Title XVI facilities, the formula for calculating whether your facility meets the \$10,000 criterion is as follows: the annual compliance level, plus the amount of any noncompliance deficits which have not been made up and the annual compliance levels for any unassessed periods, is not more than \$10,000.

Step 1

Calculate your facility's annual compliance level as described in Part One, Chapter III. 124.514(b)(1)(ii)(A)

Step 2

Determine the amounts of any assessed noncompliance deficits which have not been made up and the annual compliance levels for each unassessed year.

Step 3

For each unassessed year, the facility may accept no credit or the facility can submit an independent certified audit to establish the amount of uncompensated services provided. The audit must be conducted in accordance with established policies and procedures, and will be reviewed by the Department. If the audit finds, to the Department's satisfaction, that no or a lesser deficit exists, the facility will receive credit for those amounts. If you wish to have an independent audit, contact your regional office to obtain the instructions for independent auditors conducting uncompensated services assessments.

Step 4

Add the annual compliance level (Step 1) and the amount of assessed noncompliance deficit and the annual compliance level for each unassessed year (Step 2) and subtract creditable amounts certified by an independent auditor (Step 3). (Step 1 + Step 2 - Step 3 must be no more than \$10,000.)

If the amount computed in Step 4 above is \$10,000 or less (in 1987, the effective date of the regulations), and you have a program of discounted health services, you may be eligible for certification under the small annual obligation compliance alternative. See Chapter II - "How to Apply for the Small Annual Obligation Compliance Alternative."

For subsequent fiscal years, the \$10,000 limit for eligibility will be adjusted by the change in the CPI between the CPI available in the facility's fiscal year the regulations become effective and the CPI available in the fiscal year for which you are applying for the compliance alternative. For example, suppose you are applying for the alternative in your fiscal year beginning January 1, 1989. If the difference between the CPI available in the fiscal year in which the regulations became effective (Fiscal Year 1988 for a January 1 fiscal year start date) and the CPI available for your Fiscal Year 1989 is 6.6 percent, then the \$10,000 limit for eligibility would increase to \$10,660 (\$10,000 + \$660). 124.514(b)(1)(i)(B)

CHAPTER II

HOW TO APPLY FOR THE
SMALL ANNUAL OBLIGATION COMPLIANCE ALTERNATIVE

If you feel your facility qualifies for certification under the small annual obligation compliance alternative, submit the following to your regional office: 124.514(c)

1. Documentation of your "program of discounted health services;"
 - a. If your facility provides health services at a substantially reduced rate, provide a complete description of your facility's program of discounted health services, including charging and collection policies, objective eligibility criteria, procedures used to notify people about your program, and procedures used for determining patient eligibility; or
 - b. If your facility provides all services to all persons at no or nominal charge, provide a description of the no or nominal charge program;
2. For Title VI facilities, an Uncompensated Services Assurance Report covering years not previously assessed or reported;
3. For Title XVI facilities which have received an independent audit, the audit report.

CHAPTER III

OPERATION OF AN UNCOMPENSATED SERVICES PROGRAM UNDER THE SMALL ANNUAL OBLIGATION COMPLIANCE ALTERNATIVE

**PROGRAM OF
DISCOUNTED
HEALTH
SERVICES**

Once your facility is certified under the small annual obligation compliance alternative, your facility is obligated to provide uncompensated services in accordance with the program of discounted health services approved by the Department.

**LEVEL OF
UNCOMPEN-
SATED
SERVICES**

Your facility must also provide an amount of uncompensated services not less than that amount computed in Chapter I for determining eligibility for the small annual obligation compliance alternative (Step 3 for Title VI facilities and Step 4 for Title XVI facilities).

124.514(d)

For each year after the first year under this compliance alternative, the annual compliance level must be adjusted by a change in the CPI between the CPI available in the year in which your facility is initially certified and the CPI available before the start of each fiscal year.

**PERIOD OF
OBLIGATION**

In general, facilities which received grants under Title VI are obligated to provide uncompensated services for 20 years from the date the project was completed. Facilities which received loans are obligated until the loan is repaid. Facilities which received Title XVI assistance are obligated indefinitely.

