IMPLEMENTATION OF HILL-BURTON AMENDMENTS, 1974

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON
LABOR AND PUBLIC WELFARE
UNITED STATES SENATE

NINETY-THIRD CONGRESS

SECOND SESSION

ON

EXAMINATION OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE'S IMPLEMENTATION OF THE 1970 AMENDMENTS TO THE HILL-BURTON ACT

NOVEMBER 25, 1974

Printed for the use of the Committee on Labor and Public Welfare

U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 1974

44-376 O

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IMPLEMENTATION OF HILL-BURTON AMENDMENTS, 1974

MONDAY, NOVEMBER 25, 1974

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE
COMMITTEE ON LABOR AND PUBLIC WELFARE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:35 a.m., in room 4232, Dirksen Senate Office Building, Senator Edward M. Kennedy [chairman of the subcommittee], presiding.

Present: Senator Kennedy.

Committee staff present: Philip Caper, M.D., professional staff member; and Jay B. Cutler, minority counsel.

OPENING STATEMENT BY SENATOR KENNEDY

Senator KENNEDY. I would like to welcome our witnesses and guests to this oversight hearing concerning the Department of Health, Education, and Welfare's implementation of the 1970 Amendments to the Hill-Burton Act.

Specifically, during this subcommittee's hearing concerning proposed health facilities legislation currently awaiting floor action in the Senate, held on July 14, 1974, questions were raised with respect to the vigor and effectiveness with which the Department had implemented specific provisions included in the 1970 Senate bill amending the Hill-Burton Act.

The Senate position on those provisions was subsequently accepted by the House Conferees and became enacted as part of the 1970 Hill-Burton Amendments.

Amendments were made in the Hill-Burton authority existing at that time to accomplish two goals.

First of all, the committee reaffirmed its position that hospitals assisted through the Hill-Burton program render a reasonable volume of free services to those unable to pay. In addition, the committee made a number of changes in the existing law which would allow the Department of HEW to implement the committee's conviction that increased emphasis be placed upon the funding of outpatient facilities serving disadvantaged populations.

As a result of the questions raised before this subcommittee concerning the effectiveness of the Department's attempts to implement these amendments to existing Hill-Burton authority, Senator Javits and I asked the General Accounting Office to conduct an evaluation of the implementation of the program.

The purpose of this hearing is to hear the General Accounting Office (GAO) report, and to give the Department and interested public witnesses an opportunity to respond.

The first witness this morning representing the General Accounting Office is Gregory Ahart, Director, Manpower and Welfare Division.

Mr. Ahart joined GAO in 1957, and since that time has been engaged in carrying out that agency's responsibilities for auditing, investigation and accounting work with respect to various executive departments and agencies.

Among other responsibilities, the Manpower and Welfare Division has oversight responsibilities for all Federal health programs.

Mr. Ahart, we want to welcome you to the committee this morning.

STATEMENT OF GREGORY J. AHART, DIRECTOR, MANPOWER AND WELFARE DIVISION, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY MATTHEW S. WATSON, SENIOR ATTORNEY, OFFICE OF GENERAL COUNSEL; WILLIS L. ELMORE, ASSISTANT DIRECTOR, MANPOWER AND WELFARE DIVISION; AND ROBERT E. GARBARK, STAFF, MANPOWER AND WELFARE DIVISION

Mr. AHART. Thank you. I would like to introduce my associates at the table.

On my left is Matthew Watson, senior attorney from the Office of General Counsel. On my immediate right is Willis L. Elmore, Assistant Director, Manpower and Welfare Division. On his right is Mr. Robert Garbark from Mr. Elmore's staff.

We are pleased to be here today to discuss compliance with certain legislative requirements of the Hill-Burton program administered by the Health Resources Administration of the Department of Health, Education, and Welfare (HEW).

Specifically, we will discuss (1) implementation of the requirement that special consideration be given to constructing or modernizing outpatient facilities in poverty areas, and (2) compliance by hospitals assisted by the Hill-Burton program with the requirement that they provide a reasonable volume of free services to residents of the communities in which they are located.

The 1970 amendments to the Public Health Service Act provided that the Hill-Burton program give special consideration to constructing and modernizing outpatient facilities in rural or urban poverty areas and providing services to residents of those areas.

The 1970 amendments also provided that, at the option of the State agency, the Federal share of the cost of certain health facilities could be as much as 90 percent. The 90-percent level of financial participation can be authorized for health facility projects that (1) will provide services primarily to persons in an area that the Secretary of Health, Education, and Welfare deems a rural or urban poverty area, or (2) offer potential for reducing health care costs by sharing services with other health care facilities, by interfacility cooperation, or by constructing or modernizing freestanding outpatient facilities.

Section 622 of the Hospital Survey and Construction Act, enacted by the Congress in 1946, directed that regulations governing the ap-

proval of hospital construction be issued. These regulations were to require that, before a State agency could recommend approval of an application for a hospital or addition to a hospital, there must be assurance that a reasonable volume of services to persons unable to pay would be made available in the facility or portion thereof to be constructed or modernized. Under the regulations, an exception may be granted if such a requirement were not financially feasible.

Implementing regulations were issued on October 22, 1947, and defined free services as hospital service offered either at below cost or free to persons unable to pay. The reasonable volume of free services called for in the act was not clearly defined by the regulations.

These regulations basically remained unchanged until January 6, 1972, when new regulations were published. The regulations were changed to simply state the language of the statute. HEW comments explaining the change stated that numerous court suits concerning the 1947 regulations were in process and that new regulations designed to define the scope of "assurance" more clearly and to govern its enforcement were being prepared.

HEW issued revised regulations on July 22, 1972. These regulations which are still in effect define a reasonable volume of free services, furnish guidance to State agencies on eligibility criteria and qualifying services, and set forth requirements for evaluation and enforcement of compliance.

The present HEW regulations provide that facilities can meet the reasonable volume of free services requirement by (1) offering free or below cost services annually in an amount which is not less than the lesser of 3 percent of operating costs—after deducting medicare and medicaid reimbursements—or 10 percent of total Federal assistance received, or (2) certifying that free or below cost services will not be refused to any person regardless of their ability to pay—open door option.

On September 25, 1974, we issued a report dealing with the Hill-Burton program to this subcommittee. In that report, we provided information on the extent to which certain State Hill-Burton agencies were assisting or encouraging projects which would service poverty communities to apply for Federal assistance for constructing or modernizing outpatient facilities. We also reported on the need for outpatient facilities and the use of funds made available for this purpose and the implementation of the free service requirement.

We gathered information principally at HEW headquarters, four HEW regional offices, several State Hill-Burton agencies and hospitals, and the American Hospital Association.

Because of time constraints, the scope of our review was limited to obtaining information from readily available records, without verification, and from interviews with officials at the locations we visited. The reliability of the information obtained depends, for the most part, on the assumed accuracy of the records and oral comments.

At 10 State agencies visited, we found no formal outreach programs, nor plans to initiate such programs to encourage the construction or modernization of outpatient facilities in poverty areas. Officials in two States attributed the lack of outreach efforts in their States to the inability of potential poverty area project sponsors to raise their share of project costs.

Officials in three States said that an outreach program was not needed, because sufficient applications were always available to exhaust Hill-Burton funds allocated to their States. However, two of these officials acknowledged that large amounts were transferred from the outpatient funds category because a sufficient number of applications were not received to utilize outpatient funds.

Any special consideration being given to outpatient facilities in poverty areas was not evident, except that some States chose the 90-percent Federal financial participation rate.

Of 20 State plans examined, 11 indicated that the State had selected the 90-percent rate for eligible projects. The participation rate for the other nine States ranged from 33 to 80 percent.

Records of 13 State agencies were examined to determine how many outpatient facilities in poverty areas received Hill-Burton assistance during fiscal years 1971 through 1974; 8 of the 13 States had provided no financial assistance for constructing or modernizing outpatient facilities in poverty areas.

State officials said, however, that it was possible that some projects funded for hospital construction or modernization included the hospital's outpatient facility as part of the total project.

To obtain information on the need for outpatient facilities, we examined 15 State plans and found that 4 plans indicated that no additional outpatient facilities were needed. Four other plans showed a need for adding only one facility.

Of 11 State plans showing a need for outpatient facilities, only 3 indicated that the need was in a poverty area. The others showed no need in poverty areas or did not indicate where needs were.

Senator KENNEDY. How was need determined?

Mr. AHART. This is one of the problems, Mr. Chairman. There is no standardized or uniform way to assess the needs for outpatient facilities.

HEW, as I will mention a little bit later, has issued a contract to ABT Associates, Inc., in Cambridge, Mass., to try to help in determining a method to find needs for outpatient facilities.

At the present time, each State pretty much assesses their own needs, and they use varying systems and varying formulas to try to determine what the need is for outpatient facilities.

In the report issued on May 3, 1974, to this subcommittee, we reported that of 16 State plans reviewed, 6 showed no need for additional outpatient facilities, and 1 showed a need for a single additional facility. The States discussed in our May report differed from those in our September report.

In summary, of 31 State plans examined for the two reports, 10 showed no need for outpatient facilities and 5 showed a need for only one additional facility.

Some of the State plans reviewed did not disclose how outpatient facility needs were determined. Also, we noted that some State agencies had no system for inventorying existing outpatient facilities.

Our May report disclosed that HEW headquarters officials said that the Hill-Burton program had no acceptable method for determining outpatient facility needs.

Senator KENNEDY. Have you formed any impression since the issuance of your report in May as to what the Department of HEW is

planning to do about setting up a method for assessing the needs for outpatient facilities?

Mr. AHART. The only information that I have, and my colleagues may have additional information, Mr. Chairman, is that they did issue, as I mentioned, a contract in June of 1974 with ABT Associates to try to come up with methodology for properly assessing the needs for outpatient facilities.

I would assume the needs in poverty areas are included in the total package. Beyond that, I have no information on the progress.

The Public Health Service Act requires that funds made available for the Hill-Burton program be initially allocated to five categories—the construction of long-term care facilities, outpatient care facilities, hospitals and public health centers, and rehabilitation facilities, and for the modernization of these four types of facilities.

The act provides that every State shall receive a minimum allotment for each of the five categories. Under certain circumstances, States are permitted to transfer funds from one category to another; however, amounts above the minimum allotment may only be transferred to the hospital and public health center construction category from the modernization category. This requirement limits the annual transfer of funds from the outpatient facility category to the hospital and public health centers construction category to $200,000.

An examination of records for 15 State agencies disclosed 6 instances, involving 4 States, in which the transfer of funds out of the outpatient category during fiscal years 1971 and 1972 appear to be improper. We also noted that most of the 15 State agencies had transferred substantial amounts out of the outpatient category. The amounts transferred by each of the agencies are shown in the attachment to this statement.

We can go into more detail on those transfers which we felt were improper under the law, if you wish.

Senator KENNEDY. I think we should go into the matter a little bit at this point. It will all, of course, be printed in the record, but I would be interested in hearing about two or three of the States now.

Mr. AHART. In Delaware there was one transaction that we questioned the propriety of. This involved a transfer with HEW approval of $248,100, fiscal year 1971 outpatient funds to the hospital and public health center category. This exceeded the $200,000 limitation.

In Kansas, on July 7, 1971, $578,000 was transferred from the outpatient category to the modernization category. On exactly the same date, the same amount was transferred from the modernization category to the hospital and public health center category.

Senator KENNEDY. What does this transferring of funds imply in terms of language of the statute?

Mr. AHART. Basically, this seemed to be a device to do indirectly what the statute prohibits being done directly. In other words, under the statute they could not have transferred the $578,000 from the outpatient category to the hospials and public health centers category but, by first transferring it to the modernization category, immediately followed by a transfer from that fund to the hospital and public health center category, they accomplished the same purpose by indirect means.

Senator KENNEDY. During your investigations, did you come across any attempts by HEW to police or to rectify this situation and, if so, what did you find?

Mr. AHART. We did not go into any depth, Mr. Chairman, in questioning the HEW officials on why these approvals were granted.

In each case, to my knowledge, these approvals were given by HEW officials. And since they were transactions on the same date and approval granted, we would expect that HEW was aware of the effect of the transfers and what was going on.

Now, the other two States had similar types of transfers, Mr. Chairman, the direct transfers which exceeded $200,000 amount or transfers into the modernization category and immediately or soon thereafter into the hospital and public health center category. The other two States involved were Mississippi and Virginia.

Turning now to the free service requirement.

Nine State agencies were visited to determine how the free service requirement was being implemented and how compliance with the requirement was to be evaluated and enforced. For 715 facilities located in the nine States and subject to the requirement, 563 had informed the State agency of the option under which they chose to operate. The open door option was selected by 332 of the 563 facilities.

Determining which persons are eligible for free services is done at the facility level. None of the State plans reviewed provided the facilities with guidance on how to determine eligibility. Furthermore, determining eligibility using the criteria set forth in some of the State plans could take a significant amount of administrative time by facility personnel. We found that, although methods and procedures varied, most of the 20 facilities we visited were attempting to determine patients' ability to pay.

Twelve of the facilities had selected the option which required a specified amount of free services to be provided annually. Six of the 12 facilities provided information which showed that they had furnished the required amounts for their most recent fiscal year. We also found that the facilities were generally not using "bad debts" to meet the free service requirement.

All of the State plans reviewed satisfactorily set forth the manner in which the free service requirement was to be evaluated and enforced. Evaluation is generally to be accomplished by matching the required amount of free services with the amount shown on financial statements submitted by the facilities.

None of the State agencies reviewed had an active program for verifying the data submitted by the facilities.

Senator KENNEDY. Are you saying that if the facilities indicated they were following an open door policy, that, as far as your investigation was concerned, you could not really tell either the effectiveness or the numbers that were involved in this type of policy? Nor could you determine the amounts of costs or types of services that were being provided?

Mr. AHART. Well, it would be difficult to tell unless the hospital kept some records.

We did inquire only at those facilities that had indicated that they were going to provide a specific amount, at least a specific amount. At the open door facilities, we did not get figures on how much free services were being provided.

Senator KENNEDY. Did the State agencies that you talked to have any information concerning the figures?

Mr. AHART. I defer to my colleagues as to whether any of the States we visited had information from open door policy facilities.

Mr. GARBARK. There was some information available but not for all facilities.

Some hospital facilities had reported the amount of free service they were providing, but not all.

Senator KENNEDY. Did you gain any firm impression that the value of those services that were being provided was being passed on to or tunneled up to HEW?

Did you question HEW concerning the three different alternatives that were prescribed in the legislation; the means under which they could provide services, what the value of the services was in each of the different areas, and what the costs were in each of the different areas?

Mr. AHART. The facilities could choose to provide services at 3 percent or at 10 percent, and would be required to keep records showing they met the requirement and furnish such information to the State agency involved.

Senator KENNEDY. Was the material made available to you?

Mr. AHART. That material was available to us. Also the information that was available indicated they did meet the requirement.

On the open door policy, it is a matter of whether or not the hospital does or does not refuse service on the basis of ability to pay. As I will indicate in the statement, I think most States rely upon complaints that they receive of denial of service to police that particular requirement.

Officials to three State agencies cited lack of personnel as the reason for not making site visits to determine compliance. Generally, State agencies relied on complaints for indications of noncompliance. Officials at two State agencies said that they did not have the authority to enforce the free service requirement.

In summary, we believe that the outpatient facility information, which we gathered, indicates that HEW and the Hill-Burton State agencies have been passive in the initiation of projects for the construction or modernization of outpatient facilities, particularly in poverty areas.

Although implementation of the free service requirement under the 1972 regulations is in its infancy at the State and local level, must of the facilities for which information was obtained seemed to be providing the required amounts of free services. However, we cannot conclude from our information that the State agencies have the means to adequately monitor or enforce the free service requirement.

Mr. Chairman, this concludes our statement. We shall be happy to respond to any questions.

Senator KENNEDY. As I understand from what you mentioned earlier in your testimony, you say "Our May report disclosed that HEW headquarters officials said that the Hill-Burton program had no acceptable method for determining outpatient facility needs."

In June they contracted with a consulting group in Massachusetts to find out how that best could be done, 3½ years after we had passed the legislation. They tried to determine need versus passage

of the legislation back in 1971 or 1970. Those are just statistics which your study shows, but I think they say a lot concerning the sense of urgency in that particular provision.

What do you think needs to be done to stimulate HEW and State agency involvement in the construction and modernization of outpatient facilities in poverty areas?

Mr. AHART. I think there are several things that need to be done. I think, first, as you just mentioned, very basic to this kind of program is the clear establishment of what the needs are, so that priorities could be set in light of specific needs of the State.

So, first of all, urging HEW to complete the methodology for determining the needs for outpatient facilities we think is very basic to accomplishing the objectives of these particular amendments.

Second, once these needs are established, I think there has to be outreach efforts at the State level and perhaps HEW level to go out to the areas that need facilities and see what could be done to help them formulate projects that would be responsive to the assessed needs.

The third, of course, would be for HEW to properly monitor and evaluate what is being done out there, and whether the States are, in fact, doing what needs to be done by way of outreach, and technical assistance, to help facilities be put in places where they are needed.

There is a possibility that requiring States to up the percentage of Federal participation, rather than making it an option on their part for projects that meet specific needs in poverty areas, could be helpful in this regard.

And the final one, and we touched on this in the statement, is if there was a specific restriction on the transfer of any funds out of outpatient facility category until the State could demonstrate that the needs in poverty areas either have been met or there is no way with proper outreach and technical assistance to find sufficient projects to use those funds. We think that would be helpful.

Senator KENNEDY. Those are the things we were attempting to do in 1970.

Did you find, in your investigation, what monitoring devices were taking place within HEW, for example in areas of outreach, or in monitoring what the States were doing in compliance with the free service provisions?

Mr. AHART. We have not specifically addressed that in our report, Mr. Chairman.

Monitoring in many of HEW's programs is rather low level and low key. I suspect that is true in this program as well.

Mr. Garbark and Mr. Elmore might have more personal insight into the specific program.

Senator KENNEDY. When you talked to HEW, did they say they could give you information as to what the States are doing, and periodic types of reviews of what they are doing? What kind of reaction and response did you get to such requests for specific information?

Mr. ELMORE. Mr. Chairman, I think it would be a fair statement to say that neither the HEW headquarters people nor the State agency people are spending a lot of time in the field monitoring or evaluating the implementation of the free service requirement.

The monitoring, as we see it, depends now on the budget submitted by the hospital, compared with the financial statement showing the amount of free care provided.

HEW regulations provide that is all of the monitoring that is necessary. At the State level, they are lacking in people to get out and monitor and check on implementation.

Senator KENNEDY. Why did some States elect a Federal participation rate less than 90 percent?

Mr. AHART. I think there are a couple of reasons for that.

One of the reasons is that basically many of the State agencies would like to spread the money around to generate more projects than would otherwise be possible if they went the full rate on certain of them.

In other instances, the States felt that even if the percentage were raised to 90 percent, sponsors in poverty areas would still not be able to come up with matching funds or 10-percent money.

Pennsylvania officials in commenting to us, said that the reason they did not have an effective outreach program is that they believe that the sponsors would not be able to come up with the 10 percent matching money despite the fact that Pennsylvania has selected 90-percent participation in the areas provided for under the law.

Senator KENNEDY. Could you review a little with us some of the techniques that are being used by the hospitals to determine free eligibility?

Mr. AHART. I would like to ask Mr. Elmore to respond to this.

As I indicated in my statement, there are varied techniques, some rather simple, some rather complicated.

Mr. ELMORE. Yes, Mr. Chairman, we found that most of the hospitals were making some attempt to determine eligibility. They were doing it by various means.

They would gather some financial data from the patients themselves. Sometimes they would use a social worker on the staff of the hospital. They would check with credit agencies on some occasions. And they would also check with the patient's doctor to see what he could pay.

That is just about as far as they go. They do not go out and verify the information the patient gives them—his income, his expenses, his debts and so forth. Combined with the patient's financial capability, they also consider the cost of the hospitalization to determine how much he can afford to pay.

Senator KENNEDY. Did you form any impressions concerning the effectiveness of the existing State Hill-Burton agencies and their capacity, their will to carry out a properly oriented program toward outpatient facilities?

Mr. AHART. It seems to us that the attitude has been rather passive or quite passive; if applications come in, they are considered.

In some cases, as indicated in the report, States would really discourage the submission of applications because they felt that the needs might be greater in another area.

But, to generally characterize it, we would have to say their attitude is one of passivity, a very passive attitude toward it. They are not doing very much to actively seek meeting the intent of the law.

Senator KENNEDY. The center of our interest is how effective HEW has been in compliance with the legislation and needs of two particular areas concerning the outpatient facility; services in the poverty areas, and the free service requirements under the Hill-Burton Act.

Could you perhaps summarize your evaluation of the effectiveness of the Department in meeting those particular statutory requirements?

Mr. AHART. Well, taking the last one first, Mr. Chairman, the legislative requirement for a reasonable volume of free services has been on the books since 1946.

Until the HEW regulations were issued in July 1972, what constituted a reasonable volume of free services had never been administratively refined for the guidance of the States or for the guidance of the facilities that receive assistance. The States were not given any guidance on how they were expected to police these requirements.

So, you had long passage of time, some 26 years, I guess, between enactment of the statute and definitive regulations on the matter.

Since that time, the States have been pretty much left to police this themselves. They actually tell us they do not really have the resources to do an effective job of policing, that is to go out and make site visits. In some cases, they do not really feel they have the authority to enforce this Federal requirement on the facilities that receive assistance.

Turning to the emphasis given in the statute——

Senator KENNEDY. So your conclusion on that particular aspect is that it is a hit-and-miss situation which, for the most part, is dependent on the good faith of the particular hospitals in terms of their implementation.

But, from what you said here, there is very little in terms of what you have been able to discover, either at the State or at the Federal level, to indicate just how much compliance there has really been on this particular provision.

Mr. AHART. That is a good summary, yes, sir.

Senator KENNEDY. To carry this one step further, were you, or your associates, able to form any kind of impression as to how really effective this has been when you monitored, or were you able to monitor any of the particular hospitals?

Mr. AHART. In general, the hospitals that we visited were making efforts to meet the requirements of the legislation as defined by the regulations, either open door policy or meeting the 3 percent or 10 percent requirements under the other option. So, as a general impression, yes, they were trying to meet that.

Senator KENNEDY. OK.

Now, with the other point.

Mr. AHART. Turning to the emphasis in the 1970 amendments on outpatient facilities, basically very little has been done at either the Federal or the State level to bring that about.

Most of the States, or the States that we visited were not actively providing outreach services or technical assistance to try to bring needed projects into being. This has to be stated with recognition that nobody really has told the States how they are supposed to determine needs in the outpatient facility area.

I think that, for the benefit of the subcommittee, it is only fair to state that the legislative requirement that special consideration be given to outpatient facilities in urban and rural poverty areas is a

little bit fuzzy in trying to give guidance to HEW to what extent that these should be given preference when you have a relatively equal assessment of needs.

So, perhaps, that might be given some clarification.

Senator KENNEDY. The conference report itself substantively provides that priorities should be given to projects, construction, and modernization of outpatient facilities which are limited in or provides services for residents of rural or urban poverty areas. Projects for facilities which alone, or in construction with other facilities, will provide comprehensive health care, projects for facilities which will provide training and help for allied health professionals, projects for facilities which are to provide, to a significant extent, the treatment of alcoholism.

We were attempting to provide the degree of specificity to do the job. We are not supposed to draft the regulations ourselves on these matters, but we were trying to draft language in as clear and precise way as possible, to give the congressional intent. I certainly thought that would have been clear enough. But, as we have seen, it has not been as far as the implementation of those provisions.

I want to thank you very much. Your testimony has been very, very helpful.

[The prepared statement of Mr. Ahart along with additional material supplied for the record follows:]

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

For Release on Delivery
Expected at 10:30 a.m. EST
November 25, 1974

STATEMENT OF
GREGORY J. AHART, DIRECTOR
MANPOWER AND WELFARE DIVISION
BEFORE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON LABOR AND PUBLIC WELFARE
UNITED STATES SENATE
ON
COMPLIANCE WITH CERTAIN LEGISLATIVE
REQUIREMENTS OF THE HILL-BURTON PROGRAM
ADMINISTERED BY
HEALTH RESOURCES ADMINISTRATION
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. Chairman and Members of the Subcommittee, I am pleased to appear here today to discuss compliance with certain legislative requirements of the Hill-Burton program administered by the Health Resources Administration of the Department of Health, Education, and Welfare (HEW).

Specifically, I will discuss (1) implementation of the requirement that special consideration be given to constructing or modernizing outpatient facilities in poverty areas and (2) compliance by hospitals assisted by the Hill-Burton program with the requirement that they provide a reasonable volume of free services to residents of the communities in which they are located.

OUTPATIENT FACILITIES

The 1970 amendments to the Public Health Service Act provided that the Hill-Burton program give special consideration to constructing and

modernizing outpatient facilities in rural or urban poverty areas and providing services to residents of those areas.

The 1970 amendments also provided that, at the option of the State agency, the Federal share of the cost of certain health facilities could be as much as 90 percent. The 90 percent level of financial participation can be authorized for health facility projects that (1) will provide services primarily to persons in an area that the Secretary of Health, Education, and Welfare deems a rural or urban poverty area or (2) offer potential for reducing health care costs by sharing services with other health care facilities, by interfacility cooperation, or by constructing or modernizing freestanding outpatient facilities.

FREE SERVICE REQUIREMENT

Section 622 of the Hospital Survey and Construction Act, enacted by the Congress in 1946, directed that regulations governing the approval of hospital construction be issued. These regulations were to require that, before a State agency could recommend approval of an application for a hospital or addition to a hospital there must be assurance that a reasonable volume of services to persons unable to pay would be made available in the facility or portion thereof to be constructed or modernized. Under the regulations an exception may be granted if such a requirement were not financially feasible.

Implementing regulations were issued on October 22, 1947, and defined free patient care as hospital service offered either at below cost or free to persons unable to pay. The reasonable volume of free patient care called for in the act was not clearly defined by the regulations.

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These regulations basically remained unchanged until January 6, 1972--when new regulations were published. The regulations were changed to simply state the language of the statute. HEW comments explaining the change stated that numerous court suits concerning the 1947 regulations were in process and that new regulations designed to define the scope of "assurance" more clearly and to govern its enforcement were being prepared.

HEW issued revised regulations on July 22, 1972. These regulations which are still in effect, define a reasonable volume of free services, furnish guidance to State agencies on eligibility criteria and qualifying services, and set forth requirements for evaluation and enforcement of compliance.

The present HEW regulations provide that facilities can meet the reasonable volume of free services requirement by (1) offering free or below cost services annually in an amount which is not less than the lesser of 3 percent of operating costs (after deducting Medicare and Medicaid reimbursements) or 10 percent of total Federal assistance received or (2) certifying that free or below cost services will not be refused to any person regardless of their ability to pay (open door option).

GAO REVIEW

On September 25, 1974, we issued a report (B-164031(5)) dealing with the Hill-Burton program to this Subcommittee. In that report, we provided information on the extent to which certain State Hill-Burton agencies were assisting or encouraging projects which would serve poverty communities to apply for Federal assistance for constructing or

modernizing outpatient facilities. We also reported on the need for outpatient facilities and the use of funds made available for this purpose and the implementation of the free service requirement.

We gathered information principally at HEW headquarters, four HEW regional offices, several State Hill-Burton agencies and hospitals, and the American Hospital Association. Because of time constraints, the scope of our review was limited to obtaining information from readily available records, without verification, and from interviews with officials at the locations we visited. The reliability of the information obtained depends for the most part, on the assumed accuracy of the records and oral comments.

Outpatient facilities

At 10 State agencies visited, we found no formal outreach programs, nor plans to initiate such programs to encourage the construction or modernization of outpatient facilities in poverty areas. Officials in two States attributed the lack of outreach efforts in their States to the inability of potential poverty area project sponsors to raise their share of project costs. Officials in three States said that an outreach program was not needed because sufficient applications were always available to exhaust Hill-Burton funds allocated to their States. However, two of these officials acknowledged that large amounts were transferred from the outpatient funds category because a sufficient number of applications were not received to utilize outpatient funds.

Any special consideration being given to outpatient facilities in poverty areas was not evident, except that some States chose the 90 percent Federal financial participation rate. Of 20 State plans examined,

11 indicated that the State had selected the 90 percent rate for eligible projects. The participation rate for the other nine States ranged from 33 to 80 percent.

Records of 13 State agencies were examined to determine how many outpatient facilities in poverty areas received Hill-Burton assistance during fiscal years 1971 through 1974. Eight of the 13 States had provided no financial assistance for constructing or modernizing outpatient facilities in poverty areas. State officials said, however, that it was possible that some projects funded for hospital construction or modernization included the hospital's outpatient facility as part of the total project.

To obtain information on the need for outpatient facilities, we examined 15 State plans and found that 4 plans indicated that no additional outpatient facilities were needed. Four other plans showed a need for adding only one facility. Of 11 State plans showing a need for outpatient facilities, only 3 indicated that the need was in a poverty area. The others showed no need in poverty areas or did not indicate where needs were.

In a report issued on May 3, 1974, to this Subcommittee, we reported that of 16 State plans reviewed, 6 showed no need for additional outpatient facilities and 1 showed a need for a single additional facility. The States discussed in our May report differed from those in our September report. In summary, of 31 State plans examined for the 2 reports, 10 showed no need for outpatient facilities and 5 showed a need for only 1 additional facility.

Some of the State plans reviewed did not disclose how outpatient

facility needs were determined. Also, we noted that some State agencies had no system for inventorying existing outpatient facilities. Our May report disclosed that HEW headquarters officials said that the Hill-Burton program had no acceptable method for determining outpatient facility needs. In June 1974 HEW contracted with a consulting firm to (1) study the various methods used to determine outpatient facility needs and (2) recommend an approach to determining such needs. HEW expects to receive the consulting firm's final report in December.

The Public Health Service Act requires that funds made available for the Hill-Burton program be initially allocated to five categories--the construction of long-term care facilities, outpatient care facilities, hospitals and public health centers, and rehabilitation facilities and for the modernization of these types of facilities. The act provides that every State shall receive a minimum allotment for each of the five categories. Under certain circumstances States are permitted to transfer funds from one category to another; however, amounts above the minimum allotment may only be transferred to the hospital and public health center construction category from the modernization category. This requirement limits the annual transfer of funds from the outpatient facility category to the hospital and public health centers construction category to $200,000.

An examination of records for 15 State agencies disclosed 6 instances, involving 4 States, in which the transfer of funds out of the outpatient category during fiscal years 1971 and 1972 appear to be im-

proper. We also noted that most of the 15 State agencies had transferred substantial amounts out of the outpatient category. The amounts transferred by each of the agencies are shown in the attachment to this statement.

Free service requirement

Nine State agencies were visited to determine how the free service requirement was being implemented and how compliance with the requirement was to be evaluated and enforced. For 715 facilities located in the 9 States and subject to the requirement, 563 had informed the State agency of the option under which they chose to operate. The open door option was selected by 332 of the 563 facilities.

Determining which persons are eligible for free services is done at the facility level. None of the State plans reviewed provided the facilities with guidance on how to determine eligibility. Furthermore, determining eligibility using the criteria set forth in some of the State plans could take a significant amount of administrative time by facility personnel. We found that, although methods and procedures varied, most of the 20 facilities we visited were attempting to determine patients' ability to pay.