124.514(e) (1)

However, the period of obligation may be extended for Title VI facilities as a result of deficits incurred. For example, there are 4 years remaining in your grant. You also have an outstanding deficit, as of the time of certification, equal to 1 year's annual compliance level. Therefore, the obligation would be extended by 1 year for a remaining period of obligation of 5 years (see Chapter 1, Step 2).

In addition, the period of obligation may be extended where the annual compliance level has not been met under the compliance alternative.

Under the small annual obligation compliance alternative, uncompensated services provided in excess of a facility's annual compliance level cannot be used to reduce its annual compliance level in a future year or to complete its obligation in fewer years.

124.514(e) (2)

**PERIOD OF
CERTIFICATION**

Certification under the compliance alternative is effective until withdrawn by the Department.

**WITHDRAWAL OF
CERTIFICATION**

Withdrawal of certification may occur for the following reasons: 124.514(d)

1. The facility has failed to remedy areas of noncompliance identified by the Department;
2. The facility has failed to remedy a change in the program of discounted health services which was found to be unacceptable by the Department;
3. There has been a pattern of substantial noncompliance; or
4. Failure to submit the annual certification described below.

DEFICIT

You have a deficit if the amount of uncompensated services you provided in a fiscal year is less than your annual compliance level for that year. For a Title VI facility, a deficit incurred under the compliance alternative will result in the period of obligation being extended until the deficit is made up.

REPORTING

WHEN

Within 90 days after the close of your fiscal year you must submit, to the regional office, the following: 124.509(c)

WHAT

1. A certification, signed by the responsible official of your facility, of the amount of uncompensated services provided in the previous fiscal year; and
2. a. A certification, signed by the responsible official of your facility, that there has been no material change in the factors upon which the certification was based; or
b. 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. This means that if you change your program of discounted health services, you must send information, including the date the change occurred, about the revised program.

Where the facility changes its program of discounted health services and the Department approves the changes, your facility can continue operating under the new program. However, if the Department finds the new program to be unacceptable, it will specify required changes and will extend your facility's obligation, to compensate for the length of time the facility operated an unacceptable program.

No form will be provided for your report. The report is simply a statement of the amount of uncompensated services provided and whether or not there have been any material changes (and, if so, documentation to support those changes).

COMPLAINTS

Your facility remains subject to the complaint provisions of the regulations which permit individuals to file complaints concerning a facility's noncompliance with the regulatory requirements. If a complaint is filed against your facility, the judgment will be based on whether your facility was operating in accordance with the program of discounted health services you described and the Department approved.

124.511(a)

The vast majority of complaints filed against facilities are from individuals who allege that they were not notified of the uncompensated services program. Therefore, it is important that you provide notice to individuals in accordance with your approved program.

INSTITUTION OF SUIT

If legal action is brought against your facility alleging noncompliance with the regulations, notify the appropriate Regional Health Administrator of HHS within 10 working days after you receive a summons or complaint. The addresses of the HHS regional offices appear in Appendix 1.

RECORDKEEPING

WHAT RECORDS

The uncompensated records you maintain establish the basis for the data you provide in your annual certification. Be sure to keep documentation of the uncompensated services you provide, so as to substantiate patient eligibility in accordance with your program of discounted health services.

124.510(b)

If your facility wishes to stop providing uncompensated services and stop providing notice during a fiscal year, records must be maintained on a current basis which document that your facility has met its compliance level for the year or for the period specified in your program of discounted health services.

ACCESS TO RECORDS

The records which document your compliance must be made available for public inspection, consistent with personal privacy. Confidential patient medical information need not be provided or made available. If copies of inspected materials are requested by organizations other than HHS or State Agencies, you may apply a reasonable charge to these requests. Records must be provided to HHS or State Agencies on request.

**RECORD
MAINTENANCE**

Keep records for at least 3 years following submission of your annual certification letter, except where a longer period is required as a result of an assessment investigation. In such a case, keep records for 180 days following the close of an investigation. An investigation is considered closed after HHS issues its findings.

CHAPTER IV

COMPLIANCE UNDER THE SMALL ANNUAL OBLIGATION COMPLIANCE ALTERNATIVE

HHS will periodically investigate and assess each facility to determine compliance with the uncompensated services regulations. This includes certifying the amount of uncompensated services you provided as well as identifying areas of noncompliance and prescribing corrective action as necessary. 124.511(b)

A facility which substantially complies with the procedural requirements of the rule will receive full credit for the uncompensated services it reports, up to its annual compliance level. On the other hand, a facility which systematically fails to comply with procedural regulatory requirements will be subject to receiving no credit for the entire year, despite the presence of otherwise creditable accounts. 124.512(b), (c)

SUBSTANTIAL COMPLIANCE

The determination of substantial compliance is based on whether the facility provides uncompensated services to eligible persons who had equal opportunity to apply for those services. The specific factors that will be considered in making the determination are:

1. Did the facility systematically follow the program of discounted health services approved by HHS?

For example, if your program of discounted health services includes providing notice of your uncompensated services program to each person upon admission, then it must do so in order to receive uncompensated services credit.

2. Can any violations be remedied by corrective action?

Where a remedy is available which results in uncompensated services being provided to eligible individuals, the facility will receive credit for those services. For example, where a facility erroneously provides an individual with uncompensated services at a reduced charge when the person was eligible for services at no charge, it can remedy that error by ceasing collection on the amount erroneously charged and/or refunding patient payments improperly

collected. However, there are some areas of noncompliance which cannot be remedied adequately and will result in the total loss of uncompensated services credit, such as failure to provide individual notice in accordance with its program of discounted health services.

3. Has the facility implemented corrective action previously prescribed?

If your facility was found in noncompliance with certain aspects of the regulations and was directed to take corrective action, it must do so in order to receive uncompensated services credit for the period of time covered by the corrective action.

**SUBSTANTIAL
NONCOMPLIANCE**

Facilities found to be in substantial noncompliance are subject to receiving no credit for the period of noncompliance. 124.512

The following areas of noncompliance may result in the disallowance of all of the uncompensated services claimed during that time:

1. Failure to provide notice in accordance with your program of discounted health services approved by the Department;
2. Failure to submit your annual certification;
3. Failure to maintain records of uncompensated services provided under your program of discounted health services; and
4. Failure to take corrective action prescribed by the Department.

**WITHDRAWAL OF
CERTIFICATION**

A pattern of substantial noncompliance may result in withdrawal of certification under the small annual obligation compliance alternative. 124.514(d)

**PARTIAL
CREDIT**

Partial credit may be given when there is neither substantial compliance nor substantial noncompliance. For example, where an assessment finds that your claim includes amounts for services provided to ineligible persons according to your program of discounted health service, the ineligible accounts may be disallowed. 124.512(d)

APPENDIX 1

ADDRESSES OF HHS REGIONAL OFFICES

REGION I

Connecticut, Maine, Massachusetts,
New Hampshire, Rhode Island, Vermont

Regional Health Administrator
John F. Kennedy Federal Building
14th Floor
Government Center
Boston, Massachusetts 02203
Telephone: 617-565-1426

REGION II

New York, New Jersey, Puerto Rico,
Virgin Islands

Regional Health Administrator
26 Federal Plaza
Room 3337
New York, New York 10278
Telephone: 212 264-2560

REGION III

Delaware, Maryland, Pennsylvania, Virginia,
West Virginia, District of Columbia

Regional Health Administrator
P.O. Box 13716
3535 Market Street
Room 10200
Philadelphia, Pennsylvania 19104
Telephone: 215-596-6637

REGION IV

Alabama, Florida, Georgia, Kentucky,
Mississippi, North Carolina,
South Carolina, Tennessee

Regional Health Administrator
101 Marietta Tower
Suite 1106
Atlanta, Georgia 30323
Telephone: 404-331-2316

REGION V

Illinois, Indiana, Michigan,
Minnesota, Ohio, Wisconsin

Regional Health Administrator
105 West Adams Street
17th Floor
Chicago, Illinois 60603
Telephone: 312-353-1385