Twelve of the facilities had selected the option which required a specified amount of free services to be provided annually. Six of the 12 facilities provided information which showed that they had furnished the

required amounts for their most recent fiscal year. We also found that the facilities were generally not using "bad debts" to meet the free service requirement.

All of the State plans reviewed satisfactorily set forth the manner in which the free service requirement was to be evaluated and enforced. Evaluation is generally to be accomplished by matching the required amount of free services with the amount shown on financial statements submitted by the facilities. None of the State agencies reviewed had an active program for verifying the data submitted by the facilities. Officials at three State agencies cited lack of personnel as the reason for not making site visits to determine compliance. Generally, State agencies relied on complaints for indications of noncompliance. Officials at two State agencies said that they did not have the authority to enforce the free service requirement.

SUMMARY

We believe that the outpatient facility information which we gathered indicates that HEW and the Hill-Burton State agencies have been passive in the initiation of projects for the construction or modernization of outpatient facilities particularly in poverty areas.

Although implementation of the free service requirement under the 1972 regulations is in its infancy at the State and local level, most of the facilities for which information was obtained seemed to be providing the required amounts of free services. However, we cannot conclude from our information that the State agencies have the means to adequately monitor or enforce the free service requirement.

Mr Chairman this concludes our statement. We shall be happy to answer any questions that you or other Members of the Subcommittee might have.

ATTACHMENT

OUTPATIENT FACILITY FUNDS TRANSFERRED
FISCAL YEARS 1971 AND 1972

State	Initial allocation to outpatient facilities	Transfers In	Transfers Out	Adjusted allocation	Percent reduction in funds due to net transfers
Alabama					
FY 71	$1,958,645	0	$1,140,000	$ 818,645	58.2
FY 72	1,904,969	$155,280	1,433,769	626,480	67.1
Colorado					
FY 71	698,258	0	363,015	335,243	52.0
FY 72	756,316	136,597	564,264	328,649	56.6
Delaware					
FY 71	200,000	200,000	248,100	151,900	24.1
FY 72	200,000	197,425	117,425	280,000	(a)
Kansas					
FY 71	798,831	0	789,872	8,959	98.9
FY 72	796,118	0	796,118	0	100.0
Maryland					
FY 71	1,031,147	0	454,069	577,078	44.0
FY 72	1,031,050	286,647	2,337	1,315,360	(a)
Mississippi					
FY 71	1,512,339	0	993,839	518,500	65.7
FY 72	1,401,268	0	1,401,268	0	100.0
Missouri					
FY 71	1,655,193	0	1,605,193	50,000	97.0
FY 72	1,672,673	0	204,153	1,468,520	12.2
Montana					
FY 71	278,915	0	252,685	26,230	90.6
FY 72	294,566	0	267,068	27,498	90.7
North Dakota					
FY 71	281,757	0	281,757	0	100.0
FY 72	288,394	0	288,394	0	100.0
Pennsylvania					
FY 71	3,785,040	0	0	3,785,040	0
FY 72	4,852,446	0	185,333	4,667,113	3.8

ATTACHMENT

State	Initial allocation to outpatient facilities	Transfers In	Transfers Out	Adjusted allocation	Percent reduction in funds due to net transfers
South Dakota					
FY 71	$ 298,046	0	$ 269,908	$ 28,138	90.6
FY 72	299,489	0	266,825	32,664	89.1
Utah					
FY 71	454,762	0	454,762	0	100.0
FY 72	478,323	0	478,323	0	100.0
Virginia					
FY 71	1,890,094	0	1,890,094	0	100.0
FY 72	1,838,748	0	1,097,506	741,242	59.7
W. Virginia					
FY 71	942,586	166,418	705,532	403,472	58.9
FY 72	930,711	0	554,986	375,725	59.6
Wyoming					
FY 71	200,000	52,161	0	252,161	(a)
FY 72	200,000	355,508	271,890	283,618	(a)

a/Indicates an increase in funds after transfers.

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-164031(5)

SEP 25 1974

The Honorable Edward M. Kennedy
Chairman, Health Subcommittee
Committee on Labor and Public
Welfare
United States Senate

Dear Mr. Chairman:

By letter dated June 24, 1974, you and Senator Javits requested that we provide information on (1) the implementation by the Hill-Burton health facilities program of the requirement that special consideration be given to projects for the construction or modernization of outpatient facilities in poverty areas, and (2) the compliance by hospitals assisted by the Hill-Burton program with the requirement that they provide a "reasonable volume" of free services to residents of the communities in which they are located.

In subsequent discussions with your office we were also requested to provide information on:

--the extent to which State Hill-Burton agencies are offering and providing technical assistance and making outreach efforts to assist and encourage projects which would serve poverty communities to make application for Federal assistance and obtaining priority funding for construction or modernization of outpatient facilities,

--the manner in which State Hill-Burton agencies determine poverty areas and give priority to projects in such areas,

--the extent to which State Hill-Burton agencies have transferred funds from the outpatient facilities category to other categories, and

--the extent to which "bad debts" are being reported as free services by Hill-Burton assisted hospitals.

The information we developed concerning outpatient facilities and free services is discussed in enclosures I and II, respectively. Certain legal issues were raised by your office and these are discussed in enclosure III.

We gathered information principally at Department of Health, Education, and Welfare (HEW) headquarters; HEW regions, State Hill-Burton agencies and hospitals shown in enclosure IV and the American Hospital Association in Chicago. Ten State agencies were visited but certain State plan information available at the HEW regional office was gathered on additional States. The scope of our work was, due to time restraints, limited to obtaining information from readily available records without verification and through interviews with appropriate officials at locations visited. The reliability of the information obtained is dependent, for the most part, on the assumed accuracy of the records and oral comments.

We believe, however, that the outpatient facility information indicates that HEW and State Hill-Burton agencies have been passive in the initiation of projects for the construction or modernization of outpatient facilities, particularly in poverty areas.

At the ten State agencies visited, we found no formal outreach program to encourage the construction or modernization of outpatient facilities in poverty areas nor were there any plans to initiate such programs. Technical assistance was being given to applicants generally through aid in preparing and processing the necessary application documentation. Any priority being given to outpatient facilities in poverty areas was not evident other than the use by certain States of the option to provide a Federal financial participation rate of 90 percent for projects which are located in poverty areas and will serve such areas. We also noted that State agencies, with HEW approval have transferred a substantial amount of funds out of the outpatient category. The legality of a few of these transfers is questionable. This matter is more fully discussed in enclosures I and III.

To stimulate HEW and State agency involvement in the construction or modernization of outpatient facilities, the Subcommittee may wish to consider legislative provisions which would

--require the establishment of outreach programs by the State agencies to encourage the construction or modernization of outpatient facilities in poverty areas,

--require HEW to monitor and evaluate the outreach efforts of the State agencies,

--require HEW to furnish the States with guidance for determining outpatient facility needs,

--require State agencies to fund up to 90 percent of eligible costs for projects which are located in poverty areas or will serve poverty communities, and

--restrict the transfer of Federal funds out of the outpatient facility category until outreach efforts can conclusively show that such funds cannot be used before their availability expires.

The implementation of the free service requirement is in its infancy at the State agency and local facility level. While the State plans reviewed contained provisions which essentially met the Federal requirements, none of the State agencies had an active program for monitoring compliance with the requirement. Most intend to rely on complaints to monitor compliance. Also, some facilities have not informed the State agencies of how they intend to meet the reasonable volume of free services requirement.

Implementation of the free service requirement at the facility level was varied but most of the facilities, for which information was obtained, seemed to be providing the required amount of free services. We found that facilities were generally not following a practice of using "bad debts" to meet the free service requirements.

Due to time restraints established by your office, we have not followed our normal practice of giving HEW and the States an opportunity to comment on the matters discussed in this report. Other than sending a copy of this report to Senator Javits, we plan no further distribution unless you agree or publicly announce its contents.

Sincerely yours,

Comptroller General
of the United States

Enclosures - 4

ENCLOSURE I

OUTPATIENT FACILITIES

Background

In August 1946 the Congress enacted the Hospital Survey and Construction Act (Public Law 79-725, which added title VI of the Public Health Service Act (42 U.S.C. 291)). The legislation established the Hill-Burton program of Federal assistance to the States for constructing and modernizing health facilities.

Under the existing Hill-Burton program, Federal assistance is available in the form of grants, direct loans, and loan guarantees with interest subsidies for constructing and modernizing hospitals and outpatient, long-term care, and rehabilitation facilities.

The Hill-Burton program operates in each State through a designated State agency. According to the authorizing legislation, a State can participate in the program only if a State plan for hospital and medical facilities construction and modernization is submitted to the Public Health Service for approval. The State plan, from the year of initial approval, is to be revised annually. It must (1) designate the need (beds and facilities) for inpatient and outpatient care for people residing in the State, (2) provide for the distribution of beds and facilities in service areas throughout the State, and (3) assign relative priorities for the construction and modernization of facilities by service area.

In 1970 Congress, concerned with the lack of ambulatory services for persons in poverty areas, amended the Public Health Service Act to provide that priority consideration be given to the construction and modernization of outpatient facilities that will be located in, and provide services for residents of, an area determined by the Secretary of HEW to be a rural or urban poverty area. The 1970 amendments also provided that, at the option of the State agency, the Federal share of the cost of certain facilities could be as much as 90 percent.

The 90 percent level of Federal financial participation is limited to health facility projects that (1) will provide services primarily for persons in an area determined by the Secretary of HEW to be a rural or urban poverty area or (2) offer potential for reducing health care costs through shared services among health care facilities, through interfacility cooperation, or through the construction or modernization of freestanding (separated from hospitals) outpatient facilities. Regulations implementing the changes to the Hill-Burton program under the 1970 amendments were issued by HEW on January 6, 1972.

ENCLOSURE I

Outreach/Technical Assistance

To determine what efforts the State agencies have made to encourage the construction or modernization of outpatient facilities in poverty areas, we reviewed State plans and discussed outreach activities with officials of 10 State Hill-Burton agencies visited. We found that no formal outreach programs existed nor were there any plans to initiate such programs. Several State agency officials said that outreach efforts are made by periodically advertising in newspapers the availability of the State plan for review by the public.

Officials in two States attributed the lack of outreach efforts in their States to potential poverty area project sponsors' inability to raise their share of project costs. Officials in three States said that an outreach program is not needed because sufficient applications are always available to exhaust the Hill-Burton funds allocated to the State. However, two of these officials acknowledged that large amounts were transferred from the outpatient funds category because a sufficient number of applications were not received to utilize outpatient funds.

In one State we were told that the State's Hospital Advisory Council sets the priority for the use of Hill-Burton funds and that fiscal years 1973 and 1974 funds were earmarked for the construction of Public Health Centers. We were told that if a prospective applicant contacted the State agency relative to outpatient facility funding, he would most likely be discouraged from submitting an application. Officials in this State agency consider Public Health Centers to be outpatient facilities.

While there was a lack of outreach effort by the State Hill-Burton agencies visited, we found no similar lack of technical assistance provided to prospective applicants. However, technical assistance is generally given to applicants by the State agencies, after tentative funding decisions, and generally consists of assistance in preparing and processing the necessary application documentation.

Methods Used to Determine Poverty Areas and Related Priorities

HEW regulations provide that the Secretary will determine a rural or urban poverty area to be any area which has been found by the State agency, on the basis of the latest available published data from the Bureau of the Census, to be an area in which the median annual family income ranks in or below the 20th. percentile of the median family incomes for all areas in the State. Our review of 10 State plans showed that most of the States had identified poverty areas in the manner described above. Alternative methods of determining poverty areas are permitted by HEW regulations and one State has, with HEW approval, classified all counties within the State as poverty areas.

ENCLOSURE I

A discussion of the propriety of a 1971 memorandum from Hill-Burton headquarters releasing States from designating poverty areas is included in enclosure III, page 28.

With respect to priority determinations for poverty areas, all 10 plans contained a provision stating that special consideration would be given to facilities which will be located in or will serve poverty populations. However, explanations were generally not provided on how special consideration is to be given to poverty areas. We could not readily determine if any applications for outpatient facilities in nonpoverty areas were given priority over applications for facilities in poverty areas. Generally, State agency officials claimed that no applications for outpatient facilities in poverty areas have been denied.

The priority to be given a poverty area with the same relative need as a nonpoverty area is discussed on page 24 of enclosure III.

Federal Share of Project Costs for Outpatient Facilities in Poverty Areas

As mentioned previously, the 1970 amendments provided that a State agency may, at its option, allow a Federal participation rate of 90 percent in the cost of projects in poverty areas. We reviewed 20 State plans and found that 11 of the 20 States would provide a Federal participation rate of up to 90 percent of eligible project costs in poverty areas, as shown on page 6 of this enclosure.

Need for Outpatient Facilities

Of 15 State plans we examined, four indicated that no outpatient facilities were needed beyond those which existed, four others showed a need for adding only one such facility, and one showed that two facilities needed to be added. Of the 11 State plans showing a need for outpatient facilities only three showed some need to be in poverty areas and the others showed no need in poverty areas or did not indicate whether any of their need was in poverty areas.

In a report issued on May 3, 1974, to your Subcommittee, we reported that of 16 State plans reviewed, six showed no need for additional outpatient facilities and one showed a need for only one additional facility. The States discussed in our May report are different from those discussed in this report. Our May report also disclosed that HEW headquarters officials told us that the Hill-Burton program has no acceptable method for determining outpatient facility needs.

Some of the State plans reviewed did not indicate how outpatient facility needs were determined. Others showed methods such as the application of a ratio of outpatient facilities to population, or a relationship of outpatient facilities to hospitals or service areas. Some State

officials indicated that outpatient facility needs are determined on a judgmental basis and cited the lack of an accepted standard as a factor hindering need determinations. We also noted that some States have no system for inventorying all outpatient facilities in the State. Frequently only the facilities which are licensed by the State, usually those which are a part of a hospital, and those freestanding facilities which have received Hill-Burton funds are known to the State agency.

HEW has contracted with a consulting firm to (1) study the various methods used to determine outpatient facility needs, and (2) recommend to HEW an approach to the determination of such needs.

To further assess the emphasis given to outpatient facilities, particularly in poverty areas, we determined the number of outpatient facilities which were assisted by 13 State agencies using Hill-Burton outpatient funds available for fiscal years 1971 through 1974. Eight of the 13 State agencies had provided no financial assistance for the construction or modernization of outpatient facilities in poverty areas. Information for each State is shown on pages 7 and 8 of this enclosure.

Several State agency officials pointed out that it is possible for projects which have been funded using Hospital and Public Health Center and Modernization funds to have included outpatient facilities as part of the total project.

Transfer of Funds Out of Outpatient Category

Section 602(e) of the Public Health Service Act (42 U.S.C. 291(e)) provides that Federal funds made available to State agencies be allocated for the new construction of (1) long-term care facilities, (2) outpatient care facilities[1], (3) rehabilitation facilities, (4) hospitals and public health centers, and (5) modernization of the four types of facilities.

The act prescribes the manner in which the funds are to be allocated to each of the five categories but provides that, notwithstanding the allocation formula, each State shall receive a minimum allotment for each of the five categories. In certain circumstances States are permitted to transfer funds from one category to another, however, transfers above the minimum allotment may not be made to the hospital and public health center construction category from any category other than the modernization category. This requirement limits the annual transfer of funds from the outpatient facility category to the hospital and public health center construction category to $200,000. Limitations on the transfer of funds among the categories is discussed in more detail in enclosure III, page 19.

[1]Funds in the outpatient category may be used for both construction and modernization.

ENCLOSURE I

Information on 15 State agencies was examined to obtain information on fund transfers. The extent to which the 15 State agencies transferred 1971 and 1972 funds from the outpatient category to other categories is shown on pages 9 and 10 of this enclosure. At four State agencies we found six fund transfers during fiscal years 1971 and 1972 which appear to be improper (see page11 of this enclosure).

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ENCLOSURE I

FEDERAL PARTICIPATION RATE IN ELIGIBLE PROJECT COSTS

FOR OUTPATIENT FACILITIES IN POVERTY AREAS

States	Rate	Maximum dollar amount
Alabama	90 percent	none shown
Colorado	90 percent	none shown
Delaware	90 percent	none shown
Florida	90 percent	$1,000,000
Georgia	40 percent	$ 750,000
Kansas	90 percent	$ 600,000
Kentucky	61 percent	none shown
Maryland	75 percent	none shown
Mississippi	33 percent	$1,000,000
Missouri	90 percent	$1,000,000
Montana	90 percent	none shown
North Carolina	61 percent	$1,500,000
North Dakota	90 percent	none shown
Pennsylvania	90 percent	none shown
South Carolina	90 percent	none shown
South Dakota	50 percent	none shown
Tennessee	80 percent	none shown
Utah	50 percent	none shown
Virginia	50 percent	$1,000,000
Wyoming	90 percent	none shown

ENCLOSURE I

NUMBER OF FACILITIES RECEIVING OUTPATIENT FUNDS FOR CONSTRUCTION AND MODERNIZATION IN FISCAL YEARS 1971 THROUGH 1974

State	Construction		Modernization	
	Total	In poverty area	Total	In poverty area
Alabama				
FY 71	2	0	0	0
FY 72	4	0	0	0
FY 73	4	0	0	0
FY 74	1	0	0	0
Colorado				
FY 71	2	0	0	0
FY 72	0	0	[a]1	0
FY 73	0	0	[a]1	0
FY 74	0	0	1	0
Delaware				
FY 71	2	1	0	0
FY 72	1	1	0	0
FY 73	b	b	b	b
FY 74	b	b	b	b
Kansas				
FY 71	0	0	0	0
FY 72	0	0	0	0
FY 73	0	0	0	0
FY 74	0	0	0	0
Maryland				
FY 71	3	2	0	0
FY 72	3	2	2	1
FY 73	b	b	b	b
FY 74	b	b	b	b
Mississippi				
FY 71	1	1	1	1
FY 72	0	0	1	1
FY 73	3	3	0	0
FY 74	1	1	0	0
Missouri				
FY 71	0	0	0	0
FY 72	2	1	0	0
FY 73	0	0	0	0
FY 74	0	0	0	0

ENCLOSURE I

State	Construction		Modernization	
	Total	In poverty area	Total	In poverty area
Montana				
FY 71	0	0	0	0
FY 72	0	0	0	0
FY 73	0	0	0	0
FY 74	0	0	0	0
North Dakota				
FY 71	0	0	0	0
FY 72	0	0	0	0
FY 73	0	0	0	0
FY 74	0	0	0	0
Pennsylvania				
FY 71	6	1	0	0
FY 72	4	0	0	0
FY 73	b	b	b	b
FY 74	b	b	b	b
South Dakota				
FY 71	0	0	0	0
FY 72	0	0	0	0
FY 73	0	0	0	0
FY 74	0	0	0	0
Utah				
FY 71	0	0	0	0
FY 72	0	0	0	0
FY 73	0	0	0	0
FY 74	0	0	0	0
Wyoming				
FY 71	[a]2	0	0	0
FY 72	[a]1	0	2	0
FY 73	0	0	[a]1	0
FY 74	0	0	[a]1	0

[a] Facility received funds from both fiscal years

[b] We were advised that HEW had issued a policy memorandum which prohibited the obligating of fiscal years 1973 and 1974 Hill-Burton funds by State agencies until State plans included approved free-care provisions. As of August 1974 all States in HEW Region III had submitted their proposed free-care provisions and had been advised of required revisions. However, none of the States have submitted their final revised plans, therefore, they have not been authorized to disburse fiscal years 1973 and 1974 funds.

ENCLOSURE I

OUTPATIENT FACILITY FUNDS TRANSFERRED

FISCAL YEARS 1971 AND 1972

State	Initial allocation outpatient facilities	Transfers In	Transfers Out	Adjusted allocation	Percent reduction in funds due to net transfers
Alabama					
FY 71	$1,958,645	0	$1,140,000	$818,645	58.2
FY 72	1,904,969	$155,280	1,433,769	626,480	67.1
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Pennsylvania					
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ENCLOSURE I

OUTPATIENT FACILITY FUNDS TRANSFERRED

FISCAL YEARS 1971 AND 1972

State	Initial allocation outpatient facilities	Transfers In	Transfers Out	Adjusted allocation	Percent reduction in funds due to net transfers
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FY 72	1,838,748	0	1,097,506	741,242	59.7
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FY 71	942,586	166,418	705,532	403,472	58.9
FY 72	930,711	0	554,986	375,725	59.6
Wyoming					
FY 71	200,000	52,161	0	252,161	*
FY 72	200,000	355,508	271,890	283,618	*

*indicates an increase in funds after transfers

ENCLOSURE I

QUESTIONABLE TRANSFER OF FISCAL YEAR 1971 AND 1972 FUNDS

We reviewed records of 15 States and found that in four States, the following six transfers of funds appeared to be contrary to congressional intent as discussed on page 19 of enclosure III.

Delaware - On November 15, 1972, HEW approved the transfer of $248,100 of fiscal year 1971 funds from the outpatient facility category to the hospital and public health center category.

Kansas - On July 7, 1971, $578,831 of fiscal year 1971 funds were transferred from the outpatient facility category to the modernization category, and on the same date $578,831 was transferred from the modernization category to the hospital and public health center category. On March 2, 1973, $596,118 of fiscal year 1972 funds were transferred from the outpatient facility category to the modernization category. On the same date $873,818 was transferred from the modernization category to the hospital and public health category.

Mississippi - On February 29, 1972, HEW approved the transfer of $793,839 of fiscal year 1971 funds from the outpatient facilities category. Of the amount transferred $332,201 went to the long-term care facility category and $461,638 went to the hospital and public health center category. On February 29, 1972, $1,201,268 of fiscal year 1972 outpatient facility category funds were transferred as follows: $250,000 to the modernization category, $151,700 to the long-term care facility category, and $799,568 to the hospital and public health center category.

Virginia - On March 21, 1972, HEW approved the transfer of $1,479,807 of fiscal year 1971 funds from the outpatient category to the modernization category. On April 5, 1972, the State agency requested approval to transfer the same amount from the modernization category to the hospital and public health center category. HEW gave its approval for the transfer on April 27, 1972.

ENCLOSURE II

FREE SERVICE REQUIREMENT

Legislative Background

Section 622 of the Hospital Survey and Construction Act (42 U.S.C. 291) enacted by the Congress in 1946 provided that regulations be issued by HEW which:

> "* * * may require that before approval of any application for a hospital or addition to a hospital is recommended by a State agency, assurance shall be received by the State from the applicant that, * * *, (2) there will be made available in each such hospital or addition to a hospital a reasonable volume of hospital services to persons unable to pay therefor, but an exception shall be made if such a requirement is not feasible from a financial standpoint."

This legislative provision has remained basically unchanged up to the present time. Senate hearings held in 1945 indicated that while it was generally agreed that the hospitals should provide care for indigents, the total cost of such care should be shared by the State, county, local community or charitable organizations.

Implementation of Free Service Provision

Implementing regulations issued by HEW on October 22, 1947, provided that "free patient care" means hospital service offered at below cost or free to persons unable to pay. Included as persons unable to pay were both the legally indigent and persons who are otherwise self-supporting but are unable to pay the full cost of needed hospital care. A reasonable volume of free patient care called for in the act was not clearly defined by the regulations. The regulations provided that determinations of reasonable volume give consideration to conditions in the area to be served by the applicant, including the amount of free care that may be available from sources other than the applicant.

The 1947 regulations basically remained unchanged until January 6, 1972, at which time new regulations were published. The regulations were changed to essentially state the language of the statute. HEW comments explaining the change stated that numerous court suits were in process relative to the subject regulations and that new regulations designed to define the scope of the "assurance" more clearly and to govern its enforcement was being prepared.

Interim regulations were issued by HEW on July 22, 1972, with an effective date of August 6, 1972. However, the effective date for facility compliance was November 4, 1972. These regulations provided a definition of a reasonable volume of free services, furnished guidance

to State agencies on eligibility criteria and qualifying services, and established requirements for evaluation and enforcement of compliance.

All facilities which have received Hill-Burton financial assistance in the past 20 years are subject to compliance with the regulations. In the case of grants, the compliance period is 20 years after completion of the project for which financial assistance was provided. In the case of direct loans and loan guarantees, the compliance period is equal to the time required to repay the loan.

The HEW regulations provide that the reasonable volume of free services requirement could be met by facilities by (1) offering free or below cost services in an amount which is not less than the lesser of 3 percent of operating cost (after deducting Medicare and Medicaid reimbursements) or 10 percent of total Federal assistance received, or (2) certifying that free or below cost services would not be refused to any person regardless of their ability to pay (open door option).

The regulations also provide that the requirement to furnish free services could be waived by the State agency if a facility can demonstrate to the State agency that it is financially unfeasible for it to meet the requirement.

State Hill-Burton agencies are responsible for securing implementation and compliance by facilities with the free service requirement. At nine State agencies visited we inquired as to how facilities in the States intended to comply with the requirement that a reasonable volume of free services be furnished.

Of 715 facilities subject to the requirement, 563 or 79 percent of the facilities had selected one of the above options. Problems in interpreting the regulations and delay in implementing actions by the State agencies are factors contributing to the reasons why most facilities in States, except for one State, have not made a selection.

We noted that one State agency on May 15, 1973 requested each State facility to which the requirement applied to select a free service option to operate under for the next fiscal year. At the time of our review in August 1974, 122 of 183 facilities had made a selection. Our review of the State agency indicated that very little followup had been performed to determine why the facilities had not selected an option.

For the 563 facilities who had selected one of the options, 332 facilities had selected the open door option. Sixty-three percent of 394 facilities in nonpoverty areas selected the open door option as compared to 49 percent of 169 facilities in poverty areas. See page 16 of this enclosure for additional information on the 715 facilities.

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Although State plans set forth eligibility criteria for free services, the determination of persons eligible for such services is made at the facility level. One State plan stated that it was the responsibility and prerogative of the facility to determine persons unable to pay. None of the plans reviewed provided guidance to the facilities on how to make the eligibility determinations. Furthermore, the determination of eligibility, using the criteria set forth in some of the State plans could require a significant amount of administrative time by facility personnel. For example, the criteria adopted by one State agency requires that consideration be given to 25 different sources of income. Another State agency criteria, requires the facility to determine cash value of life insurance and the value of personal property for each individual in the family, in establishing the assets or financial resources of the family.

Most of the 20 facilities visited were making some attempt to determine whether or not a person is able to pay for the services using some sort of financial information to make such determination. The methods and procedures used to document a persons ability to pay varied from facility to facility.

For example, one hospital administrator informed us that two primary sources used to determine a persons ability to pay was the local retail credit agency and the patient's doctor. Another used information provided by a social service department to determine ability to pay.

One hospital simply asks the patient if he can pay the bill. If the patient says no, the hospital sends one bill and if payment is not received, the amount due is recorded as uncollectable.

Only 10 of 20 facilities have advertised the availability of free services and this was generally accomplished by an annual notice in a local newspaper.

Of the 20 facilities, 12 had selected the option which requires that a specified amount of free services be provided annually. Six of the 12 facilities provided us information showing that they had furnished the required amount of free sevices for their most recent fiscal year.

Regarding the Subcommittee's concern about the use of "bad debts" to meet the free service requirement, we found that this practice is generally not being followed by the facilities visited.

Evaluation and Enforcement

All State plans reviewed set forth the manner in which the free service requirement was to be evaluated and enforced. The evaluation and enforcement provisions were generally consistent with the Federal regulations.

The evaluation function is essentially accomplished by matching the amount of free services required with the amount of free service provided as shown on financial statements submitted by the facilities. None of the State agencies reviewed had an active program for verifying the information submitted by the facilities.

Officials at three State agencies told us that they did not have sufficient personnel to conduct site visits to determine facility compliance. Most of the State agencies reviewed plan to rely on complaints as an indication of noncompliance.

We were told by officials at two State agencies that they lacked the authority to enforce the free service requirement.

The American Hospital Association in commenting on the enforcement provision included in HEW regulations, stated the provision requires State agencies to impose more severe sanctions than authorized by Federal statute.

ENCLOSURE II

OPTIONS SELECTED BY FACILITIES TO MEET FREE SERVICE REQUIREMENT

	Number of facilities	Facilities that selected an option	Options selected		
			Open door	10 percent	3 percent
Alabama					
Nonpoverty	173	122	81	18	23
Poverty	10	5	4	-	1
Colorado[a]					
Nonpoverty	14	11	7	4	-
Poverty	4	2	2	-	-
Delaware					
Nonpoverty	3	3	3	-	-
Poverty	2	2	2	-	-
Kansas					
Nonpoverty	67	35	33	1	1
Poverty	10	9	9	-	-
Maryland					
Nonpoverty	47	37	19	14	4
Poverty	13	9	6	3	-
Mississippi					
All poverty	72	71	21	6	44
Missouri					
Nonpoverty	85	[b]65	24	19	22
Poverty	10	9	2	1	6
Pennsylvania[c]					
Nonpoverty	129	114	75	20	19
Poverty	65	59	34	16	9
Utah[a]					
Nonpoverty	8	7	7	-	-
Poverty	3	3	3	-	-
Total all facilities	715	563			
Percent of total	-	79			
Total nonpoverty	526	394	249	76	69
Percent by option	-	100	63	19	18
Total poverty	189	169	83	26	60
Percent by option	-	100	49	15	36

[a]Includes only facilities funded fiscal year 1971 through 1974.
[b]Two facilities are not included because of improper selection of options.
[c]Nine facilities are not included because State officials could not make a poverty/nonpoverty designation.

ENCLOSURE III

ANALYSIS OF CERTAIN DEPARTMENT OF HEALTH, EDUCATION AND WELFARE POLICIES IMPLEMENTING THE HILL-BURTON PROGRAM

LEGISLATIVE BACKGROUND OF THE HILL-BURTON PROGRAM:

The legislative history of the Hill-Burton program may be summarized as follows:

1. 1946: Enactment of the Hill-Burton Program, §2 of the Hospital Survey and Construction Act of 1946, Public Law 79-725, August 13, 1946, 60 Stat. 1040. This Act, which added new title VI to the Public Health Service Act of 1944, Pub. L. 78-410, July 1, 1944, 58 Stat. 682, authorized grants to States for surveying needs and developing State plans for construction of facilities and assisting in constructing and equipping needed public and voluntary nonprofit general, mental, tuberculosis and chronic disease hospitals, and public health centers.

2. 1949: Passage of the Hospital Survey and Construction Amendments of 1949, Public Law 81-380, October 25, 1949, 63 Stat. 898. The 1949 statute authorized the Public Health Service to conduct and provide grants for research, experiments, and demonstrations relating to the development, effective utilization, and coordination of hospital services, facilities, and resources.

3. 1954: Passage of the Medical Facilities Survey and Construction Act of 1954, Public Law 83-482, July 12, 1954, 68 Stat. 461. This Act broadened the Hill-Burton program to provide specific grants for the construction of public and voluntary nonprofit nursing homes, diagnostic or treatment centers, rehabilitation facilities, and chronic disease facilities.

4. 1958: Further amendments to the Hill-Burton program were enacted by Public Law 85-589, August 1, 1958, 72 Stat. 489. The 1958 Act gave sponsors who met the standard eligibility and priority qualifications under the program the option to take a long-term loan in lieu of a grant.

5. 1961: Passage of the Community Health Services and Facilities Act of 1961, Public Law 87-395, October 5, 1961, 75 Stat. 824. This Act increased the appropriation authorization for the construction of nursing homes from $10 million to $20 million annually. The 1961 Act also raised annual research appropriation authorizations to $10 million and authorized appropriations for experimental and demonstration construction and equipment projects.

6. 1964: Enactment of the Hospital and Medical Facilities Amendments of 1964, Public Law 88-443, August 18, 1964, 78 Stat. 447. This Act extended the hospital and medical facilities survey and construction program through June 30, 1969. It also authorized appropriations over a 5-year period totaling $1.34 billion in grants and loans for new construction, modernization, and replacement of hospitals, long-term care facilities (including nursing homes), public health centers, diagnostic or treatment centers, and rehabilitation facilities. And, $160 million was authorized for modernization and replacement over a 4-year period beginning with fiscal year 1966. Other provisions of the 1964 act authorized $350 million for long-term care facilities over a 5-year period. This category combined previously separate grants programs for chronic disease hospitals and nursing homes.

Other authorizations over the 5-year period included: hospitals and public health centers, $680 million; diagnostic or treatment centers, $100 million; and rehabilitation facilities, $50 million.

The Act additionally authorized a program of project grants to help develop comprehensive regional, metropolitan area, or other local area plans for health and related facilities. (Previously, demonstration grants supported area-wide planning efforts.) 1/

7. 1967: The Partnership for Health Amendments of 1967, Public Law 90-174, December 5, 1967, 81 Stat. 533, were passed. In this Act, §304 of the Public Health Service Act was amended by repealing § 624, which authorized a program of project grants for research and demonstrations, under the Hill-Burton program. At the same time, there was established under §304, the National Center for Health Services Research and Development, which assumed, among other responsibilities, the authority to administer a program of project grants for research and development, similar to the §624 program which had been repealed.

8. 1968: Enactment of the Hospital and Medical Facilities Construction and Modernization Assistance Amendments of 1968, title IV of Public Law 90-574, October 15, 1968, 82 Stat. 1011. This Act extended the hospital and medical facilities survey and construction program through June 30, 1970. 2/

1/ The 1966 Comprehensive Planning and Public Health Service Amendments (Public Law 89-749) transferred such authority from the Hill-Burton program as of June 30, 1967.

2/ S. Rep. No. 91-657, 91st Cong., 2d Sess., 5-6 (1970).

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9. 1970: Enactment of the Medical Facilities Construction and Modernization Amendments of 1970, Public Law 91-296, June 30, 1970, 84 Stat. 336. This act authorized a 3-year extension of the existing grant program; a 3-year guaranteed loan program for certain types of private facilities; and a program of direct loans for construction or modernization of public facilities.

LIMITATIONS ON TRANSFER OF ALLOTMENTS

Existing provisions of the Hill-Burton program prescribe five broad areas of Federal aid for construction and modernization of public and other nonprofit health care facilities: the first four categories provide grants to states to support new construction of facilities for (1), long-term care, (2), outpatient care, (3), rehabilitation and (4), hospitals and public health centers. The fifth category provides funds for the modernization of existing facilities of the four types described above.

Under the program, funds for the various health facilities categories are distributed to the States pursuant to an allotment formula based upon population and other factors, 42 U.S.C. 291b(a). The statute provides, however, that notwithstanding the allocation formula, each State shall receive a minimum allotment for each of the five grant categories. With specific regard to the allotment of funds to support new construction of outpatient facilities, the statute provides:

> "(b)(1) The allotment to any State under subsection (a) of this section for any fiscal year which is less than--
>
> * * * * *
>
> (B) $100,000 for the Virgin Islands, American Samoa, the Trust Territory of the Pacific Islands, or Guam and $200,000 for any other State in the case of an allotment

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for grants for the construction of public or other nonprofit outpatient facilities, * * * shall be increased to that amount * * *" (Emphasis added.) 42 U.S.C. 291b(b)

In certain circumstances a State is authorized the transfer of allotments from one category to another:

"(c)(1) Upon the request of any State that a specified portion of any allotment of such State under subsection (a) of this section for any fiscal year be added to any other allotment or allotments of such State under such subsection for such year, the Secretary shall promptly (but after application of subsection (b) of this section) adjust the allotment of such State in accordance with such request and shall notify the State agency; except that the aggregate of the portions so transferred from an allotment for a fiscal year pursuant to this paragraph may not exceed the amount specified with respect to such allotment in clause (A), (B), (C), or (D), as the case may be, of subsection (b)(1) of this section which is applicable to such State.

(2) In addition to the transfer of portions of allotments under paragraph (1), upon the request of any State that a specified portion of any allotment of such State under subsection (a) of this section, other than an allotment for grants for the construction of public or other nonprofit rehabilitation facilities, be added to another allotment of such State under such subsection, other than an allotment for grants for the construction of public or other nonprofit hospitals and public health centers, and upon simultaneous certification to the Secretary by the State agency in such State to the effect that--

(A) it has afforded a reasonable opportunity to make applications for the portion so specified and there have been no approvable applications for such portion, or

(B) in the case of a request to transfer a portion of an allotment for grants for the construction of public or other nonprofit hospitals and public health centers, use of such portion as requested by such State agency will better carry out the purposes of this title,

> the Secretary shall promptly (but after application of subsection (b) of this section) adjust the allotments of such State in accordance with such request and shall notify the State agency.
>
> (3) In addition to the transfer of portions of allotments under paragraph (1) or (2), upon the request of any State that a specified portion of an allotment of such State under paragraph (2) of subsection (a) of this section be added to an allotment of such State under paragraph (1) of such subsection for grants for the construction of public or other nonprofit hospitals and public health centers, and upon simultaneous certification by the State agency in such State to the effect that the need for new public or other nonprofit hospitals and public health centers is substantially greater than the need for modernization of facilities referred to in paragraph (a) or (b) of section 291a of this title, the Secretary shall promptly (but after application of subsection (b) of this section) adjust the allotments of such State in accordance with such request and shall notify the State agency." 42 U.S.C. 291b(c)

In summary, 42 U.S.C. 291b(c) provides that (1), any amount up to the minimum allotment for any category may be transferred to another category without limitation and (2), sums in excess of the minimum allotment may also be shifted between categories with two exceptions:

> a. No funds beyond the minimum allotment may be transferred from the rehabilitation facilities category and;
>
> b. No funds in excess of the minimum allotted to a category may go into the new hospital construction category unless such funds come from the modernization category and the former modernization funds are accompanied by a certification from the State that the need for new hospital construction is greater than that for modernization of existing facilities.

This interpretation is consistent with the intent of the 1970 amendment which enacted the current language of the section. The Conference Report on the 1970 amendments to the Act, H.R. Rep. No. 91-1167, 91st Cong., 2d Sess., 20-21 (1970) stated as follows:

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"The House bill left existing law unchanged with respect to transfers of allotments among the various categories of assistance authorized under the program, except that authority for transfers from the modernization category to the allotment for construction of hospitals and public health center was eliminated. The managers on the part of the House receded from this provision, and accepted the transfer authorities contained in the Senate amendment as follows:

First, any State may make transfers, in the discretion of the State agency, of any amount up to the minimum amount alloted to any State for a particular category.

This provision will benefit the smaller States, by permitting them to shift relatively small sums from one allotment category or another without being required to comply with relatively elaborate certification requirements.

Secondly, all amounts above these minimums may be transferred from one category of assistance to another (for example, from construction of facilities for long-term care to modernization) without restriction on the amounts, except that (1) no funds may be transferred from the rehabilitation facilities category or (except as indicated in the next sentence) to the new hospital construction category, and (2) all other transfers must be justified on the basis that either there are no approvable applications in the category from which funds are transferred, or in the case of transfers from the new hospital construction category, the purpose of the program will be better served by such a transfer. Further, transfers may be made from the modernization category to the category of new hospital construction if the State agency certifies that the need for the latter is greater." (Emphasis added.)

See also the Codifier's note at 42 U.S.C. 291b.

HEW regulations implementing this provision, 42 C.F.R. 53.94, do not address the question of whether funds may be transferred from one category to another category through an intermediate category. However, an affidavit of Dr. Harold M. Graning, Director, Division of Facilities Utilization, Health Resources Administration,

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HEW, filed in the case not related to this audit (National Association of Neighborhood Health Centers, Inc., et al. v. Weinberger, et al., pending in the U.S. District Court for the District of Columbia, Civil Action No. 74-52,) expresses HEW's understanding of the congressional policy.

> "Hill-Burton funds allocated to the outpatient facilities category can be awarded to projects for the construction or modernization of other types of facilities only if such funds are first transferred to another allotment category in accordance with the provisions of section 602(e) of the Public Health Service Act (42 U.S.C. 291(e)) and 42 CFR § 53.94. Under these provisions a State may, without HEW concurrence, transfer up to $200,000 from the outpatient facilities category (with the exception of the Virgin Islands, American Samoa, Guam, and the Trust Territory of the Pacific Islands which are limited to $100,000) to any other category. Transfers from the outpatient facilities category exceeding this amount may be made only if the State certifies to the Secretary that it has afforded a reasonable opportunity for the submission of applications for the portion to be transferred and that there have been no approvable applications for such portion(as part of such certification a State must set forth the method by which a reasonable opportunity to submit applications has been afforded, 42 CFR § 53.94(a)); provided, however, that funds cannot be transferred under this procedure to the public or other nonprofit hospitals and public health centers category (i.e., no more than the $200,000 or $100,000 amount may be transferred from the outpatient facilities category to the hospitals and public health centers category)." (Emphasis added.)

In some States, funds alloted to the outpatient facilities category have been transferred into the modernization category and then immediately into the new hospital and public health centers construction category. As discussed above, Congress clearly provided that funds in excess of the minimum allotment could not be transferred from outpatient facilities to new hospital construction. Transfer to an

intermediate category recognizes the statutory restriction and may be an attempt to avoid it.

On the basis of the language of the Act and its legislative history, we believe that it would be improper to do indirectly what cannot be accomplished directly. The direct transfer of moneys in excess of the minimum amount allotted to a State from the outpatient facilities category to the new hospital construction category would be clearly unlawful. A sham to accomplish the same purpose would similarly be improper. There may, however, be circumstances where funds in good faith are transferred from the modernization category to the new construction category and then, due to a change in circumstance, it becomes advisable to transfer funds from the outpatient category to the modernization category. Conceivably, the prohibition may not attach even to some transfers for good reason from the outpatient to the modernization category, and subsequently to the new construction category, again for such good cause as is generated by the needs of the two categories directly involved in the separate transfer. Such good faith transfers would have to be examined on a case by case basis.

PRIORITIES TO BE ACCORDED NONPOVERTY AREAS BASED ON RELATIVE NEEDS OF SERVICE AREAS

The statutory provision relevant to this question is 42 U.S.C. 291c(a)(4):

> "The Surgeon General, with the approval of the Federal Hospital Council and the Secretary of Health, Education, and Welfare, shall by general regulations prescribe--
>
> Priority of projects; determination
>
> (a) the general manner in which the State agency shall determine the priority of projects based on the relative need of different areas lacking adequate facilities of various types for which assistance is available under this part, giving special consideration--
>
> * * * * *
>
> (4) in the case of projects for construction or modernization of outpatient facilities, to any outpatient facility that will be located in, and provide services for residents of, an area determined by the Secretary to be a rural or urban poverty area;

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The HEW regulations implementing of the statute, 42 C.F.R. 53.81 and 53.94 (1973) follows its terms:

§53.81 General.

"The general manner in which the State agency shall determine the priority of projects included in the State construction program shall be based on the relative need of different service areas lacking adequate facilities and shall conform to the principles set out in this subpart. In addition to the specific considerations set forth in this subpart with respect to particular types of projects, special consideration shall be given.

(a) To facilities which, alone or in conjunction with other facilities, will provide comprehensive health care, including outpatient and preventive care as well as hospitalization;

(b) To facilities which will provide training in health or allied health professions; and

(c) To facilities which will provide to a significant extent for the treatment of alcoholism.

○ ○ ○ ○ ○

§53.94 Outpatient facilities for construction and modernization.

(a) In determining the priority of projects for construction or modernization of outpatient facilities, special consideration shall be given to any outpatient facility that will be located in, and provide services for residents of, an area determined by the Secretary pursuant to §53.149 to be a rural or urban poverty area.

(b) Subject to the provisions of paragraph (a) of this section priority of projects for new construction of outpatient facilities shall be determined on the basis of the relative need for additional outpatient facilities in the area to be served by the facility, taking into account existing services available and their utilization.

(c) In determining the priority of projects for modernization of outpatient facilities, special consideration shall be given (in addition to that

specified in paragraph (a) of this section) to facilities serving areas of high population density." (Emphasis added.)

The legislative history of the statute supports the view that some general priority is to be accorded to poverty areas with respect to projects for the construction or modernization of outpatient facilities but does not further clarify the weight to be accorded this consideration.

1. The statement by the Conferees on the 1970 Act includes the following language:

> "The House bill would have retained priorities as set forth in existing law, except that it provided that the State agency could waive the priority for construction in rural areas. The Senate amendment contained the same provision with respect to waiver of construction priorities for rural areas, and added a number of additional categories.
>
> "The conference substitute provides that priority shall be given to projects for construction or modernization of out-patient facilities which are located in and provide services for residents of rural or urban poverty areas; * * *." H.R. Rep. No. 91-1167, supra, 22-23. (Emphasis added.)

2. The Senate Committee report on H.R. 11102, the bill which became the Act of 1970:

> "Under the existing law (sec. 604(a)(6)) a State is to establish in its State plan an order of priority for projects for modernization and construction. Under section 603(a), in establishing the order of priority for projects for the construction of hospitals, a State is to give special consideration for projects for hospitals serving rural communities and areas with relatively small financial resources. Under the amendment made by this section [of H.R. 11102] a State is no longer required to give special consideration to projects for hospitals serving rural areas. However, the amendment does provide that the State may, at its option, continue to give special priority consideration for hospital projects serving rural communities.
>
> "This section [of the bill] further amends section 604(a) of the act by establishing new priority preferences which will be employed by the States in developing an order of priority for approving projects. Speci-

fically, outpatient facilities located in rural or urban areas, * * *." S. Rep. No. 91-657, supra, 16-17. (Emphasis added.)

On the basis of the statute and its legislative history, we conclude that the Hill-Burton Act, as amended, does not authorize HEW to give priority to nonpoverty outpatient facilities projects over poverty projects of the same type based solely on the relative needs of the service areas for outpatient facilities. The Act requires that some consideration must be accorded to poverty status. To give priority status to a nonpoverty area project over a poverty area project, the need in the nonpoverty area must outweigh the need and other special consideration of the poverty area. We think HEW regulations properly recognize this point.

We also note that HEW regulations are structured so as to permit the designation of a poverty "subservice" area within a nonpoverty service area. 42 C.F.R. 53.129 states:

> "For purposes of determining the priority of projects for construction or modernization of outpatient facilities pursuant to section 603(a)(4) of the Act and of establishing a Federal share of any project (not to exceed 90 per centum of the cost of construction) pursuant to section 645(b)(4) of the Act, the State plan shall include a designation of areas in the state which are proposed by the State agency, in accordance with this section, to be rural or urban poverty areas. For purposes of this section, 'area' means a service area (or the nearest approximation thereto for which current census data are available, based on geographic boundaries such as counties or census tracts) or a subservice area which is designated in the State plan as providing the basis for the provision of outpatient services." (Emphasis added.)

Pursuant to this regulation, special consideration may be given to outpatient facilities projects in poverty subservice areas located within nonpoverty service areas. In this way, a nonpoverty service area may, by virtue of a poverty area being determined to be located within it, receive preferential aid for a needed outpatient facility.

There is some question, however, whether in practice special consideration is actually being given to poverty areas as required in the regulations. In the Affidavit of Dr. Graning referred to above, it is stated:

> "* * * even though an outpatient project is located in a poverty area, it is not entitled to priority over nonpoverty area projects located in other service areas unless the service area in which the poverty area project is located has a higher relative need for outpatient facilities than the service areas in which nonpoverty outpatient projects are located."

This would imply that no special consideration must be given to poverty areas, since a poverty area project would have to show greater need than other projects in order to gain a priority status. Such need would entitle the project to a higher priority regardless of its location in a poverty area.

PROPRIETY OF THE 1971 MEMORANDUM RELEASING STATES FROM DESIGNATING POVERTY AREAS

The subject memorandum, dated September 2, 1971, from the Health Care Facilities Service (HCFS) in HEW, stated in pertinent part that:

> "The proposed Public Health Service Regulations, Part 53, revised to implement the provisions of P.L. 91-296, require that State agencies use the latest available published data from the Bureau of the Census to determine poverty areas. We have been advised by staff of the Bureau of the Census that family income data from the 1970 census will not be published until approximately February 1972. We have been advised further that at this time the latest published data from the Bureau of the Census is from the 1960 census. We do not recommend that State agencies use 1960 census data; therefore, State agencies will not be required to designate poverty areas in State plans until after family income data based on the 1970 census are published by the Bureau of the Census and are made available to State agencies through this office." (Emphasis added.)

The need for the memorandum was created by HEW regulations which provide that the Secretary will automatically determine that an area is a poverty area if it has certain characteristics as shown in "the latest available published data from the Bureau of the Census," 42 C.F.R. 53.129. The regulations make no other provision for secretarial determinations of poverty areas. Census data is published approximately two years after the census year. Thus in 1971, 1970

census data was not available and the latest available data was over 11 years out of date. Although the Secretary is not required by the statute to use census data, in the absence of other regulations, following the recommendation in the quoted memorandum would leave the Secretary with no standard upon which to determine poverty areas. The absence of any standard for making such determinations, and the consequent ignoring of the requirement to designate such areas, is contrary to §291c(a)(4) of the statute quoted on page 8, above, which requires that "special consideration" be given to poverty areas designated by the Secretary. While it is true that the Secretary could independently make the determination of poverty areas, unless the basis for such determination is known in advance states could not give "special consideration" to poverty areas in formulating their plans as is required in the statute. We therfore conclude that the 1971 memorandum was improper to the extent that it purported to exempt the Secretary from making any determination of poverty status upon which states could base their priorities.

Consistent with the above, other activities within HEW reached the conclusion that that portion of the memorandum which dispensed with all designation of poverty areas was improper. In a memorandum dated January 31, 1972, HEW's Public Health Division stated:

> "That Policy Memorandum [the memorandum of September 2, 1971], which was the subject of our memorandum to you of November 9, 1971, indicated that States would not be required to designate poverty areas until after the 1970 census data becomes available--which was expected to be approximately February of 1972--and apparently permitted States to approve applications for outpatient facility projects without having made such designations.
>
> "In our November 9, 1971, memorandum, we stated that the Policy Memorandum raised serious legal problems; specifically, that
>
> > "* * * it ignores, and implicitly permits States to ignore, the statutory provision which requires that outpatient facilities to be located in urban or rural poverty areas be given "special consideration" by State agencies in their determination of priority of projects (sec. 603(a)(4))";
>
> "As a result of that memorandum, and in cooperation with your Office, we prepared a regulatory provision which was designed to alleviate the difficulties presented by reliance on outdated census figures in the designation of poverty areas. That provision (42 CFR

53.129(c)) appears in the new Hill-Burton regulations, which as you know were published in the Federal Register on January 6, 1972, and are now effective.

"It is now clear, therefore, not only that States must designate poverty areas before any applications for outpatient facilities may legally be approved, as we previously advised, but that a method exists for making such designations on a realistic basis without waiting for the 1970 census data.

"We reiterate our strong conviction that the policy expressed in Policy Memorandum No. B-1-71 and Dr. Graning's December 21 letter, to the extent that it will permit States to approve applications for outpatient facility projects without having first designated urban and rural poverty areas, is inconsistent with both the statute and the regulations and without legal foundation." (Emphasis added.)

ENCLOSURE IV

LOCATIONS VISITED BY GAO

HEW Regions	State	Hospitals
Region III (Philadelphia)	Pennsylvania	Methodist Hospital and Thomas Jefferson University Hospital, Philadelphia
	Maryland	Lutheran Hospital and St. Agnes Hospital, Baltimore
		St. Joseph's Hospital, Towson
	Delaware	Kent General Hospital, Dover
		St. Francis Hospital, Wilmington
	Virginia	- - - - -
Region IV (Atlanta)	Alabama	St. Margaret's Hospital, Inc., Montgomery
		Crenshaw County Hospital, Luverne
	Mississippi	Rankin General Hospital, Brandon
		Vicksburg Hospital, Inc., Vicksburg
Region VII (Kansas City)	Kansas	Community Memorial Hospital, Marysville
		Providence - St. Margaret Health Center, Kansas City
	Missouri	Memorial Community Hospital, Jefferson City
		Menorah Medical Center, Kansas City
		Sac-Osage Hospital, Osceola
Region VIII (Denver)	Colorado	Beth Israel Hospital and Mercy Hospital, Denver
	Utah	St. Marks Hospital and Holy Cross Hospital, Salt Lake City

Note: Information concerning the States of Florida, Georgia, Kentucky, Montana, North Carolina, South Carolina, North Dakota, South Dakota, Tennessee and Wyoming was obtained by reviewing documents at the respective HEW Regional Offices.

Senator KENNEDY. Our next witness representing the administration is Dr. Kenneth Endicott, Administrator of Health Resources Administration.

Dr. Endicott has been a commissioned officer in the Public Health Office since 1940. From 1942 to 1969 he served in the research arm of the Public Health Service, National Institutes of Health. In 1969 he was Director of the National Cancer Institute. From 1969 to 1973, he was Director of the Bureau of Manpower Legislation. We welcome you.

STATEMENT OF KENNETH ENDICOTT, M.D., ADMINISTRATOR, HEALTH RESOURCES ADMINISTRATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY HARALD GRANING, M.D., DIRECTOR, DIVISION OF FACILITIES UTILIZATION SERVICE, HRA, HEW; GENE RUBEL, DIRECTOR, COMPREHENSIVE HEALTH PLANNING, HRA, HEW; AND SIDNEY EDELMAN, ESQ., ASSISTANT GENERAL COUNSEL FOR PUBLIC HEALTH, HEW

Dr. ENDICOTT. Mr. Chairman, we welcome the opportunity to appear before you today to report on the administration of the Hill-Burton program, and to discuss with you the observations made recently by this committee in Senate Report 93–1285, dated November 12, 1974, and a special report of the General Accounting Office, which was presented to you on September 25, 1974.

We look forward to a discussion of the conclusions of this document, believing that it can be of great assistance to us in the administration of the existing Hill-Burton program, as well as providing guidance for the development of program procedures for any new successor program, which may be enacted into law.

With this in mind, as we discuss the specific observations of the special GAO report, we shall provide our recommendations with respect to what changes we will make administratively.

Since the special GAO report on the Hill-Burton program has been available to us only a few days, we have not formulated completely all of our proposed modifications and recommendations. These outstanding changes will be supplied later for the record.

[The information referred to and subsequently supplied follows:]

HRA ADMINISTRATION CHANGES TO BE MADE IN RESPONSE TO THE SPECIAL GAO REPORT ON THE ADMINISTRATION OF THE HILL-BURTON PROGRAM

In response to the findings contained in the special GAO report, the following actions are being initiated:

(1) The Office of General Counsel, DHEW, is drafting amendments to current regulations which will require that no transfers may be made until 18 months after funds are appropriated.

(2) A review of previous transfers will be made. In any case where improper transfer was made, adjustments will be made in the FY 73 and FY 74 allocations.

(3) An outreach program will be designed and implemented. This program will include assistance from the Bureau of Community Health Services, Health Services Administration. Advice will also be sought from the Association of Neighborhood Health Centers in program design and implementation.

(4) An attempt to expedite the development of standards for the measurement of need for outpatient facilities will be made, using the materials generated by the ABT contract as a base.

(5) Alternative methods for monitoring the "reasonable volume of free care" shall be examined.

Dr. ENDICOTT. The existing program and recommendations for change:

Before addressing the specific comments of the special GAO report, we would like to reiterate the administration's position in respect to the kind of health facility construction assistance role that should be played by HEW.

The original enactment of Hill-Burton was based on the desire to increase the number of and to better distribute hospital beds.

In 1946, while the eight States with the highest income had four beds per 1,000 populations, there were only 2.5 beds per 1,000 population in the eight States with the lowest income. Today, this imbalance has been corrected and, indeed, the facilities in the poorer States are, on the average, newer facilities. Today the need is not for additional beds and hospitals, but for the modernization, including replacement, of existing hospitals and for increased ambulatory care facilities.

As contained in our proposal to the committee, presented on June 14, 1974, we would recommend that the program be limited to project grants for high risk health facilities and that such grants be further limited to the modernization or replacement of public or other nonprofit hospitals, and the construction or modernization of ambulatory care facilities. That proposal further called for cost-sharing by the States in the support of such construction projects, and required all participating medical facilities to adopt reforms in the manner in which they finance future modernization and renovation.

At this time, I would like to address some of the specific GAO report comments.

Special consideration to outpatient facilities in poverty areas:

The special GAO report discusses the extent to which special consideration is given to projects for the construction or modernization of outpatient facilities in poverty areas.

Section 603(a) of the Hill-Burton statute requires that special consideration be given to any project meeting one or more of seven characteristics enumerated. One of these seven is for "projects for construction or modernization of outpatient facilities, to any outpatient facilities that will be located in and provide services for residents of, an area determined by the Secretary to be a rural or urban poverty area."

Since the beginning of the program in 1946, and continuing through the 1970 amendments, the phrase "special consideration" has been interpreted to mean that when two or more applications are received from the same service area or from two service areas with the same relative priority, then project applications containing one or more of the seven characteristics should be given preference over those that do not.

Traditionally, priority status has been determined on the basis of comparing the relative needs of different service areas for specific types of facilities. Need determinations for outpatient facilities are prepared by each State as no adequate national criteria have yet been developed. Often, need determinations are made on the basis of facility to population ratios.

Thus, it is possible and would be consistent with the intent of the legislation that a new and growing suburban community without outpatient facilities could be granted a priority status over an inner-city

area serviced by a large municipal hospital even though the demand for outpatient services is greatest in the latter case.

The committee may be interested in a DHEW Office of General Counsel opinion on our interpretation of special consideration which we would like to submit for the record.

In addition to the lack of adequate national criteria to determine outpatient needs, a project application that incorporates more than one of the seven characteristics mentioned earlier is considered more desirable than an application containing only one. In this way an application from a poverty area with only one need or with only enough matching funds to support one general service might be preempted by a multiservice proposal from a nonpoverty community having an equal relative need to a poorer community.

We believe that the Administration's proposal for a targeted project grant program, limited to modernization of existing inpatient facilities and modernization and construction of ambulatory facilities in medically underserved areas, would sufficiently narrow the range of projects that would have priority status, thereby eliminating the biases that currently exist in the Hill-Burton program.

Senator KENNEDY. Before going on, are you familiar with the statute itself which gives, under the general regulations in section 603, various priority items?

Dr. ENDICOTT. Yes, sir.

Senator KENNEDY. That section lists the seven different priority items. No. 4 states that in the case of projects for construction or modernization of outpatient facilities, to any outpatient facility, that will be located in and provide services for residents of an area determined by the Secretary to be a rural or urban poverty area.

Could you tell us what steps were taken by HEW to implement that particular statutory requirement? What specifically did you really do to make sure that that legislative requirement actually became something that was positive and beneficial to the people as we in the Congress had intended?

Dr. ENDICOTT. Mr. Chairman, in beginning my statement I neglected to introduce the men who are accompanying me here.

Mr. Sidney Edelman from the Office of General Counsel; Mr. Gene Rubel, who is in charge of Hill-Burton CHP; and Dr. Harald Graning, director in charge of the Hill-Burton hospital program.

I would like to refer this question to Dr. Graning, who was present at the time the amendments were enacted.

Dr. GRANING. Mr. Chairman, the references that you just cited in the law indicate that there are seven different kinds of projects that are to get "special consideration."

This same phrase has been in the law since 1946. Until 1970, the only type of project that was identified that should get special consideration was one that was in the rural area. And, as indicated in Dr. Endicott's statement, the manner in which the law was finally passed, on the basis of the interpretation of Office of General Counsel, we have continued to give priorities, first of all, on a service area basis. Thus, it would be conceivable that a project could come in that would have several of the very definite social values enumerated in the "special consideration" roster.

Yet, if it comes in from an area in which there are already too many hospital beds, or an area in which there is no need for modernization—

there is no possible way in which the project could be funded. Perhaps Mr. Edelman might want to speak further to this, but this has been our interpretation consistently since enactment of 1970 amendments.

Senator KENNEDY. Let's elaborate a little further on this matter. I am trying to find out if what we pass in Congress has any meaning, or whether it is just a channel at the Department for stamping applications as they come through.

Can you elaborate a little more on that subject? We are trying to find out what we have to do to give the priority, which I thought we gave in 1970.

Dr. ENDICOTT. Mr. Chairman, I am going to call on Mr. Edelman to comment.

But my impression of the basic difficulty in this area is that we have too many competing priorities without having really ranked them in terms of what really does come first. Perhaps Mr. Edelman could enumerate further.

Mr. EDELMAN. As Dr. Graning said, the concept of "special consideration" has been in the statute from the beginning. The enactment of the seven categories in 1970 did not change the substantive language of the section in any respect, except to indicate special consideration was going to be given to additional kinds of facilities.

In determining the question of priority and special consideration, section 603 still says the general manner in which a State agency shall determine the priority of projects is based on the relative needs of different areas lacking adequate facilities of the various types for which assistance is available under this part, giving special consideration to the list of categories.

In approaching this from the legal point of view, it does seem to us that what this statute contemplated is that the first thing that would be done would be to determine the relative need of various areas for the specific types of facilities. Having arrived at a priority based on relative need, the special types of facilities which are listed in paragraph (a) will be given consideration, depending on the extent to which they met the statutory criteria, which means that if a project came in which was located in a rural or urban poverty area, but a determination has been made by the State there was no need for any additional outpatient facilities in that area, as Dr. Graning said, we see no legal basis on which that project could be funded if there was no need for it.

Now, similarly, if two projects come in from the same area, and assuming there was a demonstrated need for additional outpatient facilities, in that situation, all other things being equal, the project which would serve the poverty area would then get the special consideration or the higher priority within the priority.

And this would apply, whether the applications came from the same area or from different areas with similar degrees of relative need for outpatient facilities.

Senator KENNEDY. Could you give us some examples of how that policy was actually implemented? Can you give me a list of facilities?

Mr. EDELMAN. I would have to turn to Dr. Graning as to how it actually worked out.

Dr. GRANING. The policy has been consistently implemented in that manner.

Senator KENNEDY. Can you give me the names of facilities that have actually been constructed or built following that policy?

Dr. GRANING. The limited amount of money available to the States has made it quite important that the State Hill-Burton plan be a well-publicized document in the sense that communities know what the relative standing is.

And the service area, for instance, that could not be reached in 1 fiscal year would look forward to an ensuing year with funds that could be used at that time. And so priorities have always been on a service area basis.

As has been indicated, the interpretation of special consideration was an expression on the part of Congress that those particular projects—and I was a participant in terms of encouraging the funding of this kind of project—those particular projects had more social value than other projects.

In other words, the project could provide treatment for alcoholics, a project that had a teaching facility, that offered comprehensive health care, these were all desirable projects. And the special consideration feature became operative within the service area priority.

The program has been consistently administered that way, at least since I have been associated with it.

Senator KENNEDY. Can you give us any examples where these priorities for the poverty, either rural poverty or urban poverty areas, has been decisive factors in actually providing these facilities?