REGION VI

Arkansas, Louisiana, New Mexico,
Oklahoma, Texas

Regional Health Administrator
1200 Main Tower Building
18th Floor
Dallas, Texas 75202
Telephone: 214-767-3879

REGION VII

Iowa, Kansas, Missouri,
Nebraska

Regional Health Administrator
Federal Office Building
601 East 12th Street
Room 501
Kansas City, Missouri 64106
Telephone: 816-426-5291

REGION VIII

Colorado, Montana, North Dakota,
South Dakota, Utah, Wyoming

Regional Health Administrator
Federal Office Building
1961 Stout Street
4th Floor
Denver, Colorado 80294
Telephone: 303-844-6163

REGION IX

Arizona, California, Hawaii, Nevada,
Guam, Trust Territory of Pacific
Islands

Regional Health Administrator
Federal Office Building
50 United Nations Plaza
3rd Floor
San Francisco, California 94102
Telephone: 415-556-5810

REGION X

Alaska, Idaho, Oregon, Washington

Regional Health Administrator
2201 Sixth Avenue
7th Floor
Seattle, Washington 98121
Telephone: 206-553-0430

APPENDIX 2

State Agencies with Agreements with HHS
to Administer the Uncompensated Services Program

There are currently no State Agency agreements.

Federal Register

**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

[Editorial Note: This reprint incorporates corrections published in the *Federal Register* of Monday, December 21, 1987.]

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: Charlotte Pascoe.

FOR FURTHER INFORMATION CONTACT: Charlotte Pascoe, 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. 99-79.

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(i)(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 §§ 124.511(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. 300a-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. 300a, 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? * 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

* 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. 291(e)(1), not the uncompensated services assurance.

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),

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 any 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 from 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 facility 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 obligation, 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 compliance 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 alternative 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 thus 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 must 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 the 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 or uncompensated services.
124.505	Eligibility criteria.
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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) or 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 a 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 proper 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 not 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) *Pastservice 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 § 124.515 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 0915-0103 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 a 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 assurance unless it supplies documentation sufficient to show compliance with the applicable provisions of this subpart.

(4) Section 1827 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 eligible 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 noncompliance 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 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.

(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 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.

(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 or 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 the 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.

[FR Doc. 87-27316 Filed 12-2-87; 8:45 am]

[Editorial Note: This reprint incorporates corrections published in the Federal Register of Monday, December 21, 1987.]

BILLING CODE 4160-15-M

UNCOMPENSATED SERVICES ASSURANCE REPORT

PART A: IDENTIFICATION DATA

1. FACILITY NAME AND ADDRESS (include Zip Code)	2. FACILITY IDENTIFICATION NUMBER
	3. TELEPHONE NUMBER (include Area Code)

PART B: BASIC INFORMATION

4. FISCAL YEAR REPORTED FY _____ BEGINNING _____ ENDING _____ _____ _____	5. REASONS FOR SUBMISSION (Check All That Apply) <input type="checkbox"/> a. Deficit <input type="checkbox"/> b. Deficit—Financial Inability (Attach Facility Audited Financial Statements) <input type="checkbox"/> c. Completion of Obligation <input type="checkbox"/> d. Department Request (Other Than Deficit) <input type="checkbox"/> e. Annual Report (Trust)
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6. FACILITY STATUS

NO CHANGE IN STATUS

(CHECK APPROPRIATE BOX BELOW IF STATUS HAS CHANGED SINCE LAST AUDIT OR REPORT PROVIDED)

<input type="checkbox"/> a. Transfer of Ownership <input type="checkbox"/> c. Closed <input type="checkbox"/> e. Management Contract <input type="checkbox"/> g. Other (Specify) _____	<input type="checkbox"/> b. Merged with _____ <input type="checkbox"/> d. Converted to _____ <input type="checkbox"/> f. Lease Agreement
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MONTH / YEAR OF CHANGE