Dr. GRANING. A little later in the doctor's testimony we cite some instances, yes, sir.

Senator KENNEDY. How do you explain the situation in Kansas, for example, where you take 100 percent of the money that has been transferred from the outpatient facilities and put into inpatient facilities?

Dr. GRANING. As Dr. Endicott indicated, we have not had this report long enough to make an investigation, but should it turn out that the transfer was illegal, we would then ask the State agency to transfer the money back to outpatient category.

Senator KENNEDY. You must have some monitoring.

Do you wait until two Members of the Senate make these allegations and charges, and then ask GAO to do a report before you to make a determination?

Dr. GRANING. Sir, I can speak to one of them specifically, the reference to Delaware.

Senator KENNEDY. Do these transfers of funds actually happen which GAO alleged in their report? And if so, have you known it has been happening? If you have known it has been happening, what have you done to stop it?

Dr. GRANING. In the instance of Delaware, they transferred money to the hospital and public health center category. It actually went to public health centers that provided outpatient function.

The regional office in Philadelphia was well aware of what proposed use of this money was going to be, and it was to help build some facilities in the State of Delaware that do, indeed, provide outpatient services.

The same situation is true in Virginia. In Virginia public health centers do offer outpatient services. We would like to have an opportunity to make an investigation of the allegations in the GAO report.

Senator KENNEDY. What about all these others? Do you monitor yourselves to make sure these things do not happen in the Department?

Dr. GRANING. As the General Accounting Office report indicated, and as Dr. Endicott's testimony will indicate, in the discussions prior to enactment of the 1970 amendments, there were representations made before both the House and the Senate about the unnecessarily restrictive attributes of the law with reference to precluding transfers.

The 1970 amendments made very broad provisions for the conditions under which it would be permissible for States to transfer money. All States were permitted to transfer the minimum dollar allotment out of any category without any justification to HEW whatsoever. This was a $200,000 figure which the General Accounting Office representatives mentioned.

Thus, if someone transferred $200,000, the excess over $200,000 would be $30,000.

We would like to have an opportunity to check whether these transfers were made at the end of the period of availability of funds and find out whether there were, indeed, any applications pending.

If any States transferred money illicitly, it represents an error on the part of the regional office involved, and we would then ask the State agency to make restitution to transfer money back to outpatient services.

But, in terms of the many transfers that have been made, certainly the performance of the States has been consistently within the intent of the law and the regulations.

Senator KENNEDY. Well, it was a rather limited study on their part because of the time problems which we put upon them. Yet we have instance after instance where either 100 percent or 97 percent is being transferred out of the outpatient facility, in spite of what we have put in the legislation, to give a priority for rural and urban poverty areas.

I know you are trying to make a strong case for something that seems to be virtually indefensible. I am willing to try to be convinced or informed about it. However, I find it difficult to accept the fact that these transfers are actually being transferred to use for a similar kind of function in which the Congress had intended. I understand the principal thrust of your response, as illustrated by your Virginia example.

Dr. GRANING. It may be of interest to the subcommittee to know that, or to think about this in the perspective that we went from $20 million a year, which is funding level in 1969, to $70 million a year.

In terms of total moneys that have been transferred out of the category, outpatient category, for whatever reason, for 1974, 2 percent transferred; 1973, 4 percent; 1972, 27 percent; 1971, 30 percent.

The law, as passed by the Congress, specifically provides for situations under which it is permissible to transfer money out of categories. The State agencies confronted with situations in which they had no approvable applications for outpatient categories——

Senator KENNEDY. Don't you think it is rather interesting that they do not have any requests in poverty or rural poverty areas?

Do you feel any responsibility to try and help or reach out to try and stimulate some interest in these areas, or do you just channel these applications as they come through?

Dr. GRANING. I recall specifically, for instance, the State of Washington was looking forward to the enactment of 1970 amendments in

order that they could give 90 percent funding to freestanding outpatient facility that could not make it in any other way.

As has been indicated, there are problems in putting up the necessary matching funds. It also perhaps is useful to mention that if you were to take a look at the distribution of outpatient facilities in the United States in 1940, 1950, 1960, and 1970, you would find that most of the outpatient facilities are already located in urban communities and in that portion of urban community that is the lower social economic area. It is not an appropriate yardstick to appraise the utilization of funds solely on the basis of where do the outpatient facilities' dollars go, because modernization category has also been used to help modernize facilities in urban hospitals in innercity areas, and would not be eligible for additional outpatient facilities which is what the outpatient category provided for, but it would be eligible for modernization money.

Therefore, to appropriately appraise their stewardship, one should take a look at both utilization modernization money and outpatient money.

Senator KENNEDY. Could you review for us how you are set up to establish the poverty areas, and how you attempt to implement the provisions of the law since the time that the amendments were passed?

Dr. GRANING. The States were invited to identify and to rank poverty areas, and the lowest 20 percentile of the State would constitute that State's poverty area. This approach was taken because it was recognized the legislation stipulated that the State could, at its option, increase the Federal share to 90 percent, and it seemed reasonable to us to believe that the State would not increase the option unless it truly believed they were dealing with a poverty area.

We did not embrace the concept of identifying poverty areas on a national basis, recognizing the concept of poverty in Connecticut might be quite different than the concept of poverty in some other State.

So, our approach was that of giving the States an opportunity to rank poverty areas. The lowest 20 percentile would automatically be considered.

At the request of the State agency, the Secretary could concur in terms of designating an area as a poverty area that fell between the 20 and 30 percentile. The Bureau of the Census did not have information available to us on poverty areas until 1972, February.

The implementing regulations with the loan program, and so forth, came out in January 1972. However, this delay in getting designation of poverty areas was not actually a deterrent to the funding of the freestanding facilities, for the law made specific provision that the state could fund freestanding facilities at the percentage level where it was located. States were authorized to move ahead in terms of funding freestanding facilities. They could not use 90 percent funding mechanism for a hospital or for an outpatient facility associated with the hospital until they had designated poverty areas which was done immediately subsequent to distribution of poverty information from the Bureau of the Census in February 1972.

Dr. CAPER. I have a question for you.

The statute required special consideration be given to facilities in poverty areas. It did not require that the Department base determination of poverty areas on census data.

Yet, in September 1971, a memo originating from Health Care Facilities Service in HEW to the State Hill-Burton directors, stated that "We do not recommend State agencies use 1960 census data"—this is, for determination of poverty areas—

> Therefore, state agencies will not be required to designate poverty areas in state plans until after family income data based on the 1970 census are published by the Bureau of the Census and made available to state agencies through this office.

What justification was there for essentially delaying the designation of poverty areas until the census data became available since census data was not required?

Dr. GRANING. I appreciate your asking that question, because the work involved in the computation of poverty areas was very extensive, and the known migration from rural to urban areas in the decade between 1960 and 1970, and the impact that this had on the distribution of poverty areas within a State, was such that if a State had gone through all of that work and then started using 1960 information, it would not be in the public interest, at least we did not think it would be in the public interest. And since we knew that freestanding facilities could be funded anyway, we indicated that it would be more appropriate to wait from September of 1971 to February of 1972 to get this new data.

Now, the sudden influx of outpatient fund money, as compared to previous years, put the States in a situation where they had ample amount of money for funding operations, that came in from outpatient categories. We have been saying consistently, in fact we had occasion to query States recently, and they insist that they have not disapproved at any time any application otherwise approvable for an outpatient facility.

It may be of use to mention that in terms of the emphasis on outpatient facilities at the present time, of the 245 facilities that have been constructed or modernized by Hill-Burton program in fiscal 1974, 133 were ambulatory in character. This represents 54 percent.

Mr. Chairman, some of these matters are contained in Dr. Endicott's statement.

Senator KENNEDY. Fine, please continue.

Dr. ENDICOTT. Federal share of project costs for outpatient facilities in poverty areas:

The 1970 amendments provided that a State agency may, at its option, increase the Federal rate of participation up to 90 percent in the case of projects for interfacility cooperation, projects providing services primarily for persons in a rural or urban poverty area, and projects for the construction or modernization of freestanding outpatient facilities.

As the GAO report had indicated, the necessary 1970 census data for the computation of poverty areas did not become available from the Department of Commerce until February 1972 and, accordingly, the States were unable to utilize that data source for making poverty area determinations until that time.

Since this 1970 provision has been in effect, a total of 91 projects have received an additional Federal incentive share with 51 of these projects in rural or urban poverty areas and 28 for the construction

or modernization of freestanding outpatient or ambulatory care facilities. The remaining 12 projects were for interfacility cooperation.

Senator KENNEDY. Before you continue on, can you tell us how many of those serve poverty populations?

Dr. ENDICOTT. Fifty-one. We could supply a list of them for the record.

Senator KENNEDY. Do all of the projects in poverty areas serve just poverty people?

Dr. ENDICOTT. Yes, sir.

Senator KENNEDY. I would be interested in more definitive figures.

Dr. ENDICOTT. Yes. We will furnish them.

[The information referred to and subsequently supplied follows:]

Hill-Burton Projects Approved by States for Incentive Financing
(Increased Federal Share) as of July 1974

State	Proj. No.	Name of Project	Location	Total Cost	H-B Share	Type of Facility	Type of Incentive Financing: Poverty Area	Ambulatory Facility	Interfacility Cooperation
Ariz.	130	Marana Comm Clinic	Marana	$ 282,469	$ 222,000	Outpatient Fac	-	1	-
Colo.	M/153	Las Animas Co PHC	Trinidad	1,041,152	717,616	Public Hlth Ctr	1	-	-
Del.	37	Edward Pyle Service Ctr	Balti Hundred	65,476	34,000	Outpatient Fac	1	-	-
Del.	38	DeLaWarr Service Ctr	New Castle	71,476	46,000	Outpatient Fac	1	-	-
Fla.	T36	E. Jacksonville Clinic	Jacksonville	120,600	90,000	Outpatient Fac	1	-	-
Fla.	T39	Immokalee Hlth Care Ctr	Immokalee	708,160	575,000	Outpatient Fac	-	1	-
Fla.	T49	Comm Health Clinic	Jacksonville	110,400	90,000	Outpatient Fac	1	-	-
Hawaii	A/69	Kahuku Hosp	Kahuku	1,645,665	1,478,098	Gen Hosp & LTC Unit	1	-	-
Ill.	301	Garfield Park Comm Hosp	Chicago	309,035	261,875	Outpatient Fac	1	-	-
Ill.	303	Englewood Neighbhd HC	Chicago	342,237	240,000	Outpatient Fac	-	1	-
Ill.	313	Provident Hosp	Chicago	55,615	40,000	Outpatient Fac	1	-	-
Ill.	314	Ill Dept PH Hosp Cl	Chicago	54,683	49,215	Outpatient Fac	1	-	-
Ill.	317	UMWA Union Hosp	W. Frankfort	319,852	248,968	Outpatient Fac	1	-	-
Ill.	319	St Bernards Hosp	Chicago	7,402,072	1,128,849	General Hosp	1	-	-
Ill.	A/320	Provident Hosp	Chicago	22,537,418	5,868,362	Gen Hosp & OP Fac	1	-	-
Ill.	328	Christian Welfare	East St. Louis	226,413	203,772	General Hosp Fac	1	-	-
Ill.	332	Canteen Sub-Center	East St. Louis	689,364	620,428	Public Hlth Ctr	1	-	-
Ill.	333	Centerville Sub-Center	East St. Louis			Public Hlth Ctr	1	-	-

State	Proj. No.	Name of Project	Location	Total Cost	H-B Share	Type of Facility	Type of Incentive Financing		
							Poverty Area	Ambulatory Facility	Interfacility Cooperation
Ill.	335	Eurma Hayco Neighborhood HC	Carbondale	85,543	76,989	Outpatient Fac	-	1	-
Ill.	336	Metro E. HC	East St. Louis	1,710,000	926,827	Outpatient Fac	1	-	-
Ill.	341	Christian Action Min	Chicago	3,536,000	2,272,430	LTC & Outpatient Fac	1	-	-
Iowa	176	Neighborhood Hlth Ctr	Des Moines	566,000	378,498	Outpatient Fac	1	-	-
Iowa	183	Univ Hosp & Clinics	Iowa City	662,000	557,460	Outpatient Fac	1	-	-
La.	M162	Charity Hosp of La.	New Orleans	4,105,012	3,039,462	Outpatient Fac	-	-	1
La.	A722	Earl K.Long Mem Hosp	Baton Rouge	1,000,000	900,000	Outpatient Fac	-	1	-
Md.	178	Somerset Co HC	Princess Anne	555,000	305,330	Outpatient Fac	1	-	-
Md.	179	E. Baltimore St Clinic	Baltimore	588,173	385,000	Outpatient Fac	1	-	-
Mass	478	Charles Drew Family Ctr	Boston	1,170,000	1,053,023	Outpatient Fac	1	-	-
Mass	475	Howard Comm Hlth Plan	Boston	382,529	344,276	Outpatient Fac	-	1	-
Mass	474	Allston Brighton HC	Allston	253,963	228,567	Outpatient Fac	-	1	-
Mass	476	Cerebral Palsy S. Shore	Quincy	220,480	184,700	Rehabilitation Fac	-	-	1
Mich.	A226	Sidney Sumby Mem Hosp	River Rouge	1,030,725	730,725	General Hosp	1	-	-
Mich.	249	Menominee Co. Aux PHC	Minominee	175,000	105,000	Outpatient Fac & PHC	-	1	-
Mich.	250	Delray Comm HC	Detroit	1,047,300	578,288	Outpatient Fac	-	1	-
Mich	D/246	Berrien Co Prev Med Ctr	Benton Harbor	222,000	122,000	Public Hlth Ctr	-	1	-
Mich	251	New Ctr Medical Plaza	Detroit	217,000	195,000	Outpatient Fac	-	1	-
Mo.	F244	Murphy Blair Nghbrhd HC	St. Louis	448,078	372,673	Outpatient Fac	-	1	-
Nev.	36	Humboldt Co Gen Hosp	Winnemucca	1,406,834	886,706	General Hosp	1	-	-
Nev.	37	Lincoln County Hosp	Caliente	803,841	462,063	General Hosp	1	-	-
N.H.	80	Memorial Hosp	N. Conway	2,602,807	1,000,000	General Hosp	1	-	-
N.H.	G77	Linwood Med Ctr	Lincoln	293,463	232,920	Outpatient Fac	-	1	-

State	Proj. No.	Name of Facility	Location	Total Cost	H-B Share	Type of Facility	Type of Incentive Financing: Poverty Area	Ambulatory Facility	Interfacility Cooperation
N.J.	7227	Kretchmer Nghbrhd HC	Newark	500,000	410,000	Outpatient Fac	1	-	-
N.J.	7215	Jersey City Comm HC	Jersey City	1,650,000	483,840	Outpatient Fac	1	-	-
N.J.	7214	Mercer Med Ctr	Trenton	40,000	30,000	Outpatient Fac	1	-	-
N.J.	7217	American Lgn Nghbrhd HC	Newark	569,926	490,451	Outpatient Fac	-	1	-
N.J.	7229	United Cerebral Palsy	Long Branch	133,030	100,000	Rehabilitation Fac	-	1	-
N.J.	7230	Plainfield Nghbrhd HC	Plainfield	101,964	89,347	Outpatient Fac	-	1	-
N.J.	7222	Raphael Meadow PHC	Mt Holly	274,247	130,700	Public Health Ctr	-	1	-
N.J.	7213	Salem Co Health Dept	Woodstown	18,000	16,200	Outpatient Fac	-	-	1
N.J.	7226	Cooper Hosp	Camden	140,000	126,000	Outpatient Fac	-	-	1
N. Mex.	A133	Dr. J. I.Dunham Mem Cl	Chama	263,432	237,089	Outpatient Fac	1	-	-
N. Mex.	A128/128	Holy Cross Hosp	Taos	230,000	210,000	Gen Hosp & OP Fac	1	-	-
N. Mex.	135	Las Vegas Hosp	Las Vegas	295,000	265,500	General Hosp	1	-	-
N. Mex.	E137	Espanola Hosp	Espanola	459,407	413,466	General Hosp	1	-	-
N. Mex.	138	La Clinica del Pueblo	Tierrica Amarilla	40,000	36,000	General Hosp	1	-	-
N. Mex.	102	Taos County PHC	Taos	144,544	72,014	Public Health Ctr	-	1	-
N.Y.	390	Westside Hlth Services	Rochester	439,440	125,418	Outpatient Fac	1	-	-
N.Y.	394	N.Y. Med College Hosp	New York	495,000	245,000	Outpatient Fac	1	-	-

State	Proj. No.	Name of Project	Location	Total Cost	H-B Share	Type of Facility	Type of Incentive Financing: Poverty Area	Ambulatory Facility	Interfacility Cooperation
Ohio	398	Liberty Ctr Migrant HC	Liberty Center	506,476	455,827	Outpatient Fac	1	-	-
Ohio	401	West End Health Ctr	Cincinnati	830,001	540,000	Outpatient Fac	1	-	-
Ohio	402	Winton Hills Med HC	Cincinnati	487,460	438,715	Outpatient Fac	1	-	-
Ohio	344	Cincinnati Gen Hosp	Cincinnati	3,000,000	2,105,605	Outpatient Fac	1	-	-
Ohio	404	Childrens Med Ctr	Dayton	1,160,268	500,000	Outpatient Fac	-	-	1
Ohio	399	Brown Co Gen Hosp	Georgetown	719,477	295,561	Outpatient Fac	-	-	1
Ohio	390	E. Side Ambulatory Care Ctr	Cleveland	3,921,741	1,000,000	Outpatient Fac	-	-	1
Ore.	155	Wheeler Co Med Ctr	Fossil	137,035	100,000	Outpatient Fac	1	-	-
Pa.	750	Evelyn G. Frederick HC	Millersburg.	1,608,500	812,000	Outpatient Fac	1	-	-
S. C.	320	Williamsburg Co OP Fac	Hemingway	650,000	553,500	Outpatient Fac	1	-	-
S.C.	A133	Saluda Co Nrsng Home	Saluda	126,483	109,242	Nursing Home	1	-	-
S.C.	231	Mc Cormick PHC	Mc Cormick	206,000	180,000	Public Health Ctr	-	1	-
Tex.	575/D/M575	Starr Co Mem Hosp	Rio Grande	1,875,000	1,375,000	Gen Hosp & OP Fac	1	-	-
Tex.	D599	Rio Grande Radiation	McAllen	1,380,168	934,342	Outpatient Fac	1	-	-
Tex.	D600	Mc Allen Gen	McAllen	167,200	150,480	Outpatient Fac	1	-	-
Tex.	M/613	Mercy Hosp	Laredo	850,000	765,000	Gen Hosp	1	-	-
Tex.	596	Maverick Co Hosp	Eagle Pass	204,021	183,619	Gen Hosp	-	-	1
Tex.	D/596	Maverick Co Hosp	Eagle Pass	141,879	127,691	Outpatient Fac	-	-	1
Vt.	45	Island Pond Med Ctr	Island Pond	5,420	4,878	Outpatient Fac	-	1	-
Wash.	139	Pend Oreille Co PHC	Newport	298,317	252,900	Public Hlth Ctr	1	-	-
Wash	144	Mid Valley Hosp	Omak	513,008	432,000	Gen Hosp	-	-	1
W. Va.	D/127	Gilmer Co PHC Clinic	Glenville	814,733	733,260	PHC & Outpatient Fac	-	1	-
W. Va.	A/129	Clay Co PHC	Clay	761,280	685,152	Public Hlth Ctr	-	1	-

State	Proj. No.	Name of Project	Location	Total Cost	H-B Share	Type of Facility	Type of Incentive Financing: Poverty Area	Ambulatory Facility	Interfacility Cooperation
Wis.	198	St Anthonys Hosp	Milwaukee	2,115,900	1,000,000	Outpatient Fac	1	-	-
Wis.	197	Mt Sinai Medical Ctr	Milwaukee	1,937,593	748,000	Outpatient Fac	-	-	1
Am Samoa	1	Comm Hlth Service Disp	Aunuiu, Olosega, Swains	136,304	90,870	Outpatient Fac	-	1	-
Am Samoa	3	Leone, Tai, Ofu Disp	Leone, Tai, Ofu	299,376	66,528	Public Hlth Ctr	-	1	-
Guam	8	Agat Aux PHC, Merizo Aux PHC Piti Aux PHC, Talofofo Aux PHC Yona Aux PHC	Agat, Merizo, Piti, Talofofo, Yona	253,000	227,700	Public Hlth Ctr	1	-	-
Guam	7	Santa Rita Aux PHC	Santa Rita	48,000	32,000	Public Hlth Ctr	-	1	-
Guam	9	Northern Area HC	Dededo	955,225	900,000	Outpatient Fac	-	1	-
P.Rico	307	Luquillo Outpatient Fac	Luquillo	1,384,466	691,087	Outpatient Fac	-	1	-
P.Rico	308	Rio Piedras OP Fac	Rio Piedras	4,125,062	700,000	Outpatient Fac	-	-	1
Tr. Terr.	1	Outpatient Facilities	Saipan	1,634,380	1,471,949	Outpatient Fac	-	1	-

December 11, 1974
Program Planning and Evaluation Branch
Division of Facilities Utilization

Dr. ENDICOTT. Need for outpatient facilities:

The GAO report discussed at some length the need for outpatient facilities, how the need for outpatient facilities was determined, and how the need variation varied among the several States surveyed.

Without discussing the details of the problem at length, I would simply like to say that while national need determinants exist for acute care beds and long-term care beds, such specific national determinants for ambulatory care facilities are presently not in use by the Hill-Burton program. Rather, we have, up to now, permitted the States to develop, with our approval, ambulatory care need determinants. We are currently developing national criteria for the determination of ambulatory care needs.

Senator KENNEDY. Why has it taken 3 years to do that, Doctor?

Dr. ENDICOTT. Dr. Graning, would you like to answer that question?

Dr. GRANING. The matter of determining outpatient facility needs is a very complex problem. Obviously, one of the primary purposes of an outpatient facility, as we think of it today, is that of providing primary care. It also, however, serves a very useful function for physicians located near the hospital—it is more economical to utilize the hospital services laboratory, physical therapy, dietary counseling, and so forth, than to admit the patient.

The need for outpatient facility, then, is a mix between the services that the hospital is going to provide on requests to the physician who refers the patient over for specific services and the needs that the hospital is going to provide in terms of carrying primary care capacity.

We know certain things to be true. For instance, an area that has a high population density, has a greater need for outpatient facilities than one that does not. We know that the low socioeconomic levels have a higher need for outpatient facilities than those who have a higher socioeconomic level.

The availability of physicians in the area, and whether they are currently housed in their own offices or whether the community is seeking health care in trying to attract doctors who will come and work in the hospital with offices provided nearby, are all a part of the problem.

States have used varying methodologies, and it is also finally, I might make the remark, that it is only recently that outpatient facilities have been a reasonably self-supporting entity as far as hospital operations are concerned.

For many years, the hospital department lost money, and now hospitals are, to an increasing degree, contracting with physicians for providing primary care services around the clock, creating a walk-in type clinic with doctors who are there and provide services 7 days a week.

It is going to be a difficult thing to try to establish national criteria for appraising outpatient needs.

Senator KENNEDY. Why did you have to wait for 3½ years to get the study going with that other group in Cambridge?

Dr. GRANING. Sir, there really has been no evidence submitted to the effect that the States have not evolved methodologies which are appropriate for their State.

Senator KENNEDY. Then why are you wasting money in doing the other study?

Dr. GRANING. Because we are anticipating that it is quite possible that the Congress may wish to have money specifically targeted for these types of facilities, and limited to that, and if it becomes available on a project grant basis nationally, then this adds a new dimension to the problem. And we would like to have more definitive rationale for decisionmaking.

Dr. ENDICOTT. Mr. Chairman, it seems that even though the task is difficult, it is one which must be addressed and one which we are addressing, perhaps belatedly.

Outreach and technical assistance:

The GAO report correctly notes that HEW and the States have no formal outreach program to encourage the construction or modernization of outpatient facilities in poverty areas.

Also, we do not have formal outreach programs for any of the other six types of projects cited for special consideration; however, we do recognize the unique need for an outreach effort in poverty areas. We feel there is much that can be done without additional statutory authority and within the confines of the existing budgetary constraints.

We envision an outreach program as part of whatever health facilities construction assistance program may be enacted into law. We feel that any outreach effort should be two-tiered in nature—a Federal component to disseminate information on the availability of funds, and an areawide health planning agency component utilizing such agencies to provide technical assistance to potential applicants in local communities.

Transfer of funds of the outpatient category:

The GAO had correctly indicated that "State agencies, with HEW approval, have transferred a substantial amount of funds out of the outpatient category."

As the committee recalls, the question of the conditions under which States could transfer funds among the five categories was discussed at length at the time of the 1970 amendments. Paraphrased, the existing law permits transfer among the categories under the following two conditions:

First, all States may without HEW concurrence transfer out of any category the minimum allotment of that particular category; for example, $100,000 from rehabilitation facilities, $200,000 from outpatient facilities, and $300,000 from each of the categories long-term care, modernization and the construction of hospitals and public health centers.

Second, States may request that portions of any allotment, except the rehabilitation category, be transferred to any other allotment, except the allotment for the construction of hospitals and public health centers. If the money is to be added to any allotment other than hospitals and public centers, the State must provide "simultaneous certification" to the Secretary that it has afforded a reasonable opportunity to make applications for the portion so specified and there have been no approval applications for such portions—there have been no approved applications for such, that should be approvable application for such portion.

If the request involves transfer to the hospital and public health center category, the State must certify that such use would better carry out the purposes of the title.

Finally, there is an additional provision that entitles the State to transfer money from modernization to the hospitals and public health center category providing the need for hospitals or public health centers "is substantially greater than the need for modernization."

As far as the existing program is concerned we agree with the GAO report and intend to prohibit transfers of such funds from the outpatient category for the first 18 months of the availability of the funds. This would constitute a reasonable opportunity to make applications for the portion so specified. Also, it must be shown that there have been no approval applications in any specific categories. Further, we are considering that States demonstrate that efforts have been made to seek out all qualified applicants.

Senator KENNEDY. How are you going to do that?

Dr. ENDICOTT. Would you like to comment on that, Mr. Rubel?

Mr. RUBEL. What we have proposed here, and which we intend to promulgate in regulations immediately, is to put some teeth behind the provisions that exist in law but really have never been exercised.

States have been able to transfer funds perfectly legally, although we have heard from the GAO that apparently some transfers were not proper, from category to category.

The regulations that we do intend to promulgate would force the State to demonstrate actually going down the road of ensuring that there are no applicants, for example in outpatient facilities, before they are allowed to transfer the funds.

This would be an entire new activity that we have not undertaken to date.

Dr. ENDICOTT. Reasonable volume of free care—as the GAO report indicated, the Hill-Burton Act requires that regulations be issued by HEW which:

> * * * may require that before approval of any application for a hospital or addition to a hospital is recommended by a State agency, assurance shall be received by the State from the applicant that, * * *, (2) there will be made available in each such hospital or addition to a hospital a reasonable volume of hospital services to persons unable to pay therefor, but an execption shall be made if such a requirement is not feasible from a financial standpoint.

The latest definitive regulations on the subject were issued in July 1972 with an effective facilities compliance date of November 4, 1972. All facilities which have received grant assistance are subject to the free service requirement for a 20-year period, while those receiving direct loans and loan guarantees assistance are subject to the provisions for a period of time equal to the repayment time of the loan.

The regulations provide that the reasonable volume of free services requirement could be met by facilities by (1) offering free or below-cost services in an amount which is not less than the lesser of 3 percent of operating cost, after deducting Medicare and Medicaid reimbursements, or 10 percent of total Federal assistance received, or (2) certifying that free or below cost services would not be refused to any person regardless of their ability to pay the so-called open door option.

For the committee's special and appropriate interest in this area, we would like to submit for the record a State-by-State tabulation of the options selected by Hill-Burton assisted hospitals.

The GAO report states that "none of the State agencies had an active program for monitoring compliance with the requirements. Most States intend to rely on complaints to monitor compliance."

As a matter of information, all Hill-Burton assisted hospitals are presently obligated to report to the State Hill-Burton agency the extent to which they have provided uncompensated care to persons unable to pay.

However, we intend to develop what we believe will be a satisfactory monitoring mechanism to assure compliance with this requirement.

I would like to add that precisely how you want to take this will depend to some extent on the legislation which is enacted, the organizational requirements, both in the States and at the headquarters which would flow from this legislation.

So precisely how we will do this I cannot say at the moment, except that we have every intention to do so.

Mr. Chairman, we would like to conclude our formal remarks with the belief that our aforementioned proposed changes can lead to overcoming the problems outlined in the GAO report. We further look forward to working cooperatively with this committee toward the elimination of the problems cited in this report.

I think, Mr. Chairman, that is the end of the report. I think that general problem in our society which has not really been satisfactorily resolved.

There are indeed several classes of patients. Additionally, they have received different quality of care, the arrangements under which the care has been provided have been less than satisfactory, and it is rather frustrating to enact legislation directed at helping the situation only to find that it does not work out quite the way one had hoped.

I suppose we can and will make some improvements on the facility side, but I cannot escape the personal view that until we resolve the basic problem of ability to pay for services, that somehow our efforts, whatever they may be, may go awry to some extent.

Senator KENNEDY. How do you intend to monitor the free service requirement to be sure that it is not a device to charge off bad debts services to meet those requirements?

Dr. ENDICOTT. Of course, the most obvious approach is to require, as we do, financial reporting.

This can, of course, be backed up by audit, and within the limitations of sources available for audit we can pursue this course.

In terms of really satisfactory monitoring, I suspect that we probably need to go beyond fiscal audit, and to attempt on the spot program audit, which is more difficult, and requires rather expensive type personnel.

One problem which seems at the moment most difficult to monitor is the hospital which chooses what it says is an open door policy. The question then presents itself as to how one determines that indeed there is an open door, and that there are not subtle or not so subtle ways in which the door is not really all that open.

I think probably to some extent we are going to have to feel our way forward here. It is my view that if we have, as a result of the new legislation, well-staffed, aggressive, knowledgeable regional planning bodies that are hopefully on top of a whole problem of the delivery of health services, perhaps our greatest monitoring strength will really be found in those organizations, and of course, in our ability to monitor them.

Senator KENNEDY. OK. Yes, Dr. Graning?

Dr. GRANING. Mr. Chairman, something that Dr. Endicott just mentioned reminded me of something that might be of interest to the subcommittee.

We have been concerned about the fact that a hospital might take the open-door policy and keep it a deep secret, and so at the last meeting of the Federal Hospital Council on November 12, they have expressed an interest in having hospitals post notices in the admissions office and in the emergency room, indicating that the hospital is participating in a program which will provide a reasonable amount of care to persons unable to pay.

The council also recommended revision of regulations to implement the Corum decision which was a ruling by the court that invalidated a provision that permitted submittal of a bill and subsequent determination of ability to pay. The new approach to this will be that in most instances the hospital will make a determination prior to provision of service as to whether the person is or is not able to pay. Care may be given and subsequently be determined as eligible for consideration as uncompensated care when provided in emergency rooms or given to patients who cannot or did not give correct information or to patients whose health care costs prove to be much higher than they can afford.

You will note from the tabulation that you received that most hospitals in the United States for which we have reports have taken the open-door policy. There was some unfortunate misinterpretation of a notice in the Federal Register for June 22, 1973. It relieved the open-door option people from the requirement, as far as reasonable volume is concerned, for submitting a budget. Some thought they would not have to submit the dollar level of uncompensated care to the State agency.

It is not true, as was alleged earlier this morning, that the open-door option in hospitals do not report to the State agencies.

The regulations do provide that they shall submit, as does every other hospital, a report at the end of the year in terms of actual uncompensated dollar value.

Senator KENNEDY. Do the regulations require that they publish such a report, or provide it to the hospitals that are going to have open-door policies?

Dr. GRANING. All hospitals participating will have notices that they are participating.

Senator KENNEDY. They will be required to do so?

Dr. GRANING. Yes, sir.

Dr. ENDICOTT. Mr. Chairman, Mr. Rubel has a comment that he would like to offer at this point.

Mr. RUBEL. I have been associated with the Hill-Burton program a short time. But I would like to observe that we not only look backward, but try to look forward as well.

We do anticipate enactment of new legislation, and hopefully we can get our articulation into the law provisions, such that 3 or 4 years from now we are not sitting here again. We are not so sure that the bills that are pending take care of these problems to the maximum extent, but we certainly would be delighted to work with you and your staff to insure that we do come out with a clearly articulated statement that can guide us. We recognize that as long as we are operating

within a State program and within the traditional Hill-Burton program, which was enacted in such a way that the Secretary or the then Surgeon General would have minimal authority over the operations of the program, that we are going to run into problems.

We would prefer a more direct Federal program which would give us much greater control in that type of situation.

Senator KENNEDY. Thank you very much.

[The prepared statement of Dr. Endicott follows:]

FOR RELEASE ONLY UPON DELIVERY

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

STATEMENT

OF

DR. KENNETH M. ENDICOTT

ADMINISTRATOR

HEALTH RESOURCES ADMINISTRATION

BEFORE THE

SUBCOMMITTEE ON HEALTH

COMMITTEE ON LABOR AND PUBLIC WELFARE

UNITED STATES SENATE

MONDAY, NOVEMBER 25, 1974

Mr. Chairman and Members of the Subcommittee:

Mr. Speaker, we welcome the opportunity to appear before you today to report on the administration of the Hill-Burton Program and to discuss with you the observations made recently by the special report of the General Accounting Office on the Hill-Burton Program, which was presented to you on September 25, 1974.

We look forward to a discussion of the conclusions of this document, believing that it can be of great assistance to us in the administration of the existing Hill-Burton Program, as well as providing guidance for the development of program procedures for any new successor program, which may be enacted into law. With this in mind, as we discuss the specific observations of the special GAO report, we shall provide our recommendations with respect to what changes we will make administratively.

Since the special GAO report on the Hill-Burton Program has been available to us only a few days, we have not formulated completely all of our proposed modifications and recommendations. These outstanding changes will be supplied later for the record.

THE EXISTING PROGRAM AND RECOMMENDATIONS FOR CHANGE

Before addressing the specific comments of the Special GAO Report, we would like to reiterate the Administration's position in respect

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to the kind of health facility construction assistance role that should be played by HEW.

The original enactment of Hill-Burton was based on the desire to increase the number of and to better distribute hospital beds. In 1946, while the eight States with the highest income had 4.0 beds per 1000 population, there were only 2.5 beds per 1000 population in the eight States with the lowest income. Today, this imbalance has been corrected and, indeed, the facilities in the poorer States are, on the average, newer facilities. Today the need is not for additional beds and hospitals but for the modernization, including replacement, of existing hospitals and for increased ambulatory care facilities.

As contained in our proposal to the Committee, presented on June 14, 1974, we would recommend that the program be limited to project grants for high risk health facilities and that such grants be further limited to the modernization or replacement of public or other nonprofit hospitals and the construction or modernization of ambulatory care facilities. That proposal further called for cost-sharing by the States in the support of such construction projects, and required all participating medical facilities to adopt reforms in the manner in which they finance future modernization and renovation.

At this time I would like to address some of the specific GAO report comments.

SPECIAL CONSIDERATION TO OUTPATIENT FACILITIES IN POVERTY AREAS

The special GAO report discusses the extent to which special consideration is given to projects for the construction or modernization of outpatient facilities in poverty areas. Section 603(a) of the Hill-Burton statute requires that special consideration be given to any project meeting one or more of seven characteristics enumerated. One of these seven is for "projects for construction or modernization of outpatient facilities, to any outpatient facilities that will be located in and provide services for residents of, an area determined by the Secretary to be a rural or urban poverty area".

Since the beginning of the program in 1946, and continuing through the 1970 amendments, the phrase "special consideration" has been interpreted to mean that when two or more applications are received from the same service area or from two service areas with the same relative priority, then project applications containing one or more of the seven characteristics should be given preference over those that do not. Traditionally, priority status has been determined on the basis of comparing the relative needs of different service areas for specific types of facilities. Need determinations for outpatient facilities are prepared by each State as no adequate national criteria have yet been developed. Often need determinations are made on the basis of facility to population ratios. Thus, it is possible and would be consistent with the intent of the legislation that a new and growing suburban community without outpatient facilities could be granted a priority status over an inner city area serviced by a large

municipal hospital even though the demand for outpatient services is greatest in the latter case. The committee may be interested in a DHEW Office of General Counsel opinion on our interpretation of special consideration which we would like to submit for the record.

In addition to the lack of adequate national criteria to determine outpatient needs, a project application that incorporates more than one of the seven characteristics mentioned earlier is considered more desirable than an application containing only one. In this way an application from a poverty area with only one need or with only enough matching funds to support one general service might be preempted by a multiservice proposal from a non-poverty community having an equal relative need to a poorer community.

We believe that the Administration's proposal for a targeted project grant program, limited to modernization of existing inpatient facilities and modernization and construction of ambulatory facilities in medically underserved areas, would sufficiently narrow the range of projects that would have priority status, thereby eliminating the biases that currently exist in the Hill-Burton program.

FEDERAL SHARE OF PROJECT COSTS FOR OUTPATIENT FACILITIES IN POVERTY AREAS

The 1970 amendments provided that a State Agency may, at its option, increase the Federal rate of participation up to 90 percent in the case of projects for interfacility cooperation, projects providing services primarily for persons in a rural or urban poverty area, and projects

for the construction or modernization of free-standing outpatient facilities. As the GAO report had indicated, the necessary 1970 census data for the computation of poverty areas did not become available from the Department of Commerce until February 1972 and, accordingly, the States were unable to utilize that data source for making poverty area determinations until that time.

Since this 1970 provision has been in effect, a total of 94 projects have received an additional federal incentive share with 55 of these projects in rural or urban poverty areas and 26 for the construction or modernization of free-standing outpatient or ambulatory care facilities. The remaining 13 projects were for interfacility cooperation.

NEED FOR OUTPATIENT FACILITIES

The GAO report discussed at some length the need for outpatient facilities, how the need for outpatient facilities was determined, and how this need determination varied among the several States surveyed. Without discussing the details of the problem at length I would simply like to say that while national need determinants exist for acute care beds and long term care beds such specific national determinants for ambulatory care facilities are presently not in use by the Hill-Burton Program. Rather, we have up to now permitted the States to develop, with our approval, ambulatory care need determinants. We are currently developing national criteria for the determination of ambulatory care needs.

OUTREACH AND TECHNICAL ASSISTANCE

The GAO report correctly notes that HEW and the States have no formal outreach program to encourage the construction or modernization of outpatient facilities in poverty areas. Also, we do not have formal outreach programs for any of the other six types of projects cited for special consideration; however, we do recognize the unique need for an outreach effort in poverty areas. We feel there is much that can be done without additional statutory authority and within the confines of the existing budgetary constraints. We envision an outreach program as part of whatever health facilities construction assistance program may be enacted into law. We feel that any outreach effort should be two-tiered in nature: a federal component to disseminate information on the availability of funds; and an areawide health planning agency component utilizing such agencies to provide technical assistance to potential applicants in local communities.

TRANSFER OF FUNDS OF THE OUTPATIENT CATEGORY

The GAO had correctly indicated that "State agencies, with HEW approval, have transferred a substantial amount of funds out of the outpatient category." As the committee recalls, the question of the conditions under which States could transfer funds among the five categories was discussed at length at the time of the 1970 amendments. Paraphrased, the existing law permits transfer among the categories under the following two conditions:

1. All States may without HEW concurrence transfer out of any category the minimum allotment of that particular category; i.e., $100,000 from rehabilitation facilities, $200,000 from outpatient facilities, and $300,000 from each of the categories long term care, modernization and the construction of hospitals and public health centers.
2. States may request that portions of any allotment, except the rehabilitation category, be transferred to any other allotment, except the allotment for the construction of hospitals and public health centers. If the money is to be added to any allotment other than hospitals and public centers, the State must provide "simultaneous certification" to the Secretary that it has afforded a reasonable opportunity to make applications for the portion so specified and there have been no approval applications for such portions. If the request involves transfer to the hospital and public health center category, the State must certify that such use would better carry out the purposes of the title. Finally, there is an additional provision that entitles the State to transfer money from modernization to the hospitals and public health center category providing the need for hospitals or public health centers "is substantially greater than the need for modernization."

As far as the existing program is concerned we agree with the GAO report and intend to prohibit transfers of funds from the outpatient category

for the first 18-months of the availability of the funds. This would constitute a reasonable opportunity to make applications for the portion so specified. Also, it must be shown that there have been no approval applications in any specific categories. Further, we are considering that States demonstrate that efforts have been made to seek out all qualified applicants.

REASONABLE VOLUME OF FREE CARE

As the GAO report indicated, the Hill-Burton Act requires that regulations be issued by HEW which:

> "* * *may require that before approval of any application for a hospital or addition to a hospital is recommended by a State Agency, assurance shall be received by the State from the applicant that, * * *, (2) there will be made available in each such hospital or addition to a hospital a reasonable volume of hospital services to persons unable to pay therefor, but an exception shall be made if such a requirement is not feasible from a financial standpoint."

The latest definitive regulations on the subject were issued in July 1972 with an effective facilities compliance date of November 4, 1972. All facilities which have received grant assistance are subject to the free service requirement for a 20-year period, while those receiving direct loans and loan guarantees assistance are subject to the provisions for a period of time equal to the repayment time of the loan. The regulations provide that the reasonable volume of free

services requirement could be met by facilities by (1) offering free or below cost services in an amount which is not less than the lesser of 3 percent of operating cost (after deducting Medicare and Medicaid reimbursements) or 10 percent of total Federal assistance received, or (2) certifying that free or below cost services would not be refused to any person regardless of their ability to pay (open door option).

For the committee's special and appropriate interest in this area we would like to submit for the record a State-by-State tabulation of the options selected by Hill-Burton assisted hospitals.

The GAO report states that "none of the State Agencies had an active program for monitoring compliance which the requirements. Most States intend to rely on complaints to monitor compliance." As a matter of information, all Hill-Burton assisted hospitals are presently obligated to report to the State Hill-Burton Agency the extent to which they have provided uncompensated care to persons unable to pay. However, we intend to develop what we believe will be a satisfactory monitoring mechanism to assure compliance with this requirement.

Mr. Chairman, we would like to conclude our formal remarks with the belief that our aforementioned proposed changes can lead to overcoming the problems outlined in the GAO report. We further look forward to working cooperatively with this committee towards the elimination of the problems cited in this report.

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY

OFFICE OF THE GENERAL COUNSEL

ATTACHMENT 1

TO : Harald M. Graning, M.D.
Director, Division of
Facilities Utilization, HRA

DATE: November 18, 1974

FROM : Sidney Edelman
Assistant General Counsel
for Public Health

SUBJECT: Hill-Burton--Senate Report Comments on Section 603(a) of Public Health Service Act--Meaning of Term "Special Consideration"

You have requested our advice on comments contained in Senate Report No. 93-1285[1/] concerning the implementation of section 603 of the Public Health Service Act, particularly with respect to outpatient clinics. Section 603 provides in pertinent part:

> "The Surgeon General ... shall by general regulations prescribe - (a) the general manner in which the State agency shall determine the priority of projects based on the relative need of different areas lacking adequate facilities of various types for which assistance is available under this part, giving special consideration --
>
> "(4) in the case of projects for construction or modernization of outpatient facilities, to any outpatient facility that will be located in, and provide services for residents of, an area determined by the Secretary to be a rural or urban poverty area ... " (Emphasis added.)

The Committee comment (p. 60) reads as follows:

> "First of all, the Department has failed to effectively carry out the intent of this Committee in giving priority assistance to ambulatory care facilities in medically underserved areas. ... The Committee does not view these actions as being consistent

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1/ Committee on Labor and Public Welfare, "National Health Planning and Health Facilities Development Act of 1974."

> with the intent of Congress, which was clearly spelled out in the 1970 Hill-Burton amendments and the legislative history associated with those amendments.
>
> For that reason, the proposed legislation reemphasizes the intent of the Committee that priority be given to the construction or modernization of outpatient facilities that will serve residents of an area determined by the Secretary to be an urban or rural poverty area."

From the above quotation, it appears that the Committee considers that the requirement for "special consideration" for the seven categories listed under section 603(a) constitutes a "priority." While the term "special consideration" may, to a limited extent be considered as affording a "special priority" within a priority, in our view it does not require that the projects listed in the categories under paragraph (a) be given an absolute priority over all other projects.

The basic provision concerning priority and special consideration was included in section 622 (the forerunner of present section 603) at the time the statute was originally enacted in 1946 and has remained virtually unchanged through subsequent amendments. Section 622 required that general regulations be adopted to prescribe among other things:

> "(d) The general manner in which the State agency shall determine the priority of projects based on the relative need ... of different areas lacking hospital facilities, giving special consideration to hospitals serving rural communities ... " (Emphasis added.)

It is our understanding that the requirement for special "consideration" has consistently been interpreted and applied in the manner set out below. In this connection, it should be noted that the 1970 amendments referred to by the Committee (P.L. 91-296) did not make any change in the introductory language of paragraph (a) which contains the "priority" and "special consideration" requirements.

From a reading both of the earlier language and the present language contained in section 603 it is clear that the statute

contemplates that State agencies must determine the priority of projects based on the relative need of different areas lacking adequate facilities of the various types for which Hill-Burton assistance is available. Thus, priorities for the various types of facilities must in all instances be determined on a service area (i.e., geographic area) basis. Within the priorities for facilities established for a service area, special consideration must then be given to the types of projects for the given area which are listed in subparagraphs (1) through (7) of said paragraph (a).

The effect of this requirement is that when a State agency has two or more applications for the same type of facility from the same service area (or from two service areas that have equal priority for the type of facility for which the applications for assistance relate) then applications for the facility project having the characteristics enumerated in the applicable subparagraph (1) through (7) must get special consideration. For example, if two projects for the construction or modernization of outpatient facilities in a specific service area are received and one of them will be located in and provide services for residents of a rural or urban poverty area, then the latter application will be given special consideration, i.e., priority for approval. Similarly, if applications are received for outpatient facilities from two areas with equal priority, then the application for the facility which will serve the medically underserved population will be given special consideration for approval. If, however, applications for outpatient facilities are received from two areas one of which has a higher priority for the construction or modernization of outpatient facilities than the other, under the statute and the regulations the project in the higher priority area must be approved notwithstanding the fact that the project from the lower priority area is proposed to serve medically underserved residents of the latter area.

To ascribe to the term "special consideration" the meaning of an absolute priority would be inconsistent with the statutory pattern. This would mean that an outpatient facility which meets the criteria for special consideration would either have absolute priority over all other facilities of all categories from all areas for approval, (a result which we think is plainly not within the ambit of the statute) or that it would have absolute priority over an application for an outpatient facility from another area with a greater relative need for outpatient facilities, a result which we think would be plainly contrary to the language of section 603(a). Furthermore, the granting of such a priority not restricted by the type of facility involved would make the "priority" meaningless since all applications falling within the seven categories of paragraph (a) would then have an equal priority. It is only by giving special consideration to the individual projects when they compete with other projects for the same type of facilities in areas having the same priority that the statutory purpose can be achieved.

ATTACHMENT IV

Total Number of States Reporting	Total Selecting 10% Option	Total Selecting 3% Option	Total Selecting Open Door Policy	Number of States Where Public Notice Has Not Appeared	Number of Facilities and Amount of Free Care Reported	Total Failed to Meet Dollar Level	Total Number of Facilities Wanting Lower Level of Care Established	Total Number of Complaints Received	Number of States that have not Advised Facilities of Corum Decision
52	507	599	2,019	8	863 $230,980,298	61	26	17	12

REGION 1	1 - Number of Facilities Selecting			2. Public Notice of Option Appeared	3. Number of Facilities and Amount of Free Care Reported by Option	4. Failed to Meet Dollar Level	5. Number of Facilities Wanting Lower Level of Care Established	6. Corrective Action to be Taken	7. Number of Complaints Received	8. Advised on Corum Decision
State	(A) Open Door Policy	(B) 10% of Federal Support	(C) 3% of Operating Cost							
Conn.	11	None	None	No	(3) $ 447,000	(Unknown)	None	No	None	Yes
N.H.	All			No	None	N/A	N/A	N/A	2	No
R.I.	Did not implement program. To begin October 1, 1974.									
Maine	19	9	14	Yes	(A) 13 - (B) 6 - $126,431 (C) 4 - 143,818 23 - $270,249	1	N/A	Yes	None	Yes
Mass.	Program not implemented.									
Vermont	12	2	1	Not yet	*No reports	*No reports	None	Satisfied	None	Yes
TOTAL	42	11	15		26 $717,249	1			2	

*[illegible] hospital bills after a year are paid

REGION 2	1 - Number of Facilities Selecting			2. Public Notice of Option Appeared	3. Number of Facilities and Amount of Free Care Reported by Option	4. Failed to Meet Dollar Level	5. Number of Facilities Wanting Lower Level of Care Established	6. Corrective Action to be Taken	7. Number of Complaints Received	8. Advised on Corum Decision
State	(A) Open Door Policy	(B) 10% of Federal Support	(C) 3% of Operating Cost							
New Jersey	42	30	1	Yes	Not Available at this Time	None	None	Not applicable	None	Yes
New York	95 (H)	54 (H)	11 (H)	Yes	(A) - 78 - $6,620,490 (B) - 49 - $20,195,795 (C) - 9 - 879,687 136 $27,695,972	11	5 (See Report)	See Report	None	Yes
Puerto Rico	2	2	9	Yes	(A) - $75,928 (B) - $119,657 (C) - $581,948 (Other) 11,996 $789,529	Not Evaluated	2	N/A	None	Yes
TOTAL	139	86	21		136 $28,485,501		7			

REGION 3	1 - Number of Facilities Selecting			2. Public Notice of Option Appeared	3. Number of Facilities and Amount of Free Care Reported by Option	4. Failed to Meet Dollar Level	5. Number of Facilities Wanting Lower Level of Care Established	6. Corrective Action to be Taken	7. Number of Complaints Received	8. Advised on Corum Decision
State	(A) Open Door Policy	(B) 10% of Federal Support	(C) 3% of Operating Cost							
Delaware	All	--	--	Yes	(A) 5 - $566,566	None	None	N/A	None	No?
D.C.	5	5	1	Yes	(A) 2 - $268,543 (B) 5 - 1,735,176 (C) 1 - 27,716 8 $2,031,435	None	N/A	N/A	None	No
Md.	25	16	6	No	16 - Not available at present time	N/A	None	N/A	None	Yes
W.Va.	42	1	2	Yes	(A) $3,169,311 (B) 716,495 38,218 $3,924,024	2	None	Yes	None	Yes
Penn.	*200	18	17	Yes	35 - Not available at present time.	None	None	N/A	None	Yes being mailed
Virginia	98%	0	1	No	50 - Not available at present time.	1	None	no determination made	1 - not resolved	No
TOTAL		40	27		$ 6,522,025	2				

*State agency is encouraging all facilities to select Open Door Policy.

REGION 4	1 - Number of Facilities Selecting			2. Public Notice of Option Appeared	3. Number of Facilities and Amount of Free Care Reported by Option	4. Failed to Meet Dollar	5. Number of Facilities Wanting Lower Level of Care Established	6. Corrective Action to be Taken	7. Number of Complaints Received	8. Advised on Corum Decisic
State	(A) Open Door Policy	(B) 10% of Federal Support	(C) 3% of Operating Cost							
Ala.	136	24	30	Yes	(A) $25,636 (B) 505,053 (C) 137,964 $668,653	None	None	None	*3	*No
Fla.	39	58	33	Yes	29 - $5,297,144	4	*2	None	None	Yes?
Ga.	76	10	35	Yes	(A) $675,394 (B) 1,154,423 (C) 1,660,524 30 $3,490,341	None	1 (Not Finalized)	No Failures	None	Yes
Ky.	24 (H)	1 (H)	2 (H)	Yes	Not Reported	--	None	No	None	No
Miss.	21 (H)	8 (H)	43 (H)	Yes	No Reports	See Col. 3	None	See Col. 3	None	Yes
N.C.	70 (H)	12 (H)	22 (H)	Yes	No Reports	See Col. 3	None	See Col. 3	None	Yes
S.C.	18 (H)	11 (H)	27 (H)	Yes	No Reports	See Col. 3	None	See Col. 3	None	Yes
Tenn.	140	19	47	Yes	No Reports	See Col. 3	1 (1%)	No Failures	None	Yes
TOTAL	524	143	239		59 $9,456,138	4	4		3	
							*See report for		*2 of the 3	*To do s. in

REGION 5 State	1 - Number of Facilities Selecting (A) Open Door Policy	(B) 10% of Federal Support	(C) 3% of Operating Cost	2. Public Notice of Option Appeared	3. Number of Facilities and Amount of Free Care Reported by Option	4. Failed to Meet Dollar Level	5. Number of Facilities Wanting Lower Level of Care Established	6. Corrective Action to be Taken	7. Number of Complaints Received	8. Advise on Corum Decisi
Minnesota	109	11	3						None	
Indiana	66%	21%	10%	Yes	Not compiled	1	*3	State satisfied	No	Yes
Illinois	16	33	4	Yes	37 reported (A) not available (B) $5,101,350 (C) 280,430 $5,381,780	1 See report for particulars	N/A	Yes	7 see report for particulars.	No
Ohio	85% took open door policy	--	--	Yes	unknown at this time	Unknown	None	N/A	1 involving 6 hospitals. Court action pending. R.O. has been notified.	Yes
Michigan	Implemented	September 30,	1974 - No reports.							
Wisconsin	80	17	3	Yes	All - unknown at this time.	None	None	N/A	1	No
TOTAL					$5,381,780	2			9	

REGION 6	1 - Number of Facilities Selecting			2. Public Notice of Appeared	3. Number of Facilities and Amount of Free Care Reported by Option	4. Failed to Meet Dollar Level	5. Number of Facilities Wanting Lower Level of Care Established	6. Corrective Action to be Taken	7. Number of Complaints Received	8. Advised on Comm Decisio
State	(A) Open Door Policy	(B) 10% of Federal Support	(C) 3% of Operating Cost							
Ark.	35	6	40	Yes	(B) 6 - $ 387,196 (C) 40 - 1,511,334 46 - $1,898,530	None	2 (See Particulars in letter)	Yes	None	Yes
Tex.	144	31	70	Yes	(A) $103,593,506 (B) 29,111,648 (C) 7,055,029 245 $139,760,183	None	None	No Failures	None	Yes
La.	10	12	33	Yes	(B) 3 - $1,044,169 (C) 9 - 250,259 12 - $1,294,428	10	*14	Notified	None	Yes
Okla.	32	15	36	Yes	(A) $ 4,358,639 (B) 3,940,771 (C) 2,509,009 83 $10,808,419	None	None	None	None	Yes
N.M.	10	10	13	Yes	(A) 2 - $ 21,803 (B) 2 - 15,576 (C) 4 - 103,117 (D) 3 -Other 191,435 11 $331,913	4	3 (See report for particulars)	Yes	None	Yes
TOTAL	231	74	192		397 $154,093,473		5			

*See report for particulars

REGION 7 State	1 - Number of Facilities Selecting (A) Open Door Policy	(B) 10% of Federal Support	(C) 3% of Operating Cost	2. Public Notice of Option Appeared	3. Number of Facilities and Amount of Free Care Reported by Option	4. Failed to Meet Dollar Level	5. Number of Facilities Wanting Lower Level of Care Established	6. Corrective Action to be Taken	7. Number of Complaints Received	8. Advise on Corum Decisi
Iowa	75	1	5	Yes	18 (no report)	None	None	N/A	None	No
Kansas	53	4	1	Yes	No reports	No report	None	N/A	None	Yes
Missouri	35 (H)	21 (H)	29 (H)	No	(A) 9 - $ 9,024,231 (B) 8 - 2,288,433 (C) 15 - 385,062 32 $11,697,726	10	None	Yes?	None	Yes
Nebraska	47	5	5	Yes	(A) $184,653 (B) No report (C) 63,126 12 - $247,779	None	None	Yes	None	No will not
TOTAL	210	31	40		44 $11,945,505	10				

REGION 8	1 - Number of Facilities Selecting			2. Public Notice of Option Appeared	3. Number of Facilities and Total Amount of Free Care Reported by Option	4. Failed to Meet Dollar Level	5. Number of Facilities Wanting Lower Level of Care Established	6. Correct've Action to be Taken	7. Number of Complaints Received	8. Advis on Corum Decis
State	(A) Open Door Policy	(B) 10% of Federal Support	(C) 3% of Operating Cost							
Colo.	35	18	7	Yes	Unknown	Unknown	None	None	1	Yes
Montana	32	5	5	Yes	(3) $254,310 Unknown by Option	None	2	N/A	None	Yes
N.D.	27 (H) 12 (N.H) 2 Rehab. 1 PHC	2 (H) 1 (N.H.)	0	Yes	(B) 28,389	3	None	None	None	Not sent to faciliti selectin open doo policy
S.D.	30 (H) 11 (N.H)	1 (H)	15 (H) 13 (N.H.)	Yes	$664,276	9	*None	Yes	None	Yes
Utah	23	1	0	Yes	No report	None	None	None	None	Yes
Wyoming	21	0	1	Yes	1 -(C) $17,361	None	None	N/A	--?	No
TOTAL	194	28	41		$964,336	12	2		1	

*Most indicated that the requests were not sufficient to meet the dollar level indicated by the 3% option.

EGION 9 State	1 - Number of Facilities Selecting (A) Open Door Policy	(B) 10% of Federal Support	(C) 3% of Operating Cost	2. Public Notice of Option Appeared	3. Number of Facilities and Amount of Free Care Reported by Option	4. Failed to Meet Dollar Level	5. Number of Facilities Wanting Lower Level of Care Established	6. Corrective Action to be Taken	7. Number of Complaints Received	8. Advised on Coram Decisio
rizona	6	24	9	Yes	(B) 24 - $2,401,000 (C) 9 - 201,400 33 $2,602,400	2	3	Yes	None	Yes
alif.	not yet implemented									
awaii	47	--	--	Yes	None	--	None	None failed	None	Yes
evada	18	--	--	Yes	2 - $111,451	None	None	None failed	None	Yes
OTAL	71	24	9		35 $2,713,851	2	3			

REGION 10	1 - Number of Facilities Selecting			2. Public Notice of Option Appeared	3. Number of Facilities and Amount of Free Care Reported by Option	4. Failed to Meet Dollar Level	5. Number of Facilities Wanting Lower Level of Care Established	6. Corrective Action to be Taken	7. Number of Complaints Received	8. Advised on Corum Decision
State	(A) Open Door Policy	(B) 10% of Federal Support	(C) 3% of Operating Cost							
Washington	55	5	2	Yes	(A) $ 792,760 (B) 88,791 (C) 74,149 26 - $ 955,700	2	None	No	None	No
Alaska	9	0	0	Yes	6 - $ 158,280	N/A	None	No failures	None	Yes
Oregon	51	4	6	Yes	$9,596,460 Total amount of free care.	None	None	None failed	No complaint	Yes
Idaho	95%	All rest but 1	None	No	Unknown	5%	1 or 2	No	None	Yes
TOTAL					32 $10,710,440					

Senator KENNEDY. Our next witness this morning is Ms. Marilyn Rose.

Ms. Rose has appeared before the committee many, many times, and we are always grateful to hear from you.

Ms. Rose is an attorney for the Center for Law and Social Policy, a foundation supported public interest law firm since 1966, concerned about the legal problems of the poor minorities getting access to the health care, and we welcome you back.

STATEMENT OF MS. MARILYN G. ROSE, ATTORNEY, CENTER FOR LAW AND SOCIAL POLICY, WASHINGTON, D.C., ACCOMPANIED BY L. JEROME ASHFORD, EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF NEIGHBORHOOD HEALTH CENTERS, INC., WASHINGTON, D.C.; ALLAN CRIMM, SOUTHERN GOVERNMENTAL MONITORING PROJECT, SOUTHERN REGIONAL COUNCIL, ATLANTA, GA.; LEROY F. ANDERSON, ED. D., DIRECTOR, FRANKLIN C. FETTER FAMILY HEALTH CENTER, CHARLESTON, S.C.; AND JOE TOM EASLEY, DIRECTOR, SOUTHERN GOVERNMENTAL MONITORING PROJECT, SOUTHERN REGIONAL COUNCIL, ATLANTA, GA.

Ms. ROSE. Thank you, Senator Kennedy.

I would like to thank the subcommittee for this second opportunity to testify on the subject of Federal regulation and health facility construction.

My name is Marilyn Rose. I am an attorney with the Center for Law and Social Policy in Washington, D.C., and have worked for several years in the area of health problems of the poor.

I am accompanied by four other persons who have extensive experience in the same area and familiarity with the issues of concern to this subcommittee. Mr. Jerome Ashford is executive director of the National Association of Neighborhood Health Centers and previously served in various executive capacities with primary care facilities providing comprehensive health service to poverty populations in Boston, Mass.

Dr. Leroy Anderson is the director of the Franklin C. Fetter Family Health Center, a project funded under section 314(e) of the Public Health Service Act to serve low income persons in Charleston, S.C.

Mr. Ashford and Dr. Anderson are located where the problems are and are able to develop information which the GAO investigators did not have the time to do—that is from the perspective of the needs of the poverty communities.

Mr. Allan Crimm is with the Southern Governmental Monitoring Project of the Southern Regional Council. He is accompanied by the director of the project, Mr. Joe Easley. During the summer of 1974 Mr. Crimm supervised an investigating project inquiring into the compliance of the Hill-Burton facilities in 11 Southern States with the "free service" requirements of the HEW regulation. They really went into depth and their report is quite devastating.

In June 1974 I testified before this subcommittee on similar subjects as now in issue. At that time I raised two serious deficiencies in the administration of the legal obligations of the Hill-Burton Act.

I direct my attention first to the issue concerning the poverty priority for outpatient moneys. This issue involves the implementation of the 1970 amendments to the Hill-Burton Act relating to the priority for construction moneys for outpatient facilities to serve residents of poverty communities.

The other issue relates to the continued failure of State Hill-Burton agencies to enforce the "free service" obligations of the Hill-Burton Act.

Our allegations in both areas have been confirmed by our continued program monitoring as well as by the investigation and report of the General Accounting Office.

In 1970 Congress amended the Hill-Burton Act by giving a priority to poverty areas to receive outpatient moneys. The legislative history makes it clear that Congress intended to help remedy the shortage of primary health care services to residents of poverty areas, and the neighborhood health centers which had been developed by OEO and similar comprehensive health service centers were the principal potential grantees for such moneys. I have attached to this statement a summary of that history.