PART C: ANNUAL COMPLIANCE LEVEL

7. FISCAL YEAR OF MOST RECENT AUDITED FINANCIAL STATEMENT WHICH PROVIDES THE BASIS FOR ANSWERS TO LINES 8, 9, & 10	FY-
8. TOTAL OPERATING EXPENSE	\$
9. MEDICARE REIMBURSEMENTS	\$
10. MEDICAID REIMBURSEMENTS	\$
11. OPERATING EXPENSE MINUS MEDICARE AND MEDICAID REIMBURSEMENTS (Line 8) - (Line 9 + Line 10)	\$
12. 3% ANNUAL COMPLIANCE LEVEL (Line 11 x 3%)	\$
13. 10% ANNUAL COMPLIANCE LEVEL (Already Adjusted by CPI)	\$
14. ANNUAL COMPLIANCE LEVEL (Lesser of Lines 12 or 13)	\$
15. DEFICIT FROM PREVIOUS YEAR	\$
16. CPI INFLATION FACTOR	%
17. ADJUSTED DEFICIT FROM PREVIOUS YEAR (Line 15 x Line 16)	\$
18. PRORATED DEFICIT REQUIRED TO BE MADE UP IN CURRENT YEAR	\$
19. CPI INFLATION FACTOR	%
20. ADJUSTED PRORATED DEFICIT (Line 18 x Line 19)	\$
21. TOTAL DEFICIT TO BE MADE UP IN REPORTING YEAR (Line 17 + Line 20)	\$
22. EXCESS FROM PREVIOUS YEAR	\$
23. CPI INFLATION FACTOR	%
24. ADJUSTED EXCESS (Line 22 x Line 23)	\$
25. ADJUSTED ANNUAL COMPLIANCE LEVEL (Line 14 + Line 21) or (Line 14 + Line 21) - (Line 24)	\$

PART D: ALLOWABLE CREDIT FACTOR
TO BE COMPLETED ONLY BY FACILITIES WHICH PARTICIPATE IN MEDICARE

26. ALLOWABLE CREDIT FACTOR	
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PART E: UNCOMPENSATED SERVICES

27. AMOUNT OF UNCOMPENSATED SERVICES PROVIDED TO ELIGIBLE PATIENTS COMPUTED AT USUAL CHARGES	\$
28. UNCOMPENSATED SERVICES PROVIDED AT ALLOWABLE CREDIT (Line 26 x Line 27)	\$
29. DIFFERENCE BETWEEN COMPLIANCE LEVEL AND SERVICES PROVIDED (Compare Line 25 with Line 28 and Enter the Difference)	\$
a. Deficit	\$
b. Excess	\$

PART F: ADDITIONAL INFORMATION

30. ALLOCATION PLAN PUBLISHED IN NEWSPAPER (Attach Copy of Published Notice)	<input type="checkbox"/> YES <input type="checkbox"/> NO
31. DETERMINATIONS OF ELIGIBILITY	
a. Number of Requests for Services at No Charge or Reduced Charge	
b. Number of Requests Resulting in Denial	
c. Number of Eligibility Determinations Resulting in Provision of Uncompensated Services	
32. POSTED NOTICE OF UNCOMPENSATED SERVICES (Admissions/Business Offices and Emergency Room)	<input type="checkbox"/> YES <input type="checkbox"/> NO
33. INDIVIDUAL NOTICE IS PROVIDED TO EACH PATIENT (Attach Copy of Written Notice Provided)	<input type="checkbox"/> YES <input type="checkbox"/> NO

34. CERTIFICATION

I understand that all the information contained in this report is subject to public disclosure under the Freedom of Information Act. I certify that, in answering all the applicable items, I have not omitted material information reasonably available to me. I further certify that the information given is true and correct to the best of my knowledge. (A willfully false statement is punishable by law [18 U.S.C. Sec. 1001])

a. PREPARER'S NAME	b. PREPARER'S TITLE AND TELEPHONE NO. (Include Area Code)	c. PREPARER'S SIGNATURE	DATE
d. NAME OF FACILITY ADMINISTRATOR	e. FACILITY ADMINISTRATOR'S SIGNATURE		DATE

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