[The summary referred to follows:]

EXHIBIT A

LEGISLATIVE HISTORY OF 1970 OUTPATIENT AMENDMENTS

Prior to the enactment of the 1970 Amendments, the Hill-Burton Act authorized HEW to approve grants and loans for projects for "diagnostic or treatment centers" to provide ambulatory services; said centers were either publicly-owned entities (usually clinics of State or local public health departments) or were hospital-based outpatient facilities. The Federal share of the cost of approved projects ranged from 33 1/3 to 66 2/3 percent, depending upon the poverty of the States relative to each other, but not upon the poverty of the area in which the project was to be located or the poverty of the population to be served. In 1970, Congress, overriding a Presidential veto, enacted the 1970 Amendments which, inter alia, continued the categorical approach to the funding of health facilities construction and maintained that outpatient health centers be retained as a distinct category to receive such Federal moneys (42 U.S.C. §291a). The 1970 Amendments also provided that poverty areas be given a priority for the receipt of outpatient moneys for projects which would serve poverty populations (42 U.S.C. §291c(a)(4)). In the latter respect, §291c(a) was amended to establish the following priority:

> "... in the case of projects for construction or modernization of outpatient facilities, to any outpatient facility that will be located in, and provide services for residents of, an area determined by the Secretary to be a rural or urban poverty area."

The Amendments further changed the name of such facilities from the old "diagnostic and treatment center" designation to "outpatient facilities", and permitted grants to be made to "free-standing" ambulatory projects not physically connected with a hospital, and permitted states to award up to ninety percent (90%) Federal moneys to projects in poverty areas as "an incentive".*

A review of the history of the 1970 Amendments to the Hill-Burton Act overwhelmingly establishes that the intent of the outpatient facilities provision was to benefit poor people who lacked access to the health system by reason of the absence of ambulatory health services in their communities. The model for the grantee under this provision was the neighborhood health center created under the auspices of OEO, a large number of whose patients (some 40 to 60%) lack means to pay and are accorded free service paid for by grant monies to the centers themselves.

The Hill-Burton Act had been enacted in 1946 out of recognition that there was a dire shortage of hospitals (40% of the counties in the United States without any hospitals), existing hospitals were obsolete, physicians needed modern hospitals in order to engage in the modern practice of medicine, and there had been an appalling record of draft rejects from States in direct proportion to these shortcomings.**

However, by 1970 sponsors of health legislation from both sides of the aisle recognized that the need for new hospital

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* (P.L. 91-296, §116(a), §113(b)(4), 91st Cong., June 30, 1970). See Medical Facilities Construction and Modernization Amendments of 1970, Senate Report No. 91-657, U.S.Code Cong. & Admin. News, 91st Cong., 2nd Sess., pp.3342-3; Conf.Rep.No. 91-1167, pp.3365-6.

** Hearings before the Committee on Education and Labor, U.S. Senate, 79th Cong., 1st Sess. (1945), on S. 191, pp.10, 49, 76, 130-1, 177, 189-90, 237-8.

beds had been largely met, and that a principal focus of the Act now should be made instead upon the needs of the poor for ambulatory health services in poverty areas. The Administration's spokesmen at the Senate Hearings in 1969 (specifically Under-Secretary Veneman, accompanied inter alia by Dr. Graning, the Director of the Hill-Burton program), after recognizing that as a result of the Hill-Burton program, "almost 90 percent of the Nation's current needs for general hospitals' beds have been met, as compared with only 50 percent in 1948"* proposed general block grants to States for modernization or construction for any health facility (other than acute hospital beds), with a percentage earmarked for innovative projects reflecting critical needs.** With respect to the earmarked funds, Under-Secretary Veneman stated,

> "Such projects could be assisted up to 90 percent of their cost and would include such critically needed health facilities as ambulatory-care facilities and long-term care facilities serving the disadvantaged...
>
> "A problem of national significance which deserves special attention is the great lack of health facilities primarily serving urban or rural poverty residents where the near absence of local resources is acute." (Hearings, pp. 225-6)

Congress was not disposed to turning over health construction funds to the States in general block grants as desired by the Administration, but did agree with the concept of providing ambulatory services for the poor. The Senate, in S.2182, (the Senate bill under consideration), proposed a provision continuing

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* Hearings before the Subcommittee on Health, Committee on Labor and Public Welfare, U.S. Senate, 91st Cong., 1st Sess., on S.2182 (1969), p.224, hereinafter called "Hearings".

** Hearings, p. 225; see also Statement of Senator Javits at pp. 116-7.

the existing categorization of projects, with certain changes which would establish a priority for outpatient grants as follows:

> "... in the case of projects for construction or modernization of outpatient facilities, to any outpatient facility that will be located in, and provide services for residents of, an area determined by the Secretary to be a metropolitan area with low per capita income...."(Hearings, p. 9).

Witnesses, from private organizations and from Congress supported the emphasis on ambulatory facilities in poverty areas, to serve poverty populations, along the model of the neighborhood health centers which had recently been developed under the auspices of the Office of Economic Opportunity.* Senator Percy, for example, spoke extensively on the need to add to the Hill-Burton Act concepts expressed in a Neighborhood Health Center Act which he was separately co-sponsoring:

> "The Neighborhood Health Center Act amends the Hill-Burton Act to authorize the funding of comprehensive ambulatory care centers. The bill defines a 'comprehensive ambulatory care center' as a facility providing a full range of medical services for patients not requiring hospitalization....
>
> "The priority area for this type of facility would be one having low physician accessibility; that is, an area where it is difficult to obtain medical care....
>
> "I know that you are familiar indeed with problems in the urban areas. The largest Black ghetto area in America exists in the South side of Chicago. ... Probably some 30 square miles is what may be considered low-income ghetto area....
>
> "Many people in that area live in sections that do not even have a doctor working or residing any place near....
>
> "A low-income person must take several hours to get out by public transportation to the only facility available - the Cook County Hospital.

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* See, e.g., Testimony of Senator Percy, pp. 283-88; Senator Scott, pp. 302-3; American Nurses Association at p. 182 and p.184; Baltimore City Health Department, pp. 350-1; National Council of Senior Citizens, p. 352.

> The people that I have talked to indicate that they may have to wait 5 to 6 hours to be attended then chances are one out of four that they will be admitted to that hospital. Seventy-five percent of the patients are turned away because they are not bed cases....
>
> "However, in contrast, there is an area on the West side that has a neighborhood health clinic and in this area the resident simply walks to that facility with less cost to themselves and to their own health. They are inclined to go before their condition gets critical, when it is easier to go....
>
> "The same situation exists in Los Angeles....
>
> "We have learned from the experimental comprehensive ambulatory clinics funded by OEO that they are an extremely effective mechanism for getting health services to the people who need them. These clinics are an extremely worthwhile investment. Not only can preventive medicine and family planning services be made available with consequent reduction in hospital usage but, with proper use of ancillary personnel, the need for professional manpower can be dramatically reduced. For example, for the population served by the Columbia Point Neighborhood Health Center in Boston, the number of hospital admissions was cut by more than 50 percent in the first year of operations...." (Hearings, pp. 285-6)

The House Hill-Burton extension bill (H.R.11102) had none of these changes involving ambulatory projects in poverty areas. However, in Conference, the House adopted many of the Senate changes, including: (1) changing the name from "diagnostic or treatment" centers to outpatient facilities to broaden the concept of services which were contemplated by Congress to be given in such facilities; (2) permitting free-standing ambulatory grantees to obtain outpatient moneys if such facilities would provide reasonable assurance that a general hospital would be available to patients in need of hospitalization; (3) permitting a higher Federal share (up to 90 percent) in the case of rural or urban poverty projects, inter alia; and (4) providing,

> "... that priority shall be given to projects for construction or modernization of out-patient facilities which are located in and provide services for residents of rural or urban poverty areas..." (Conference Report No. 91-1167, U.S. Code Cong. & Admin. News, pp. 3365-6).

However, almost from the enactment of the 1970 Amendments, HEW and the State Agencies have subverted that congressional objective. (See GAO Report and Exhibits B and C attached herein).

Ms. ROSE. It was very clear, especially before this subcommittee, that Congress had that objective in mind.

However, the vast share of the outpatient moneys was granted to facilities not organized to deliver primary health care to large numbers of poor people unable to pay for such services.

Our monitoring of the program led to a lawsuit challenging various actions of HEW officials permitting and sanctioning those actions by State officials.[1]

The GAO report to the subcommittee, as well as the information developed through the lawsuit, confirms our allegations.

The GAO report contains a number of findings and conclusions with which we agree.[2]

Information which we have received via answers to interrogatories and examination of project files confirms and amplifies on a nationwide basis the findings and conclusions which GAO reached with the States it surveyed.

I will not discuss the GAO report. I think they discussed it very nicely.

I have attached two charts, the first of which was supplied by HEW on November 5, 1974 as part of supplemental answers to interrogatories—still not complete. This first chart (Exhibit B), lists grantees of outpatient moneys on a State-by-State basis, and designates which grants were made to projects located in poverty areas. Location, however, does not mean that the facilities were designed to treat poverty area residents unable to pay for the services.

The second chart, (Exhibit C) lists on a State-by-State basis various extractions from answers to interrogatories, for example, moneys as appropriated by Congress for fiscal years 1971 and 1972, moneys remaining in the outpatient category after transfer to other categories of some sums, and moneys granted to projects in poverty areas and nonpoverty areas.

[The exhibits referred to and subsequently supplied follow:]

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[1] *NANHC* v. *Weinberger*, U.S. District Court D.C., Civ. Act. No. 74–52.

[2] GAO found: (1) that there has been a lack of outreach activities by the State agencies to apprise and assist poverty communities in obtaining Hill-Burton moneys (p. 2); (2) that State Hill-Burton plans lack any explanation how special consideration is to be given to poverty areas for outpatient moneys (p. 3); (3) that moneys were illegally transferred to new hospital construction in some States after a sham double transfer through the modernization category (p. 11, pp. 19–24); (4) that in the States surveyed by GAO large amounts were awarded to nonpoverty areas (pp. 7–8) and/or were transferred out of the outpatient category (pp. 9–10); (5) that the Hill-Burton Act does not authorize HEW to give priority to nonpoverty outpatient projects over poverty outpatient projects based solely on the relative needs of the service areas for the outpatient facilities (p. 27); (6) that a memorandum issued in 1971 by HEW to the States authorizing a dispensation with the statutory requirements for designating poverty areas before awarding outpatient moneys was improper (p. 29).

LISTING OF PROJECTS FUNDED BY OUTPATIENT FUNDS, FY 71 & 72 APPROPRIATIONS

State	Proj.No.	City	Name of Facility	1971 HB Funds	1972 HB Funds	HEW Final Approval Date	State Initial Approval Date	In Poverty Area (Circle One)	% Poverty Area Patients (Nearest 10%)	Physically Connected To Hosp. or Other Health Facility (Circle One)
Alabama	D205	Birmingham	Western PHC	341,400	-	5/72	4/71	[illegible] No	N/A	[illegible] No
	D490	Birmingham	Childrens Hosp	477,245	-	9/72	5/71	[illegible] No	N/A	Yes [illegible]
	D505	Montgomery	Montgomery Cy Co Clinic	-	342,000	10/73	12/71	[illegible] No	N/A	[illegible] No
Arkansas	B210	Little Rock	Ark Baptist Med Center	554,028	2,005	5/71	1/69	[illegible] No	N/A	Yes [illegible]
	B224	Texarkana	St Michael Hosp	15,270	-	1/73	4/72	[illegible] No	N/A	Yes [illegible]
California	C499	Glendale	Glendale Comm Hosp	1,065,462	-	6/73	3/73	[illegible] No	N/A	Yes [illegible]
	0506	Los Angeles	S E Comprehensive HC	-	1,080,169	1/74	2/73	Yes [illegible]	N/A	[illegible] No
	0508	El Centro	El Centro Comm Hosp	185,029	75,260	6/73	3/73	Yes [illegible]	N/A	Yes [illegible]
	0509	Visalia	Kaweah Delta Hosp	-	115,235	1/74	12/72	[illegible] No	N/A	Yes [illegible]
	0511	San Pablo	Brookside Hosp	-	843,866	8/73	3/73	[illegible] No	N/A	Yes [illegible]
	0513	Barstow	Barstow Community Hosp	128,028	-	6/73	1/73	[illegible] No	N/A	Yes [illegible]
	0515	San Leandro	San Leandro Mem Hosp	826,778	-	6/73	1/73	[illegible] No	N/A	Yes [illegible]
	0517	Fresno	Valley Medical Ctr	1,206,057	29,670	6/73	2/73	Yes [illegible]	N/A	Yes [illegible]
	0520	Duarte	City of Hope Hosp	930,407	-	2/73	12/72	[illegible] No	N/A	Yes [illegible]
Colorado	D126	Wheat Ridge	Lutheran Hosp Med Ctr	99,763	-	6/70	12/69	[illegible] No	N/A	Yes [illegible]
	D127	Denver	Beth Israel Hosp	156,830	-	6/71	6/68	[illegible] No	N/A	Yes [illegible]
Connecticut	A151	Farmington	Conn U Med Dental Sch	289,966	-	6/73	10/68	[illegible] No	N/A	Yes [illegible]
	B174	West Stafford	Johnson Memorial Hosp	-	161,757	8/73	10/72	[illegible] No	N/A	Yes [illegible]
	0167	New Haven	Comm Health Care Ctr	300,000	-	1/72	7/71	Yes [illegible]	N/A	[illegible] No
	0168	New Haven	Hosp of St Raphael	300,000	-	6/73	9/72	Yes [illegible]	N/A	Yes [illegible]
Delaware	C025	Dover	Kent General Hosp	100,000	-	6/69	4/69	Yes [illegible]		Yes No
	D033	Dover	T Collins St Serv Ctr	9,406	200,000	6/73	8/72	Yes [illegible]		Yes No
	0031	Wilmington	Model City Hlt Serv Ctr	42,494	-	4/73	6/72	Yes [illegible]		Yes No
Dist. of Columbia	B047	Washington	Geor Wash Univ Hosp	270,916	510,501	4/73	2/72	[illegible] No	N/A	Yes [illegible]
	0038	Washington	Columbia Hosp for Women	23,484		6/70	4/70	[illegible] No	N/A	Yes [illegible]

EXHIBIT B

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State	Proj.No.	City	Name of Facility	1971 HB Funds	1972 HB Funds	HEW Final Approval Date	State Initial Approval Date	In Poverty Area (Circle One)	% Poverty Area Patients (Nearest 10%)	Physically Connected To Hosp. or Other Health Facility (Circle One)
Florida	T044	Mayo	Lafayette Co FHC	-	19,070	12/72	2/72	Yes [illegible]	80	[illegible] No
	B021	Orlando	Orange Memorial Hosp	-	650,000	-	2/73	[illegible] No	20	Yes [illegible]
	T030	Miami Beach	Mount Sinai Hosp	312,899	-	6/70	5/70	[illegible] No	10	Yes [illegible]
	T034	Deland	Fish Memorial Hosp	250,000	-	3/72	9/71	[illegible] No	30	Yes [illegible]
	T035	Miami	So Dade Comm Hlth Ctr	1,000,000	-	5/73	5/72	[illegible] No	40	[illegible] No
	T036	Jacksonville	E Jacksonville Clinic	-	90,000	9/73	2/73	Yes [illegible]	70	[illegible] No
	T038	Gainesville	Shands Teaching Hosp	200,000	25,000	6/73	11/71	[illegible] No	40	Yes [illegible]
	T039	Immokalee	Immokalee Hlth Care Ctr	-	575,000	6/73	8/72	Yes [illegible]	90	[illegible] No
	T041	Boynton Beach	Co Emrgcy Radio/Hosp	20,000	9,000	6/73	4/73	[illegible] No	50	Yes [illegible]
	T042	Sebring	Highlands Hosp	-	83,494	10/73	6/72	[illegible] No	50	Yes [illegible]
	T047	Pahokee	Everglades Mem Hosp	-	29,162	-	11/72	Yes [illegible]	50	Yes [illegible]
	T049	Jacksonville	Comm Health Clinic	-	90,000	9/73	2/73	Yes [illegible]	80	[illegible] No
	T050	Miami Beach	Mount Sinai Hosp	76,462	-	6/73	5/73	[illegible] No	10	Yes [illegible]
Georgia	D396	Macon	Med Ctr of Central Ga	-	7,500	6/69	5/66	[illegible] No	N/A	Yes [illegible]
	D450	East Point	South Fulton Hosp	88,461	-	11/70	6/70	[illegible] No	N/A	Yes [illegible]
	D453	La Grange	City County Hosp	-	102,227	5/71	5/70	[illegible] No	N/A	Yes [illegible]
	D455	Savannah	Memorial Medical Ctr	-	83,498	6/71	6/70	[illegible] No	N/A	Yes [illegible]
	D463	Americus	Americus Sumter Co Hosp	225,000	-	10/72	6/71	[illegible] No	N/A	Yes [illegible]
	D474	Commerce	Banks Jackson Comm	-	75,000	-	5/72	[illegible] No	N/A	Yes [illegible]
	0460	Ft Oglethorpe	Hutcheson Mem Tri-Co	325,000	70,000	5/73	7/71	[illegible] No	N/A	Yes [illegible]
	0461	Dalton	Hamilton Mem Hosp	500,000	-	11/71	8/71	[illegible] No	N/A	Yes [illegible]
	0469	Rome	Floyd Hosp	300,000	108,418	3/73	7/71	[illegible] No	N/A	Yes [illegible]
	0470	Austell	Cobb General Hosp	230,822	-	4/72	8/71	[illegible] No	N/A	Yes [illegible]
	0471	Gainesville	Hall Co Hosp	225,238	-	2/72	8/71	[illegible] No	N/A	Yes [illegible]
	0478	Atlanta	Grady Mem Hosp	-	770,000	6/73	5/72	Yes [illegible]	N/A	Yes [illegible]
	0479	Marietta	Kennestone Hosp	-	770,000	5/73	6/72	[illegible] No	N/A	Yes [illegible]
Hawaii	0067	Kealakekua	Kona General Hosp	133,723	-	8/72	4/72	[illegible] No	25	Yes [illegible]
Illinois	0301	Chicago	Garfield Park Comm Hosp	261,875	-	4/73	11/72	Yes [illegible]	50	Yes [illegible]
	0302	Chicago	Chicago Osteo Hosp	930,391	-	6/73	4/73	[illegible] No	28	Yes [illegible]
	0303	Chicago	Englewood Neighbhd HC	240,000	-	6/73	3/73	Yes [illegible]	56	[illegible] No
	0304	Beardstown	Beardstown Med Ctr	91,936	-	5/73	11/72	[illegible] No	48	Yes [illegible]
	0311	Chicago	W Town Nghbhd Hlth Ctr	327,000	-	6/73	3/73	Yes [illegible]	46	[illegible] No
	0313	Chicago	Provident Hosp	-	40,000	-	10/72	Yes [illegible]	66	Yes [illegible]
	0314	Chicago	Ill Dept Ph Hosp Cl	49,215	-	6/73	9/72	Yes [illegible]	62	Yes [illegible]
	0317	W Frankfort	U M W A Union Hosp	-	244,318	11/73	6/73	Yes [illegible]	55	Yes [illegible]
	0318	Chicago	U of Chicago Lying-In	234,112	4,932	6/73	2/73	[illegible] No	28	Yes [illegible]

LISTING OF PROJECTS FUNDED BY OUTPATIENT FUNDS, FY 71 & 72 APPROPRIATIONS

State	Proj.No.	City	Name of Facility	1971 HB Funds	1972 HB Funds	HEW Final Approval Date	State Initial Approval Date	In Poverty Area (Circle One)		% Poverty Area Patients (Nearest 10%)	Physically Connected To Hosp. or Other Health Facility (Circle One)	
Indiana	A196	Bloomington	Bloomington Hosp	270,335	-	8/71	6/71	[illegible]	No	N/A	Yes	[illegible]
	B201	Bluffton	Wells Co Comm Hosp	-	106,179	-	4/73	[illegible]	No	Not Open	Yes	[illegible]
	D189	Merrillville	Broadway Methodist Hosp	333,300	-	6/72	11/70	[illegible]	No	Not Open	Yes	[illegible]
	0195	Indianapolis	Regenstrief Health Ctr	895,472	250,657	6/72	12/71	Yes	[illegible]	Not Open	Yes	[illegible]
Iowa	0175	Des Moines	Broadlawns Polk Co Hosp	585,298	-	6/72	9/71	Yes	[illegible]	90	[illegible]	No
	0176	Des Moines	Neighborhood Hlth Ctrs	378,498	-	12/72	9/71	Yes	[illegible]	70	[illegible]	No
	0182	Oakdale	Oakdale Model Rural HC	-	224,980	-	1/73	[illegible]	No	25	[illegible]	No
	0183	Iowa City	Univ Hosp & Clinics	-	557,460	5/73	2/72	[illegible]	No	82	Yes	[illegible]

State	Proj.No.	City	Name of Facility	1971 HB Funds	1972 HB Funds	HEW Final Approval Date	State Initial Approval Date	In Poverty Area (Circle One)	% Poverty Area Patients (Nearest 10%)	Physically Connected To Hosp. or Other Health Facility (Circle One)
Kentucky	B252	Louisville	Norton Childrens Hosp	795,905	-	6/71	4/71	[illegible] No	N/A	Yes [illegible]
	D293	Lexington	Univ of KY Med Ctr	823,314	66,303	3/73	9/72	[illegible] No	N/A	Yes [illegible]
	0292	Hopkinsville	Jennie Stuart Mem Hosp	-	888,642	3/74	6/73	Yes [illegible]	"	Yes [illegible]
	0296	Frenchburg	Menifee Co Ambulant Ctr	-	389,315	-	6/72	Yes [illegible]	"	[illegible] No
Louisiana	A719	Baton Rouge	Cancer Treatment Ctr	38,360	-	4/70	5/69	[illegible] No	N/A	[illegible] No
	A720	Zachary	Lane Memorial Hosp	40,000	-	6/71	2/71	[illegible] No	"	Yes [illegible]
	A721	Ferriday	Concordia Parish Hosp	-	136,334	9/73	8/71	[illegible] No	"	Yes [illegible]
	A724	Shreveport	Confederate Mem Med Ctr	-	175,000	10/72	6/72	[illegible] No	"	Yes [illegible]
Maine	B075	Rockport	Penobscot Bay Med Ctr	126,621	-	6/73	4/71	[illegible] No	47.84	Yes [illegible]
	B076	Farmington	Franklin Co Mem Hosp	100,000	-	5/73	4/73	[illegible] No	37.76	Yes [illegible]
	0077	Portland	Maine Med Center	200,000	-	9/72	12/71	[illegible] No	37.76	Yes [illegible]
	0080	Houlton	Houlton Regional Hosp	-	174,785	1/74	11/73	Yes [illegible]	48.88	Yes [illegible]
Maryland	B169	La Plata	Physicians Mem Hosp	120,170	-	6/73	10/72	[illegible] No	?	Yes [illegible]
	0164	Baltimore	E Regional Health Ctr	-	316,478	9/73	5/71	[illegible] No	?	[illegible] No
	0171	Baltimore	Bon Secours Hosp	122,430	-	10/72	2/72	Yes [illegible]	100	Yes [illegible]
	0173	Baltimore	Comm Mental Hlth Ctr	316,478	308,522	10/72	9/72	Yes [illegible]	100	Yes [illegible]
Massachusetts	D331	Salem	Salem Ltc Rehab Fac	196,643	-	5/73	3/73	Yes [illegible]	100	Yes [illegible]
	0473	Lowell	St Josephs Hosp	542,949	-	5/73	10/72	Yes [illegible]	60	Yes [illegible]
	0474	Allston	Allston Brighton H C	165,593	62,974	5/73	3/72	Yes [illegible]	100	[illegible] No
	0475	Boston	Harvard Comm Hlth Plan	344,276	-	5/73	1/72	Yes [illegible]	-	[illegible] No
	0478	Boston	Charles Drew Family Ctr	-	853,023	-	2/74	Yes [illegible]	100	[illegible] No
	0479	Roxbury	Roxbury Dental Med Gp	-	250,000	-	4/74	Yes [illegible]	100	[illegible] No
Michigan	A105	Grand Rapids	St Marys Hosp	172,073	-	12/70	11/70	Yes [illegible]	70	Yes [illegible]
	A136	Lincoln Park	Outer Drive Hosp	450,000	-	8/72	5/72	[illegible] No	10	Yes [illegible]
	B043	Grand Rapids	Blodgett Mem Hosp	500,000	-	6/73	3/73	[illegible] No	20	Yes [illegible]
	B045	Hart	Oceana Hosp	-	200,000	-	5/73	Yes [illegible]	80	Yes [illegible]
	B068	Pontiac	Oakland County PHC	100,000	-	10/72	4/72	Yes [illegible]	70	[illegible] No
	B182	Detroit	Metropolitan Hosp	270,000	-	9/72	3/72	Yes [illegible]	80	Yes [illegible]
	C072	Wayne	Annapolis Hosp	450,000	-	8/72	5/72	[illegible] No	10	Yes [illegible]
	D246	Benton Harbor	Berrien Co Prev Med Ctr	-	37,500	-	5/73	Yes [illegible]	80	[illegible] No
	0236	Kalamazoo	Family Health Ctr	341,000	-	6/73	1/73	Yes [illegible]	100	[illegible] No

LISTING OF PROJECTS FUNDED BY OUTPATIENT FUNDS, FY 71 & 72 APPROPRIATIONS

State	Proj.No.	City	Name of Facility	1971 HB Funds	1972 HB Funds	HEW Final Approval Date	State Initial Approval Date	In Poverty Area (Circle One)	% Poverty Area Patients (Nearest 10%)	Physically Connected To Hosp. or Other Health Facility (Circle One)
Minnesota	A201	St Paul	St Josephs Hosp	220,451	-	6/72	12/71	[illegible] No	N/A	Yes [illegible]
Mississippi	E078	Pascagoula	Singing River Hosp	58,500	-	4/73	12/71	Yes [illegible]	30	Yes [illegible]
Missouri	0241	Creve Coeur	St Johns Mercy Med Ctr	-	1,000,000	-	10/73	[illegible] No	N/A	Yes [illegible]
Nebraska	0117	Scottsbluff	West Nebr Gen Hosp	55,450	8,069	1/72	6/71	[illegible] No	N/A	Yes [illegible]
	0121	Omaha	Univ of Nebr Lions Eye	-	225,660	1/74	8/73	[illegible] No	N/A	Yes [illegible]
New Hampshire	G077	Lincoln	Linwood Med Ctr	165,414	67,506	5/73	3/72	Yes [illegible]	18	[illegible] No
	0072	Littleton	Littleton Hosp	-	285,948	1/74	12/72	Yes [illegible]	10	Yes [illegible]
	0073	Manchester	Elliot Hosp	49,586	-	6/73	10/72	[illegible] No	10	Yes [illegible]
	0075	Newport	Newport Hosp	-	75,000	7/73	8/72	[illegible] No	12	Yes [illegible]
	0076	Manchester	Notre Dame Hosp	60,000	-	6/73	10/72	[illegible] No	15	Yes [illegible]
New Jersey	7102	Newark	Martland Hosp	750,000	-	6/73	12/72	Yes [illegible]	100	Yes [illegible]
	7110	Toms River	Community Mem Hosp	324,325	-	10/72	9/72	Yes [illegible]	70	Yes [illegible]
	7141	Cape May Ct Hs	Burdette Tomlin Mem	127,289	-	4/73	3/73	Yes [illegible]	80	Yes [illegible]
	7145	Jersey City	Mt Carmel Guild	400,000	-	5/73	1/73	Yes [illegible]	90	[illegible] No
	7226	Camden	Cooper Hosp	-	126,000	2/74	12/73	Yes [illegible]	90	Yes [illegible]

State	Proj.No.	City	Name of Facility	1971 HB Funds	1972 HB Funds	HEW Final Approval Date	State Initial Approval Date	In Poverty Area (Circle One)		% Poverty Area Patients (Nearest 10%)	Physically Connected To Hosp. or Other Health Facility (Circle One)	
New Mexico	A115	Albuquerque	Presbyterian Hosp Ctr	78,000	19,162	6/71	4/71	Yes	No	3	Yes	No
	A116	Espanola	Espanola Hosp	123,308	-	7/72	2/72	Yes	No	90	Yes	No
	A117	Albuquerque	S W Valley Health Ctr	-	120,000	6/73	3/73	Yes	No	None	Yes	No
	A123	Gallup	Rehoboth Christian Hosp	-	100,000	7/73	8/72	Yes	No	None	Yes	No
	A124	Albuquerque	Bernalillo Co Med Ctr	-	40,000		6/72	Yes	No	2	Yes	No
	A133	Chama	Dr J I Dunham Mem Cl	-	68,000	1/74	12/73	Yes	No	86	Yes	No
New York	8357	Norwich	Chenango Mem Hosp	70,000	-	9/72	10/69	Yes	No	N/A	Yes	No
	0375	Olean	Olean General Hosp	250,000	-	4/72	12/71	Yes	No	"	Yes	No
	0376	Rochester	Genesee Health Service	100,000	-	7/72	1/72	Yes	No	"	Yes	No
	0377	Albany	W M Ypung Comm Hlth Ctr	888,140	-	1/73	1/72	Yes	No	"	Yes	No
	0378	NY Brooklyn	St Johns Episcopal Hos	1,000,000	-	8/72	5/72	Yes	No	"	Yes	No
	0381	Albany	St Peters Hosp	1,000,000	-	8/72	6/72	Yes	No	"	Yes	No
	0382	Watertown	Mercy Hosp	600,000	-	5/73	10/72	Yes	No	"	Yes	No
	0384	Jamestown	Woman's Christian Assn	-	350,000	6/73	1/73	Yes	No	"	Yes	No
	0389	Rochester	Highland Hosp	-	750,000	-	5/73	Yes	No	"	Yes	No
	0390	Rochester	Westside Hlth Servs.	-	100,000	11/73	5/73	Yes	No	"	Yes	No
	0394	New York	N Y Med College Hosp	-	245,000	-	7/73	Yes	No	"	Yes	No
	0398	New York	Misericordia Med Ctr	-	800,000	-	12/73	Yes	No	"	Yes	No
	0399	N Y Jamaica	Mary Immaculate Hosp	-	600,000	-	1/74	Yes	No	"	Yes	No
North Carolina	B453	Winston Salem	N C Baptist Hosp	386,356	-	4/70	12/68	Yes	No	Cannot be	Yes	No
	B476	Mt Airy	Northern Hosp	-	130,473	8/72	3/72	Yes	No	Determined	Yes	No
Ohio	R379	Zanesville	Bethesda Hosp	88,144	-	6/70	7/69	Yes	No	N/A	Yes	No
	0344	Cincinnati	Cincinnati Gen Hosp	2,105,605	-	6/73	2/72	Yes	No	95	Yes	No
	0390	Cleveland	E Side Ambulty Care Ctr	-	1,000,000	-	1/74	Yes	No	100	Yes	No
	0398	Liberty Ctr	Liberty Ctr Migrant H C	-	270,000	-	11/73	Yes	No	100	Yes	No
	0399	Georgetown	Brown Co Gen Hosp	295,561	-	6/73	12/72	Yes	No	N/A	Yes	No
	0401	Cincinnati	West End Hlth Ctr	290,785	249,215	6/73	2/73	Yes	No	95	Yes	No
	0402	Cincinnati	Winton Hills Med H C	-	270,000	-	11/73	Yes	No	95	Yes	No
	0404	Dayton	Childrens Med Ctr	500,000	-	5/73	11/72	Yes	No	N/A	Yes	No

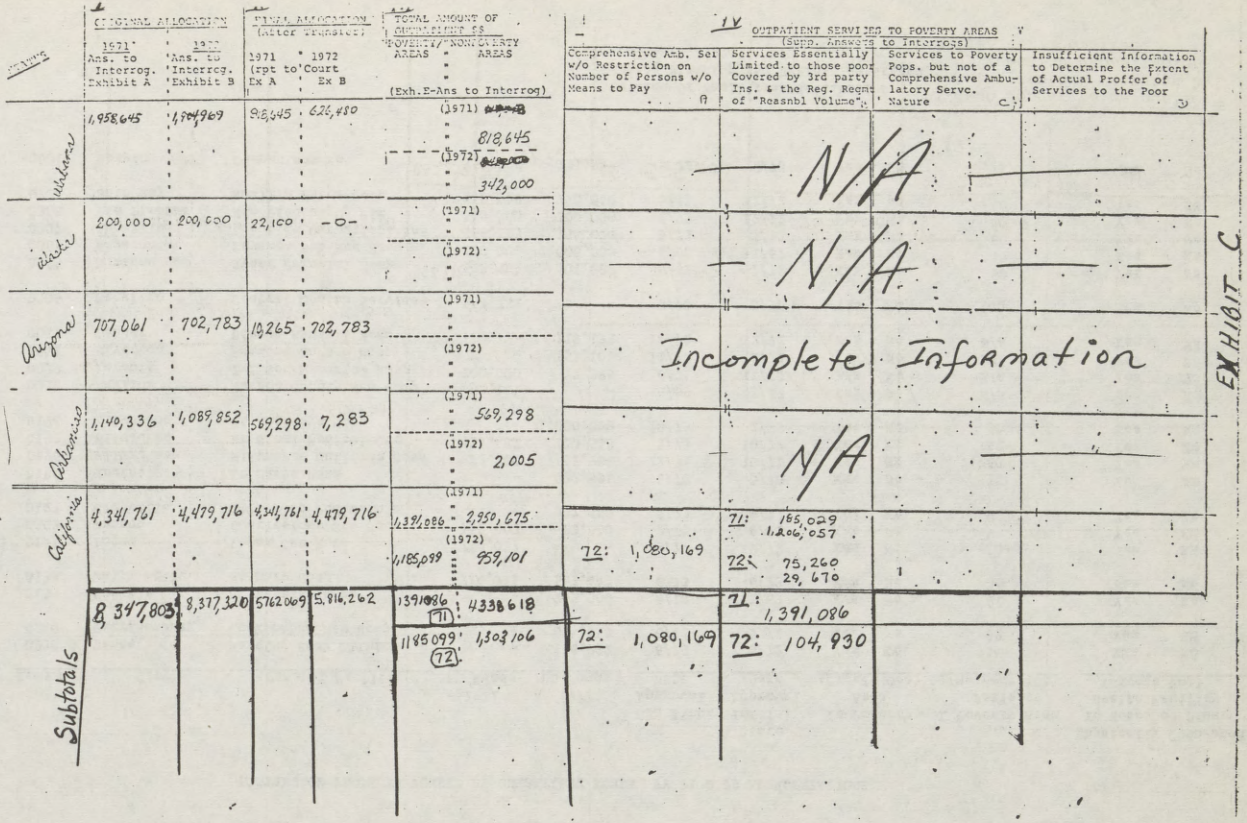
State	Proj.No.	City	Name of Facility	1971 HB Funds	1972 HB Funds	HEW Final Approval Date	State Initial Approval Date	In Poverty Area (Circle One)		% Poverty Area Patients (Nearest 10%)	Physically Connected To Hosp. or Other Health Facility (Circle One)	
Oklahoma	A337	Oklahoma City	Presbyterian Hosp	205,000	-	6/73	10/72	Yes	No	Not Open	Yes.	No
	A338	Idabel	Mc Curtain Mem Hosp	205,000	-	4/72	1/72	Yes	No	90	Yes	No
	A342	Lawton	J Taliaferro Comm MHC	489,943	331,000	6/73	10/71	Yes	No	10	Yes	No
	A343	Oklahoma City	Hillcrest Osteo Hosp	205,000		4/72	2/72	Yes	No	10	Yes	No
	0344	Oklahoma City	Mary Mahoney Mem H C	-	498,000	3/74	2/74	Yes	No	90	Yes	No
Pennsylvania	0742	Philadelphia	Comprehensive Hlth Ctr	175,762	-	3/71	7/70	Yes	No	N/A	Yes	No
	0745	Johnstown	Mercy Hosp	300,000	-	6/71	8/70	Yes	No	N/A	Yes	No
	0746	Uniontown	Uniontown Hosp	1,375,075	-	12/72	1/72	Yes	No	N/A	Yes	No
	0747	Grove City	Grove City Hosp	184,203	-	5/73	12/71	Yes	No	N/A	Yes	No
	0748	Harrisburg	Harrisburg Hosp	1,000,000	-	6/73	3/72	Yes	No	N/A	Yes	No
	0749	Meadville	Spencer Hosp	750,000	-	6/73	3/72	Yes	No	N/A	Yes	No
Rhode Island	A078	Providence	Rhode Island Hosp	273,925	-	6/69	5/69	Yes	No	10	Yes	No

State	Proj.No.	City	Name of Facility	1971 HB Funds	1972 HB Funds	HEW Final Approval Date	State Initial Approval Date	In Poverty Area (Circle One)	% Poverty Area Patients (Nearest 10%)	Physically Connected To Hosp. or Other Health Facility (Circle One)
South Carolina	D318	Charleston	Medical Univ Hosp	329,913	-	6/71	8/70	[illegible] No	N/A	Yes [illegible]
	0319	Charleston	Medical Univ Hosp	1,092,608	1,317,840	6/73	6/72	[illegible] No	"	Yes [illegible]
Tennessee	B429	Greeneville	Greeneville Green Co.PHC	71,406	14,095	1/73	12/71	[illegible] No	"	Yes [illegible]
	C040	Chattanooga	Baroness Erlanger Hosp	308,606	26,462	12/72	11/71	[illegible] No	"	Yes [illegible]
	D003	Crossville	Cumberland Medical Ctr	-	260,000	-	1/73	[illegible] No	"	Yes [illegible]
	D014	Kingsport	Holston Valley Comm	-	167,497	6/73	5/73	[illegible] No	"	Yes [illegible]
	E009	Jackson	Jackson Madison Co Hosp	-	296,452	10/73	5/73	[illegible] No	"	Yes [illegible]
	0076	Memphis	Collins Chapel Hosp	-	330,928	-	4/73	[illegible] No	"	Yes [illegible]
Texas	D501	San Antonio	Eastside Aux PHC	63,157	-	10/71	6/70	[illegible] No	0	[illegible] No
	D527	Houston	West End PHC	400,000	-	2/73	8/71	[illegible] No	0	[illegible] No
	D530	Marshall	Marshall Memorial Hosp	150,000	-	9/72	7/72	[illegible] No	0	Yes [illegible]
	D533	Lubbock	Methodist Hosp	858,000	-	12/71	6/71	[illegible] No	0	Yes [illegible]
	D535	Houston	U of Tex Anderson Hosp	1,000,000	-	11/72	7/72	[illegible] No	0	Yes [illegible]
	D537	San Antonio	Lutheran Gen Hosp	325,000	-	5/73	1/73	[illegible] No	10	Yes [illegible]
	D551	San Antonio	Eastside Neighbor HC	-	50,000	-	1/73	[illegible] No	0	[illegible] No
	D552	San Antonio	Southwest Branch PHC	-	372,000	10/73	7/72	[illegible] No	0	[illegible] No
	D552	Houston	Riverside Neighbhd H C	-	320,000	2/74	1/74	[illegible] No	0	[illegible] No
	D554	Austin	Rosewood Zaragosa Ctr	-	120,000	7/73	4/73	[illegible] No	0	[illegible] No
	D575	Rio Grande	Starr Co Mem Hosp	-	315,000	6/73	9/72	Yes [illegible]	100	Yes [illegible]
	D576	Poteet	Poteet Comm Op Fac	-	9,996	-	8/72	Yes [illegible]	100	[illegible] No
	D577	Fort Worth	Radiation Center	-	175,000	-	2/73	[illegible] No	0	[illegible] No
	D578	El Paso	El Paso Cancer Rad Ctr	841,450	-	3/73	8/72	[illegible] No	0	[illegible] No
	D579	Houston	San Jose Clinic	-	125,000	-	1/73	[illegible] No	0	[illegible] No
	D582	San Antonio	S Texas Cancer Radi Ctr	198,296	581,454	6/73	1/73	[illegible] No	10	[illegible] No
Vermont	B033	St Johnsbury	N E Vermont Reg Hosp	100,000	110,141	3/70	6/68	[illegible] No	5	Yes [illegible]
	C041	Newport	North Country Hosp	100,000	98,058	8/71	4/71	Yes [illegible]	96	Yes [illegible]
	0045	Island Pond	Island Pond Med Ctr	-	4,878	6/73	4/73	Yes [illegible]	95	[illegible] No

LISTING OF PROJECTS FUNDED BY OUTPATIENT FUNDS, FY 71 & 72 APPROPRIATIONS

State	Proj.No.	City	Name of Facility	1971 HB Funds	1972 HB Funds	HEW Final Approval Date	State Initial Approval Date	In Poverty Area (Circle One)		% Poverty Area Patients (Nearest 10%)	Physically Connected To Hosp. or Other Health Facility (Circle One)	
Virginia	0238	Dante	Hanging Rock Clinic	-	116,992	6/73	3/72	Yes	[illegible]	54	[illegible]	No
	0240	Harrisonburg	Rockingham Mem Hosp	-	614,250	6/73	5/72	[illegible]	No	32	Yes	[illegible]
Washington	D133	Seattle	University Hosp	-	295,000	6/70	1/69	[illegible]	No	10	Yes	[illegible]
	0138	Walla Walla	St Mary Hosp	724,271	567,447	6/73	6/73	[illegible]	No	10	Yes	[illegible]
West Virginia	D121	Logan	Logan Gen Hosp	215,027	-	9/72	9/72	[illegible]	No	Not Open	Yes	[illegible]
	D123	Ranson	Charlestown Gen Hosp	150,000	23,600	2/73	4/72	[illegible]	No	"	Yes	[illegible]
	D127	Glenville	Gilmer Co PHC Clinic	-	337,300	8/73	9/72	Yes	[illegible]	"	Yes	[illegible]
Wisconsin	0189	Racine	St Marys Hosp	-	432,991	6/70	5/70	[illegible]	No	10	Yes	[illegible]
	0196	Milwaukee	Milwaukee Children Hosp	72,800	12,204	12/71	10/71	Yes	[illegible]	40	Yes	[illegible]
	0197	Milwaukee	Mt Sinai Medical Ctr	637,482	110,518	3/73	10/72	Yes	[illegible]	40	Yes	[illegible]
	0198	Milwaukee	St Anthonys Hosp	-	1,000,000	10/73	2/73	Yes	[illegible]	50	Yes	[illegible]
Wyoming	D038	Rawlins	Carbon County Mem Hosp	52,161	-	6/69	3/69	[illegible]	No	N/A	Yes	[illegible]
	D039	Laramie	Ivinson Memorial Hosp	200,000	12,385	6/71	11/70	[illegible]	No	N/A	Yes	[illegible]
	0041	Riverton	Fremont Co Mem Hosp	-	153,101	11/72	2/72	[illegible]	No	N/A	Yes	[illegible]
	0042	Lander	Bishop Randall Hosp	-	118,132	11/72	2/72	[illegible]	No	N/A	Yes	[illegible]
Guam	D006	Mangilao	Central Health Services	261,752	-	8/70	3/70	Yes	[illegible]	100	[illegible]	No
Puerto Rico	B069	Humacao	Ryder Memorial Hosp	538,302	201,889	9/72	1/72	[illegible]	No	60	Yes	[illegible]
	C065	Bayamon	Bayamon Sub Reg Hosp	300,000	1,000,000	6/68	11/67	[illegible]	No	40	Yes	[illegible]
	0307	Luquillo	Luquillo Outpatient Fac	556,213	134,874	6/73	5/72	[illegible]	No	60	[illegible]	No
	0308	Rio Piedras	Rio Piedras Op Fac	500,000	200,000	6/73	12/72	[illegible]	No	40	[illegible]	No
	0309	Hato Ray	Auxilio Mutuo Hosp	110,223	170,560	5/73	12/72	[illegible]	No	40	Yes	[illegible]
Trust Territory	0001	Saipan	Outpatient Fac	750,000	721,949	6/73	2/73	Yes	[illegible]	75	[illegible]	No

Division of Facilities Utilization
Program Planning and Evaluation Branch
November 5, 1974



State	I ORIGINAL ALLOCATION 1971 Ans. to Interrog. Exhibit A	1972 Ans. to Interrog. Exhibit B	II FINAL ALLOCATION (after transfer) 1971 (rpt to Ex A	1972 Court Ex B	III TOTAL AMOUNT OF ENTITLEMENT FS POVERTY/NON-POVERTY AREAS (Exh. E-Ans to Interrog)	IV OUTPATIENT SERVICES TO POVERTY AREAS (Supp. Answers to Interrogs) Comprehensive Amb. Ser w/o Restriction on Number of Persons w/o Means to Pay A	Services Essentially Limited to those poor Covered by 3rd party Ins. & the Reg. Reqmt of "Reasnbl Volume" B	V Services to Poverty Pops. but not of a Comprehensive Ambulatory Servc. Nature C	Insufficient Information to Determine the Extent of Actual Proffer of Services to the Poor D
Alabama	1,958,645	1,804,969	98,645	626,480	(1971) ~~1,804,969~~ 818,645 (1972) ~~1,804,969~~ 342,000		N/A		
Alaska	200,000	200,000	22,100	-0-	(1971) (1972)		N/A		
Arizona	707,061	702,783	10,265	702,783	(1971) (1972)		Incomplete Information		
Arkansas	1,140,336	1,089,852	569,298	7,283	(1971) 569,298 (1972) 2,005		N/A		
California	4,341,761	4,479,716	4,341,761	4,479,716	(1971) 1,391,086 2,850,675 (1972) 1,185,099 959,101	72: 1,080,169	71: 165,029 1,206,057 72: 75,260 29,670		
Subtotals	8,347,803	8,377,320	5762069	5,816,262	1391086 (71) 4338618 1185099 (72) 1,303,106	72: 1,080,169	71: 1,391,086 72: 104,930		

EXHIBIT C

STATE	I ORIGINAL ALLOCATION (Exhibit A) 1971 Ans. to Interrog.	I ORIGINAL ALLOCATION (Exhibit B) 1972 Ans. to Interrog.	II FINAL ALLOCATION (After Transfer) 1971 (rpt to Ex A	II FINAL ALLOCATION (After Transfer) 1972 Court Ex B	III TOTAL AMOUNT OF ENTITLEMENT §5 POVERTY/NONPOVERTY AREAS (Exh. E-Ans to Interrog)	IV OUTPATIENT SERVICES TO POVERTY AREAS (Supp. Answers to Interrogs) Comprehensive Amb. Ser w/o Restriction on Number of Persons w/o Means to Pay A	Services Essentially Limited to those poor Covered by 3rd party Ins. & the Reg. Reqmt of "Reasnbl Volume" B	Services to Poverty Popn. but not of a Comprehensive Ambulatory Servc. Nature C	Insufficient Information to Determine the Extent of Actual Proffer of Services to the Poor D
Colorado	688,258	756,316	335,243	428,649	(1971) 256,593 (1972) 100,000	—	N/A	—	—
Conn	540,987	540,453	905,476	461,757	(1971) 600,000 289,966 (1972) 161,757		71: 300,000 300,000		
Delaware	200,000	200,000	151,900	397,425	(1971) (1972)		71: 100,000	71: 9,406 42,494 72: 200,000	
Dist Colum	200,000	200,000	294,400	510,501	(1971) 294,400 (1972) 510,501	— — —	N/A	— —	— —
Florida	2,518,208	2,491,189	1,909,361	2,950,356	(1971) — 1,859,361 (1972) 853,232 767,494	72: 575,000			72: 19,070* 90,000 29,162*
Subtotals	4157453	4187958	3596380	4748688	600,100 71 2,700,320 853,232 72 1,539,752	72: 575,000	71: 700,000	71: 51,900 72: 200,000	72: 138,232

*These appear to be public health centers operated by Public Health Depts. which render services free.

(2)

STATE	I ORIGINAL ALLOCATION 1971 Ans. to Interrog. Exhibit A	I ORIGINAL ALLOCATION 1972 Ans. to Interrog. Exhibit B	II FINAL ALLOCATION (After Transfer) 1971 (rpt to Ct Ex A	II FINAL ALLOCATION (After Transfer) 1972 Court Ex B	III TOTAL AMOUNT OF OUTPATIENT SS POVERTY AREAS (Exh. E-Ans to Interrog)	III NONPOVERTY AREAS	IV OUTPATIENT SERVICES TO POVERTY AREAS (Supp. Answers to Interrogs) Comprehensive Amb. Ser. w/o Restriction on Number of Persons w/o Means to Pay A	IV Services Essentially Limited to those poor Ins. & the Reg. Reqmt of "Reasnbl Volume" B	IV Services to Poverty Pops. but not of a Comprehensive Ambulatory Servc. Nature C	V Insufficient Information to Determine the Extent of Actual Proffer of Services to the Poor D
Missouri	2,176,564	2,063,416	1,894,521	1,986,643	(1971) 1,894,521		72: 770,000			
					(1972) 770,000	1,216,643				
Kansas	~~233,~~ 233,723	227,026	133,723	327,026	(1971) 133,723		—	N/A	—	—
					(1972)					
Idaho	317,315	334,854	-0-	30,334	(1971)		—	N/A	—	—
					(1972)					
Illinois	2,334,529	2,483,284	2,134,529	2,483,284	878,090 (1971)	1,256,439	71: 49,215			N: 828,875
					(1972) 284,318	4,932				72: 284,318
Indiana	1,578,602	1,681,757	1,508,635	349,115	895,472 (1971)	603,635	71: 895,472			
					250,657 (1972)	106,179	72: 250,657			
Subtotals	6640733	6790337	5771408	5,182,402	1773562 (71)	3,888,318	71: 944,687			71: 828,875
					1304975 (72)	1327754	72: 1,020,657			72: 284,318

(3)

STATE	I ORIGINAL ALLOCATION 1971 Ans. to Interrog. Exhibit A	I ORIGINAL ALLOCATION 1972 Ans. to Interrog. Exhibit B	II FINAL ALLOCATION (After Transfer) 1971 (rpt to Court Ex A	II FINAL ALLOCATION (After Transfer) 1972 Court Ex B	III TOTAL AMOUNT OF OUTPATIENT $$ POVERTY AREAS (Exh. E-Ans to Interrog)	III NONPOVERTY AREAS	IV OUTPATIENT SERVICES TO POVERTY AREAS (Supp. Answers to Interrogs) Comprehensive Amb. Ser w/o Restriction on Number of Persons w/o Means to Pay A	Services Essentially Limited to those poor Covered by 3rd party Ins. & the Reg. Regnt of "Reasnbl Volume" B	Services to Poverty Pops. but not of a Comprehensive Ambulatory Servc. Nature C	Insufficient Information to Determine the Extent of Actual Proffer of Services to the Poor D
Iowa	905,157	975,230	963,796	820,909	(1971) — (1972) 963,796	(1971) — (1972) 782,440	71: 585,298 378,498			
Kansas	798,831	796,118	8,959	-0-	(1971) (1972)		—	N/A	—	—
Kentucky	1,613,219	1,581,171	1,613,219	1,311,840	(1971) — (1972) 1,277,957	(1971) 1628219 (1972) 66,303		888,642 72:		72: 389,345
Louisiana	1,873,793	1,789,376	78,361	1,430,510	(1971) — (1972) —	(1971) 78,360 (1972) 1,411,334	—	— N/A	—	—
Maine	426,621	444,414	426,621	200,000	(1971) — (1972) 174,785	(1971) 426,621 (1972)		72: 174,785		
Subtotals	5,593,621	5,589,329	3096956	3771,259	963,796	71) 2133200	71: 963,796	71:		
					1452742	72) 2,260,077		72: 1,063,427		72: 389,345

	I ORIGINAL ALLOCATION		II FINAL ALLOCATION (After Transfer)		III TOTAL AMOUNT OF EXPENDITURE AS SUBURBAN/NONPOVERTY AREAS / POVERTY AREAS (Exh. E-Ans to Interrog)		IV OUTPATIENT SERVICES TO POVERTY AREAS (Exh. E-Answers to Interrogs)			
	1971 Ans. to Interrog. Exhibit A	1972 Ans. to Interrog. Exhibit B	1971 (rpt to Ex A	1972 Court Ex B			Comprehensive Amb. Ser w/o Restriction on Number of Persons w/o Means to Pay A	Services Essentially Limited to those poor Covered by 3rd party Ins. & the Reg. Reqmt of "Reasnbl Volume" B	Services to Poverty Pops. but not of a Comprehensive Ambulatory Servc. Nature C	Insufficient Information to Determine the Extent of Actual Proffer of Services to the Poor D
MARYLAND	1,013,147	1,131,050	[redacted] 559,078	1,317,667	2 (1971) 438,808 - 120,170 1 (1972) 308,522 - 316,478	1			71: 316,478 72: 308,522	71: 122,430
MASSACHUSETTS	1,392,843	1,390,034	[redacted] 1,249,461	1,775,034	3 (1971) 1,249,461 - (1972) 1,165,597 -			71: 196,643 545,949 145,593 344,276 72: 62,974 250,000		72: 853,023
Maryland	[redacted] 2,333,073	2,432,525	2,333,073	2,432,525	(1971) (1972)		71: 341,000	71: 172,073 270,000 72: 200,000	72: 37,500	71: 100,000 *
MINNESOTA	[redacted] 1250267	4,281,236	320,451	100,000	(1971) 220,451 (1972)		— —	N/A		— —
Mississippi	1,512,339	1,401,268	518,500	- 0 -	(1971) (1972)			71: 518,500		
Subtotals	7,501,669	7,536,113	4,980,563	5,625,226	1688369	71 [redacted] 340,621	71: 341,000	71: 2,210034	71: 316,478	71: 222,430
					1,474,519	72 316,478		72: 512,974	72: 346,022	72: 853,023

(5)

STATE	I ORIGINAL ALLOCATION 1971 (Ans. to Interrog. Exhibit A)	I ORIGINAL ALLOCATION 1972 (Ans. to Interrog. Exhibit B)	II FINAL ALLOCATION (After Transfer) 1971 (Cpt to Ex A)	II FINAL ALLOCATION (After Transfer) 1972 (Court Ex B)	III TOTAL AMOUNT OF OUTPATIENT SS		IV OUTPATIENT SERVICES TO POVERTY AREAS (Supp. Answers to Interrogs) A	B	C	D
					POVERTY AREAS (Exh. E-Ans to Interrog)	NONPOVERTY AREAS	Comprehensive Amb. Ser w/o Restriction on Number of Persons w/o Means to Pay	Services Essentially Limited to those poor Covered by 3rd party Ins. & the Reg. Reqmt of "Reasnbl Volume"	Services to Poverty Pops. but not of a Comprehensive Ambulatory Servc. Nature	Insufficient Information to Determine the Extent of Actual Proffer of Services to the Poor
Missouri	1655,193	1,672,673	45,847	1,472,673	(1971)			N/A		
					(1972)	1,000,000				
Montana	278,915	284,566	26,230	27,498	(1971)			N/A		
					(1972)					
Nebraska	492,744	518,472	55,450	233,729	(1971)	55,450		N/A		
					(1972)	233,729				
Nevada	200,000	200,000	-0-	-0-	(1971)			N/A		
					(1972)					
New Hampshire	254,586	262,946	275,000	442,506	(1971)	165,414 109,586		71: 165,414		
					(1972)	353,454 75,000		72: 67,506 285,948		
Subtotals	2,881,440	2,948,657	402,527	2,176,406	165,414	165,036		71: 165,414		
					353,454	1,308,729		72: 353,454		

(6)

	I ORIGINAL ALLOCATION		II FINAL ALLOCATION (After Transfer)		III TOTAL AMOUNT OF OUTPATIENT SS		IV OUTPATIENT SERVICES TO POVERTY AREAS (Supp. Answers to Interrogs)			
	1971 Amt. to Interrog. Exhibit A	1972 Amt. to Interrog. Exhibit B	1971 Xfrd to Ccurt Ex A	1972 Xfrd to Ccurt Ex B	POVERTY AREAS (Exh. E-Ans to Interrog)	NON-POVERTY AREAS	Comprehensive Amb. Ser w/o Restriction on Number of Persons w/o Means to Pay A	Services Essentially Limited to those poor Covered by 3rd party Ins. & the Reg. Reqmt of "Reasnbl Volume" B	Services to Poverty Pops. but not of a Comprehensive Ambulatory Servc. Nature C	Insufficient Information to Determine the Extent of Actual Proffer of Services to the Poor D
NEW JERSEY	1,601,614	1,645,838	1,601,614	1,645,838	(1971)			71: 324,325 127,289		
					(1972)			72: 126,000		
NEW MEXICO	466,193	489,209	232,523	659,162	(1971)			71: 123,308		
					(1972)					72: 68,000
NEW YORK	3,908,140	3,701,418	3,908,140	3,701,418	(1971)		71: 100,000 888,140 600,000	71: 250,000 1,000,000		72: 245,000 800,000 600,000
					2,908,140	1,000,000				
					(1972)		72: 100,000			
					2,070,000	1,100,000				
NORTH CAROLINA	~~2,584,920~~ 2,585,926	2,458,251	386,356	130,473	(1971)			N/A		
					386,356					
					(1972)					
					130,473					
NORTH DAKOTA	281,757	288,397	-0-	-0-	(1971)			N/A		
					(1972)					
Subtotals	8843636	8583110	6128633	6136891	2908140 (71)	1286356	71: 2,738,140	71: 1,824,922		
					2,070,000 (72)	1,230,473	72: 100,000	72: 126,000		72: 1,713,000

(7)

	I ORIGINAL ALLOCATION		II FINAL ALLOCATION (After Transfer)		III TOTAL AMOUNT OF OUTPATIENT FS		IV OUTPATIENT SERVICES TO POVERTY AREAS (Supp. Answers to Interrogs)			
STATE	1971 Amd. to Interrog. Exhibit A	1972 Amd. to Interrog. Exhibit B	1971 (pt to Ex A	* 1972 Contr Ex B	POVERTY AREAS	NONPOVERTY AREAS (Exh. E-Ans to Interrog)	Comprehensive Amb. Ser w/o Restriction on Number of Persons w/o Means to Pay A	Services Essentially Limited to those poor Covered by 3rd party Ins. & the Reg. Reqmt of "Reasnbl Volume" B	Services to Poverty Pops. but not of a Comprehensive Ambulatory Servc. Nature C	Insufficient Information to Determine the Extent of Actual Proffer of Services to the Poor D
OHIO	3,280,095	3,343,682	3,280,095	3,343,682	(1971)		71: 2,105,665 290,785			72: 1,000,000 270,000
					(1972)		72: 270,000 249,215			
OKLAHOMA	1,133,058	1,133,260	1,133,058	874,193	(1971)		72: 498,000	71: 205,000 205,000		
					(1972)					
OREGON	677,534	712,977	612,977	100,000	(1971)					
					(1972)					
PENNSYLVANIA	3,765,040	3,852,446	3,765,040	3,667,115	(1971)			71: 1,375,075		
					1,375,075	2,409,965				
					(1972)					
RHODE ISLAND	273,925	276,467	273,925	-0-	(1971)			N/A		
					—	273,925				
					(1972)					
					—	—				
Subtotals:	9,149,652	9,318,832	8,732,114	7,984,980	(1) 1,375,075	(1) 2,683,890	71: 2,396,390	71: 1,785,075		
							72: 1,017,215			72: 1,270,000

(a)

	I		II		III	IV			V
	ORIGINAL ALLOCATION		FINAL ALLOCATION (After Transfer)		TOTAL AMOUNT OF OUTPATIENT SS	OUTPATIENT SERVICES TO POVERTY AREAS (Supp. Answers to Interrogs)			
STATE	1971 Amt. to Interrog. Exhibit A	1972 Amt. to Interrog. Exhibit D	1971 (rpt to Ex A	1972 Court Ex B	POVERTY AREAS / NONPOVERTY AREAS (Exh. E-Amts to Interrog)	Comprehensive Amb. Ser w/o Restriction on Number of Persons w/o Means to Pay A	Services Essentially Limited to those poor Covered by 3rd party Ins. & the Reg. Reqmt of "Reasnbl Volume" B	Services to Poverty Pops. but not of a Comprehensive Ambulatory Servc. Nature C	Insufficient Information to Determine the Extent of Actual Proffer of Services to the Poor D
South Carolina	1,428,753	1,417,840	1,428,753	1,417,840	(1971) — / —				
					(1971) — / 1,422,521				
					(1972) — / 1,317,840				
South Dakota	298,046	299,487	23,138	32,664	(1971)				
					(1972)				
Tennessee	2,011,253	1,967,031	380,013	1,159,792	(1971) 380,012 /				
					(1972) 1,095,434 /				
Texas	4,697,059	4,543,993	3,836,746	2,168,450	(1971) — / 3,835,903				
					(1972) 324,996 / 1,743,454				
Utah	454,762	478,323	-0-	-0-	(1971)				
					(1972)				
Subtotals	3,959,873	8,706,679	5,743,650	2,168,450	(71) 5,638,436				
					(72) 324,996 / 4,156,728		72: 9,996		72: 315,000

N/A

N/A

N/A

N/A

	I ORIGINAL ALLOCATION		II FINAL ALLOCATION (After Transfer)		III TOTAL AMOUNT OF OUTPATIENT SS		IV OUTPATIENT SERVICES TO POVERTY AREAS (Supp. Answers to Interrogs)			
	1971 Ans. to Interrog. Exhibit A	1972 Ans. to Interrog. Exhibit B	1971 (rpt to Ex A	1972 Court Ex B	POVERTY AREAS	NONPOVERTY AREAS	Comprehensive Amb. Ser w/o Restriction on Number of Persons w/o Means to Pay A	Services Essentially Limited to those poor Ins. & the Reg. Reqmt of "Reasnbl Volume" B	Services to Poverty Pops. but not of a Comprehensive Ambulatory Servc. Nature C	Insufficient Information to Determine the Extent of Actual Proffer of Services to the Poor D
					(Exh. E-Ans to Interrog)					
VERMONT	200,000	200,000	200,000	213,077	(1971) 100,000	100,000 (1972)		71: 100,000		
					102,936	110,141		72: 98,058 4,878		
VIRGINIA	1,890,094	1,838,745	-0-	741,242	—	(1971) —				
					116,992	(1972) 614,250		72: 116,992		
WASHINGTON	910,633	964,620	724,271	1,164,620	—	(1971) 724,271		N/A		—
					—	(1972) 862,447				
WEST VIRGINIA	942,586	930,711	403,472	610,900	—	(1971) 365,027				72: 337,300*
					337,300	(1972) 23,600				
WISCONSIN	1,376,069	1,470,263	810,282	1,470,263	710,282	(1971)		71: 72,800 637,482		
					1,122,772	(1972) 432,991		72: 1,000,000 119,518 12,204		
Subtotals	5,319,382	5,404,342	2,138,025	4,200,102	810,282	1,189,298 (71)		810,282 71:		
					1,679,950	2,043,429 (72)		1,342,650 72:		72: 337,300

	I ORIGINAL ALLOCATION		II FINAL ALLOCATION (After Transfer)		III TOTAL AMOUNT OF OUTPATIENT SS		IV OUTPATIENT SERVICES TO POVERTY AREAS (Supp. Answers to Interrogs)			V
	1971 Ans. to Interrog. Exhibit A	1972 Ans. to Interrog. Exhibit B	1971 (rpt to Ex A	1972 Court Ex B	POVERTY AREAS	NONPOVERTY AREAS (Exh.E-Ans to Interrog)	Comprehensive Amb. Ser w/o Restriction on Number of Persons w/o Means to Pay A	Services Essentially Limited to those poor Covered by 3rd party Ins. & the Reg. Reqmt of "Reasnbl Volume" B	Services to Poverty Pops. but not of a Comprehensive Ambulatory Servc. Nature C	Insufficient Information to Determine the Extent of Actual Proffer of Services to the Poor D
Wyoming	200,000	200,000	252,161	283,618		(1971)	—	N/A		—
						(1972)				
Amer. Samoa	100,000	100,000	-0-			(1971)				
						(1972)				
GUAM	100,000	100,000	293,752		261,752	(1971) —				71: 261,752*
					—	(1972) —				
PUERTO RICO	2,004,738	1,937,323	2,004,738			(1971)		N/A		
						(1972)				
VIRGIN ISLANDS	100,000	100,000	-0-			(1971)				
						(1972)				
TRUST TERRITORY										71: 750,000 72: 721,949
Sub Totals	2,504,738	2,437,323	2,550,651	283,618	261,752 (71)					71: 1,011,752 72: 721,949

(11)

Ms. ROSE. Then, after examination of project files, we categorized those projects which HEW characterized as granted to projects in poverty areas based upon evidence of intent to provide comprehensive health services to persons unable to pay.

Please note the distinction which is made between projects in poverty areas and projects designed to serve poverty area residents. Despite the location of all those projects in so-called poverty areas, in fact a great number of them were not designed to serve residents of poverty areas unable to pay, in contrast with the neighborhood health centers which this subcommittee considered the model grantee for the moneys.

Thus, aside from States which admitted transferring moneys out of the outpatient category and then granting the remaining moneys to nonpoverty area grantees—for example, Alabama, Tennessee, Louisiana, North Carolina, South Carolina, Minnesota, Kansas, Nebraska, Utah, North Dakota, South Dakota, and so forth—other States made grants to facilities within designated poverty areas, but not to projects serving poverty residents unable to pay.

In most instances the grant was made for ancillary outpatient services as part of a hospital. For example, Mississippi received a total of $2,913,607 for fiscal years 1971 and 1972, transferred all but $518,500 out of the outpatient category and granted the remaining $518,500 to a hospital outpatient facility, located in a poverty area according to the State plan, but not designed to serve a poverty population unable to pay for services.

California did likewise with the outpatient funds it did not transfer out of the outpatient category for fiscal year 1971. I refer you to exhibit C to see the disposition for each State.[1]

We have found that many States, other than those which admitted transferring moneys out of the outpatient category, granted all their outpatient moneys to nonpoverty grantees. States that did the latter include Alabama, Tennessee, North Carolina, and South Carolina.

There are other such States. See exhibit C. Although the information is still not complete, it clearly demonstrates that a vast portion of the outpatient moneys was not in fact granted to projects designed to serve poverty residents. This result was triggered by some serious misconceptions of the intentions of Congress as well as a misinterpretation of the effect of the 1970 amendments on the existing Hill-Burton Act.

A critical factor, and I think it is one that HEW chiefly relies upon, was the perpetuation of the simplistic notion that need for outpatient services is determined simply by counting physical facilities in whatever service area system the State chose for determining bed needs in hospitals.

Neither HEW nor the State agencies reviewed the "service area" designations in State plans to reflect the lack of primary health care facilities to the poor.

The GAO report notes that the State plans either do not indicate how outpatient facility needs are determined, or limit determination

[1] HEW files were not complete enough in many instances to determine categorically whether facilities restricted services to the paying population. Many facilities in our IV–D category on exhibit C may, in fact, serve persons unable to pay without restriction on number. But such information was apparently not deemed necessary by HEW despite the grant of moneys to the facility as a poverty area grantee.

of need by showing a relationship of outpatient facilities to population or to hospitals or service areas.

In every State plan which I have examined, I have yet to see any consideration of the availability of physicians providing health care to segments of the population within an area unable to pay as an element in determining the need of an area for outpatient facilities.

Personnel in the Office of Health Affairs of OEO knew, as the present personnel in the Bureau of Community Health Services in HEW know, that there is a high correlation between the lack of physicians, the poverty of the population, and the need for comprehensive health services through ambulatory centers.

Beverly Hills does not need the same number of outpatient facilities as does Watts, and certainly not the same number (if any) comprehensive health care centers.

The HEW testimony ignore that matter. They were trapped by the whole concept of service areas in need, but the fact is that their service area concept is a "Catch-22"—they set up service areas, without determining what the real needs of poverty population are for ambulatory service.

I think the GAO report points out that HEW could have, or the States could have, designated subareas of poverty. They have not done so.

I heard Virginia mentioned today by HEW. The Virginia plan, after taking 20 percent of their service areas with the highest percentage of poverty (the rest are designated nonpoverty areas), includes only rural areas. They ignore the fact that the largest number of poor people are in subpockets of poverty in urban areas.

Richmond is far away from being considered any poverty area, but there are sections of Richmond that have high incidents of poverty, and the population numbers that the State has indicated in its plan show that there are far more poor people in the Richmond area than any other area of the State.

The plans are based on myths, and HEW has approved without thinking, really, the State plans. That is where HEW has the power to act. Even though they say it is a State program, they have the power to approve or disapprove plans for the rational, logical expression of congressional intent in these plans, and that is what they did not do.

Senator KENNEDY. How do they show this? What criteria should they have established in terms of poverty?

Ms. ROSE. I think that there must be consideration of various factors. First, how many physicians are located in offices in the area. Watts, for example, had something like seven physicians per population. That is a very important criteria.

There are various methods which OEO used for finding the given need for the health centers.

One factor ignored by HEW is to ascertain how many facilities there are in the area that actually serve poor people.

Now, most members of the National Association of Neighborhood Health Centers operate on the basis that grant moneys pay for services that people cannot pay for themselves. In recent survey I did, in which I asked the question, most of the health centers indicated that they serve between 40 and 50 percent of the population with grant money. I believe that Dr. Anderson will testify—that the Franklin Fetter Center is in this category.

Dr. ANDERSON. Forty-three percent.

Ms. ROSE. Forty-three percent.

You make a survey of service. There may be outpatient facilities attached to a hospital, but the hospital in a poverty area may only be affording ancillary service to inpatient. That should not be counted as an ambulatory program.

These are two factors that are very important. Nothing like this is reflected whatsoever in the State plans. We must recognize that the existing State plans were perpetuated as inadequate or indeed defective documents for the determination of need for outpatient services in poverty areas.

This failure need not have been a fatal defect had the Hill-Burton agencies and HEW recognized that the poverty priority superseded the nonpoverty determination of need for outpatient facilities.

HEW persists, however, in taking the legal position that the critical issue is the need between service areas (however determined) without regard to the need of poverty populations for primary health care.

The GAO concluded that the Hill-Burton Act, as amended, "does not authorize HEW to give priority to nonpoverty outpatient facilities projects over poverty projects of the same type based solely on the relative needs of the service area for outpatient facilities." (P. 27.)

We agree with the GAO conclusion, and believe that it reflects the intention of Congress in this regard.

Turning to one other item HEW makes reference to a claim that in several States. that public health centers are really outpatient facilities.

Well, I think maybe there are a few that are, but most public health centers are set up by the State Health Department to provide immunization, TB control, VD control, sanitation, and they are not outpatient facilities by any stretch of the imagination. They certainly do not give the comprehensive health services that the Neighborhood Health and Family Health Centers do, which this committee intended that money to go for, so you can cross them out.

I also note that HEW listed 55 poverty areas facilities. I think when we break it down and look on files, there are much fewer facilities to serve poverty residents.

If you take the first six pages on my exhibit C and add the numbers in 1971 of something like $35 million outpatient moneys about $2 million of them went to facilities which I would describe as providing comprehensive health service for the poverty population. That is a very small percentage, and I do not think it meets the congressional objective.

Turning to the second issue, in June 1974, I testified extensively concerning the continued failure of HEW and the State agencies to enforce the "free service" regulation. I reiterate my contentions set forth in that testimony that the enforcement activities of State agencies have been minimal but in most cases nonexistent.

As Mr. Crimm is prepared to testify in depth concerning the investigation by the Southern Regional Council, I shall be brief with my comments.

Obviously because of the constraints in time GAO conducted a limited investigation of this area, visiting only some 20 Hill-Burton facilities out of a potential 6,000. However, GAO did note the limited nature of the evaluation function on the State agency level, finding that it was one:

. . . essentially accomplished by matching the amount of free services required with the amount of free service provided as shown on financial statements submitted by the facilities. None of the State agencies reviewed has an active program for verifying the information submitted by the facilities.

Officials at three State agencies told us that they did not have sufficient personnel to conduct site visits to determine facility compliance. Most of the State agencies reviewed plan to rely on complaints as an indication of noncompliance. (P. 15).

Our own interviews with HEW Hill-Burton regional personnel also indicates lack of on-site investigations and audits.

Thus, in response to a questionnaire sent by my office, three regions of HEW (Region I—Boston; Region IV—Atlanta; and Region X—Seattle) indicated that they too engaged in no onsite evaluations because of limited personnel, and relied simply on the reports of the States. In most instances the State reports are simply two-page summary letters. Thus, there is no indication that any inspections and audits are being conducted by anyone.

The States are relying simply on financial statements submitted by the hospitals, and HEW also is doing no checking.

Now, I think the States and HEW regional offices say they lack the personnel, and maybe this is one area when I find some agreement with HEW. They do lack the personnel.

Most States have one person, or maybe two people, in their Hill-Burton State agency. They have always been primarily concerned with the construction aspect—many of them may be engineers. They are not accountants, and certainly have no sociology background, and they probrably do not have the personnel to do this on a statewide basis.

I have suggested, to both HEW personnel and to State agency personnel, that they do a spot check audit. Every State health agency is going to have a fiscal office. If they took the three or four or five largest Hill-Burton grantees in their State, they may find a different picture. They do not have to go to every facility that only has a $40,000 obligation.

They can go to one that has a $200,000 or $300,000 obligation.

Moreover, many facilities have operated on the assumption that as long as they select the option that they will turn no one away, they need not report their financial statements or projected budgets of free service, an assumption which has validity under a number of State plans which exempt them from so reporting. [For example, Alabama's plan.]

According to a HEW report presented at the Federal Hospital Council meeting of November 12, some 136 institutions in Alabama had selected the "open door" option, and reported giving the grand sum of $25,636 in free service.

Although the State agencies interviewed by GAO indicated that they would rely upon complaints, there have been very few complaints filed according to the reports to HEW. In view of the fact that HEW and most State agencies have not required any posting of notice of the possibility of a free service obligation, one might conclude that most poor people do not even know that such an obligation exists and that the particular hospital has an obligation in this regard, let alone know to whom one might complain.[1]

[1] This situation may soon change, as the Federal Hospital Council recently approved an HEW proposal that would require the posting of notice. This has been a demand from us for the last 2 years.

According to our own investigation as well as reports by HEW at the most recent meeting of the Federal Hospital Council, there are indeed States which have not even instituted a program, or have just completed and approved a "free service" plan, or are just receiving their first reports from hospitals.

Note that the implementing regulation was promulgated in the summer of 1972, more than 2 years ago. Among the States without even the beginnings of a program are California, Connecticut, and Virginia.

I have attached copies of a complaint which was filed with the State agency of Virginia, concerning the actions of two hospitals which have pursued to judgments claims against indigent clients of a legal service attorney. (Exhibit D.)

[The material referred to follows:]

EXHIBIT D

THE LEGAL AID SOCIETY OF ROANOKE VALLEY
702 SHENANDOAH AVENUE, N. W.
ROANOKE, VIRGINIA 24016

ATTORNEYS
CHARLES L. APPERSON
MICHAEL F. BLAIR
KENNETH S. BRIDGEMAN
EDWARD M. JASIE
ROBERT D. SAVARD

TELEPHONE
(703) 344-2088

HENRY L. WOODWARD
GENERAL COUNSEL

August 16, 1974

Robert Ham, Director
Bureau of Medical and Nursing
Facilities Services
3117 West Clay Street
Richmond, Virginia

Dear Mr. Ham:

I wrote to you previously on July 11, 1974, concerning problems that exist in the delivery of medical services to indigent persons by hospitals receiving Hill-Burton Funding. In that letter I requested certain information from you regarding the plans and compliance levels which your agency had promulgated. I also requested to know the criteria being used to determine compliance. So far I have not received a response to this letter.

As I previously advised you, local hospitals who receive Hill-Burton funding are not complying with the applicable guidelines regarding the provision of low-cost and no charge services to indigent individuals.

I have sought compliance on behalf of two families who are indigent and have not been able to reach an agreement with either Roanoke Memorial or Community Hospital. Therefore this letter represents a formal complaint to you regarding practices to be described and I further request that you seek to investigate and remedy said noncompliance.

The first situation involves Paul and Gay Crawford, residing at 415 Highland Avenue, S.E., Roanoke, Virginia. Mr. Crawford earns approximately $60 per week for the families' support, and at times less. There is one child of nineteen who is apparently still living at home. The family has sough medical treatment from both Roanoke Memorial and Community Hospital in the past. They have not been able to pay for the services rendered, and subsequently judgments were entered against them. Roanoke Memorial has one judgment against them for $49.00. Community Hospital of Roanoke Valley has two judgments against them, one in the amount of $92.40 and another in the amount of $51.50. I have asked the attorney for the hospitals, Frank Perkinson, Jr., to mark the judgment satisfied and cease collection efforts; however, he so far has not done so. He has agreed not to issue any execution on the judgments at this time. Of course, that does not satisfy the

Hill-Burton requirements, and the accounts should be cleared without further threat of collection efforts being instituted against Mr. and Mrs. Crawford.

The second situation involves Mr. and Mrs. Luther Woods, who lives at 2141 King Charles Avenue, S.E., Roanoke, Virginia. Mr. and Mrs. Woods have six children. This family of eight has an income of $520 per month on which to live. The family has been treated both at Roanoke Memorial and Community Hospital. At present time Roanoke Memorial is attempting to collect the amount of $19.00 from Mr. Woods, while Community Hospital of Roanoke Valley is attempting to collect the amounts of $32.75, $113.95, and $185.45. I have requested the collection attorney, Mr. Frank Perkinson, Jr., to mark these accounts as satisfied and to cease further collection attempts; however, I have received no assurance from him that this action has been taken.

Besides requesting that you investigate the above complaints, I also request that you send to me as soon as possible a copy of the criteria for identifying persons unable to pay for services as provided for in 42 C.F.R. §53.111 (g). This request is authorized under §53.111 (g) (3).

Since I have previously requested the above criteria and have also advised you concerning the problems regarding the provision of medical services to indigent individuals by hospitals receiving Hill-Burton funding, I believe it proper to ask you to resolve the above complaints and send me the criteria within a period of thirty days.

Thank you very much for your cooperation in this matter.

Respectfully,

Robert D. Savard

RDScb

cc: Citizens Assistance
825 East Broad Street
Richmond, Virginia

COMMONWEALTH OF VIRGINIA

MACK I. EHANHOLTZ, M. D.
COMMISSIONER

DEPARTMENT OF HEALTH
RICHMOND, VA. 23219

September 3, 1974

Mr. Robert D. Savard
Attorney
The Legal Aid Society of Roanoke Valley
702 Shenandoah Avenue, N. W.
Roanoke, Virginia 24016

Dear Mr. Savard:

Please excuse my delay in answering your letter of August 16, 1974. I have been on vacation.

Both the Roanoke Memorial Hospitals and the Community Hospital of Roanoke Valley have indicated to us that they have chosen the option in regards to hospital service for the needy as, "they have advised us that they will not deny admission to any services at their facilities to any person unable to pay therefor without charge or at a charge below reasonable cost".

This State Agency has not established as yet a criteria for identifying persons unable to pay for service and we are, at the present time, gathering data for this determination.

I am sending a copy of your letter to each of the above hospitals' administrators and I would suggest that you contact each of the administrators.

Sincerely yours,

Robert D. Ham
Director
Bureau of Medical and
Nursing Facilities Services

RDH:NEJ

CC: Mr. William H. Flannagan, Director
Roanoke Memorial Hospitals

CC: Dr. H. E. Gillespie

CC: Mr. William R. Reid, Administrator
Community Hospital of Roanoke Valley

Ms. ROSE. Despite the fact that these hospitals have checked the option of turning no one away, the State has refused to process the complaints, referring the legal service attorney back to the hospital administrators on the excuse that the State agency has not "established as yet a criteria for identifying persons unable to pay for service."

We continue to be seriously concerned that there is no enforcement program and that business as usual with regard to free service to the indigent persists.

I think I will submit the rest of my statement for the record, because I would like Mr. Crimm to make a statement, and Mr. Ashford, and Dr. Anderson both have very brief statements.

Mr. Crimm.

Mr. CRIMM. Good morning, Mr. Chairman. I am Allan Crimm, health consultant with the southern governmental monitoring project.

With me is Joe Tom Easley, director of the project. We appreciate your invitation to give testimony on this important piece of legislation now before your committee.

Senator KENNEDY. Before we continue, on this mention of an HEW report to the Hospital Council, 130 institutions in Alabama of a selected open door option, gave a total of $25,000, $25,636 free service comes to $188 per facility. How is it possible that a facility only has $188?

Ms. ROSE. What really happens, and Mr. Crimm will go into it in his testimony. Dr. Graning said they finally decided they would require hospitals to post notices.

Well, I must say that I have been contending for 2 years that free services being available is a well guarded secret.

Senator KENNEDY. Are you saying that some hospitals say they provide services, but there are no notices extended by the administrator?

Mr. CRIMM. That is exactly right.

The original 1946 legislation required all facilities to provide a reasonable volume of free service to people who could not afford to pay for it themselves.

It was just 2 years ago that HEW decided to implement regulations regarding these long requirement responsibilities which was done, as various people have mentioned, delegated to the State agencies for enforcement of the regulations.

As you know, a section of the original 1948 legislation required all Hill-Burton-funded facilities to provide a "reasonable volume of free service" to people who could not pay for such medical care themselves. Just over 2 years ago HEW issued regulations to implement these long unnoticed requirements. Responsibility for enforcement of these indigent care obligations was delegated by HEW to the State agencies.

During this past summer, our project employed field researchers in 25 cities and small towns in 11 Southern States. Their job was to interview the administrator of each Hill-Burton hospital and nursing home in their locality in order to asses compliance with the "free service" regulations. Staff from three State agencies and one regional HEW office were later contacted to evaluate their role in enforcement.

During the summer our investigators talked with staff at 44 hospitals, evenly divided between public and private, nonprofit facilities. They attempted to meet with people at 11 more facilities but were refused interviews. With a few exceptions, the staff they contacted were

contemptuous of their legal obligation to provide free service and hostile to inquiries about compliance.

A Miami hospital administrator, for example, refused to grant an interview until our investigator's credentials were approved by a hospital industry organization. Requests for even the most basic financial information about hospitals were met with refusal time and time again.

However, a number of administrators were willing to talk openly and candidly about the lack of compliance.

I have for each member of the committee a copy of the report documenting our findings of widespread abuse of the regulations and denial of medical treatment to indigents in Hill-Burton facilities. I would like to summarize briefly our findings for you.

In our meetings with hospital administrators and conversations with State agency and HEW regional officials, the following six findings emerged:

1. Some facilities use loopholes to avoid accountability for specific dollar amounts of free service.

2. Highly questionable expenses are accounted for in such a way that hospitals appear to be in compliance.

3. The obligation of all Hill-Burton facilities to provide indigent care is one of our health care system's best kept secrets. No one except hospital administrators seems to know about it.

4. Eligible people are turned away from hospital doors because they either do not live in the right area or do not need the type of medical treatment that the facility has decided to give to indigents.

5. In spite of these abuses, the State agencies do little more than collect paper which purportedly documents compliance. Several staff admitted that they are simply taking facilities at their word.

6. The regional HEW offices condone this lack of effective evaluation and enforcement. Inadequate State plans are approved, and failure by State agencies to submit annual reports is overlooked.

As a result of these unauthorized and deceptive practices and the lack of enforcement, poor Southerners are being denied the medical treatment they need and are entitled to receive.

I would like to deal with each of our major findings in more detail in the time remaining.

Each Hill-Burton facility is required to select annually one of four methods by which the amount of free service obligation is calculated. However, some facilities use a variety of illegal practices and loopholes to avoid accountability for a specific dollar amount of indigent care.

Thirty-nine facilities, or almost 15 percent of the hospitals and nursing homes in Alabama, Georgia, and Louisiana, have not chosen one of the four options. Based on documents contained in the State agency files, we found that one Georgia hospital system has miscalculated by a third the amount of free service which it is required to give under the option it selected.

Selection of the so-called open door option is the means by which many facilities avoid accountability for a specific amount of free care. Under this option, hospitals certify that they will not refuse service to anyone because of his inability to pay.

More than 45 percent of the hospitals and nursing homes in six States—Alabama, Arkansas, Georgia, North Carolina, Tennessee, and

Texas—chose this option. In none of these State have such facilities been required to document precisely how much indigent care they did, in fact, provide.

Evidence indicates that some hospitals, although agreeing to serve everyone in need of treatment, actually provide less indigent care than if they had chosen either of the other options available to them.

A Baton Rouge, La., hospital, admittedly not in compliance under one of the other options, is anticipating a change to the open door method with the concurrence of the State agency staff in order to avoid accountability for such a high dollar amount of free medical care.

Many facilities appear to be in compliance but are actually including highly questionable expenses as "free service." The administrator of a Winston-Salem, N.C., facility admitted that bad debts are used to meet the obligated level of service although this is specifically prohibited by the regulations.

A Fort Smith, Ark., hospital administrator, dissatisfied with the allegedly low amount which his facility received from medicare and medicaid, is writing off the difference between the reasonable cost it gets and the reported actual cost of providing the care.

HEW regional officials and Alabama, Arkansas, and Georgia agency staffs see nothing wrong with this practice. However, many hospitals can account for all their free service without giving medical treatment to a single indigent person for whom they are not already receiving compensation from a government program.

Southerners are denied needed medical care because of both arbitrary geographic restrictions and limitations on the types of medical care to be given to people who cannot afford to pay.

A Memphis, Tenn., facility, for example, will not admit residents of the county in which it is located. The administrator contends that indigents are supposed to go to the county operated hospital for the medical care they need.

A North Georgia hospital registered as an open door facility will not admit obstretical cases unless the physician will certify that the life of either the mother or child is in danger. Routine deliveries by indigent mothers do not ordinarily get the benefit of hospital care.

Public notifications of the availability of free service is a farce. Most administrators we talked to in both public and private nonprofit facilities contend that the public is aware of the possibility of obtaining free or below cost care. The case files of Georgia legal services we contacted belie this assertion.

The regulations required that notices be published in local papers informing the public of the free service obligations. The administrator of one Alabama facility told us that he would not voluntarily do so, but that if he were forced to publish a statement he would "hide" it in the paper. That is exactly what happens to most of the notices that are published. The one attached to this testimony was published in the legal notices section of the paper and is characteristic of the efforts employed to inform the public.

Of the 44 hospitals visited, only one, the University of Virginia Medical Center, has a notice conspicuously posted that informs people that free service is available.

The State agencies are not performing adequate annual evaluations to check the compliance of every Hill-Burton hospital as required by the free service regulations. Our investigators found one instance of

collusion between the Louisiana agency and a Baton Rouge facility not in compliance but seeking to change its option so as to avoid accountability for a high level of free service.

The Virginia State agency refused to give our investigator a list of the facilities receiving Hill-Burton money although such information is clearly public.

As for the evaluation responsibility, a direct examination of the files at the Alabama, Arkansas, and Georgia State agencies reveals that few facilities are separating free service nd uncollectible accounts in their financial statements. The majority do not submit financial information at all.

Without this as a minimum, there can be no adequate evaluation of compliance. Not a single State agency has conducted an audit of a facility to verify its documentation of compliance in spite of the variety of highly questionable expenses we found written off as free service.

The regional HEW offices condone this lack of effective State agency evaluation and enforcement of the indigent care requirements. Virginia has not yet submitted a State plan some 2 years after the regulations took effect. Others that have been approved by HEW do not contain adequate information on evaluation procedures.

Alabama's permits facilities to write off as "free services" unauthorized medicare costs. Although required by the regulations, annual reports by State agencies to HEW have not been submitted by Georgia, Tennessee, and Virginia. Alabama's report did not contain the easily verifiable information that over 20 percent of its facilities have not yet chosen an option and yet no objections were raised by the regional staff.

The health needs of the South's poor are not met. The requirements of these regulations, if enforced, would make a significant contribution toward meeting that goal. Hospitals have a legal obligation to provide free service, but the State agencies and HEW have thus far shirked their responsibility for enforcement.

The justification for such lack of diligence seems to be the contention that many facilities are in severe financial difficulties.

However, the regulations themselves allow that such a hospital may be granted a variance from the requirements of providing a higher dollar amount of free care. The financial troubles of some hospitals do not excuse widespread avoidance of responsibility by others. It is time for HEW and the State agencies to stop the devious practices facilities use to escape serving the poor.

Senator KENNEDY. I have to ask you to summarize because we are running short of time. However, I am interested in your recommendations or suggestions.

Ms. ROSE. I think Mr. Ashford has a statement which may be can be brief and submit, and Dr. Anderson——

Senator KENNEDY. What I am interested in are the recommendations that you have.

Ms. ROSE. Do you want to go on with vour recommendations?

We have difficult kinds of recommendation problems.

Mr. CRIMM. I think as far as the free service part of it goes, there are several things mentioned.

HEW people spoke previously to me, and mentioned that they would like for, I think, I think what they said, aggressive, regional bodies for

planning, and that agency—that body would also be responsible for enforcement.

I question that on the basis of what has gone on so far with the State agencies which have been responsible to both promoting the construction and modernization of facilities and enforcement.

It seems like enforcement has gotten left out. I think there is pretty ample evidence that appears in a variety of regulatory functions.

I think that spot checks are one way, spot audits, are one way of meeting compliance, but I think even more effective is the complaint mechanism, and without an effective complaint mechanism nothing can happen.

The problem of getting information at local hospitals is an enormous one, and it is being turned away again and again—people are not getting this information, people do not know who to complain to.

Most of the State agencies said they have two or three, or maybe four inquiries about the Hill-Burton regulation, but nobody seems to know about them.

Until the complaint mechanism is opened up we are not going to see any effective change.

Ms. Rose. I would like to add something there, that goes back to my testimony in the spring, that I think effective complaint mechanism is important, but unless there is an affirmative aggressive policy be people who are investigating and auditing, that is the principal function, it will not work.

No matter how many poor people may be served by the legal services lawyer, after they see the notice, you still have to have an effective program, and there has to be an affirmative program on some governmental agency level.

Mr. Ashford and Dr. Anderson who want to make brief statements.

Senator Kennedy. Very good.

Mr. Ashford. Mr. Chairman, I am L. Jerome Ashford, Executive Director of the National Association of Neighborhood Health Centers.

The Association speaks for more than 750 community health programs across the nation which striving to provide ambulatory and preventive services to American's medically underserved and medically indigent.

I will delete a good portion of my comments and try to be as brief as possible.

Senator Kennedy. We will include it all as part of the record, but I am interested in hearing your very brief recommendations and suggestions.

Mr. Ashford. Surely.

I think it has been made very clear in the testimony so far this morning that the intent of Congress was to benefit the medically served and medically indigent to the health system by reason of the absence of ambulatory health service in their communities.

As I understand the testimony surrounding the development of that legislation, the amendments, the model for potential grantees under this provision was the neighborhood health center, such as those organizations that we represent. And I am concerned this morning that seemed to be talking about two different types of ambulatory care.

The intent is to say this piece of legislation relates to community health center programs. However, the response you have been getting to your questions from the representatives of the various agencies of

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the Administration have related consistently to outpatient departments of hospitals and physician office based practice.

Those institutions and individuals do not provide the same kind or level of care that are being provided by the community health services. And I think that that distinction should be made.

One of the major problems that still exists for the community health centers, as they attempt to meet the need of the medically indigent and medically underserved is that of inadequate facilities. Approximately 85 to 90 percent of the health centers are in need of modernization or totally new construction to provide facilities, to provide the services for the population they are designed to serve.

Some of the centers have received construction moneys from the Hill-Burton program in a few States, but many of the centers have been discouraged from submitting formal applications in other States. They have been told money has been frozen in some cases. In other cases, they have been told that money has been transferred out of the outpatient facility category or, in other cases, the agencies have simply not responded to or encouraged or assisted the potential grantees in applying for such moneys.

As a result, many of the centers have long since given up on possibly obtaining the outpatient facility construction or modernization funds from the Hill-Burton program.

In addition, it is well known that in most cases, fundable applications which we have heard many talk about this morning will not be forthcoming for centers without considerable technical assistance from the Hill-Burton program agencies being made available to them.

I think that all of the centers will be greatly assisted if the agencies show a conscious effort be made to encourage application and to assist in the technical grantsmanship gain which is necessary to obtain funds.

I would point out that in response to the various claims made by representatives of HEW this morning, that if they are, in fact, short of personnel to provide such technical assistance, that HEW policy and practice does, in fact, make allowance for the provision of such technical assistance through other avenues. And I would suggest that HEW might want to consider pursuing some of those other avenues, such as technical assistance programs through private contractors to enable potential grantees to secure these funds.

Finally, you asked for recommendations.

One should be that HEW should be required to conduct a thorough audit to determine the amount of funds inappropriately used in the years 1971 through 1973; that those funds be restored and made available under revised and clearer definitions of outpatient facilities, and made available under revised and revitalized systems of appropriation.

Senator KENNEDY. Good suggestion, one which we might think about more readily.

Dr. Anderson.

Dr. ANDERSON. Thank you, Mr. Chairman.

I am Leroy Anderson. I am the project director of the Franklin C. Feeter Family Health Center in Charleston, S.C.

I am a typical example of what happens to health centers that serve 15,000 people with 32,000 medical visists and 20,000 mental visits a year, and all sorts of ancillary things like drugs and alcohol. But when it comes to the point of building a center, I am jeopardized, because

I am attached to the Medical University in Charleston, S.C., which has not been declared what you might call a poverty area.

In all of my pursuits of the Hill-Burton funds, I have been told that they have been committed or that because I am in Charleston, S.C., therefore I am not eligible for putting in an application. And to summarize all of these things, I have to say that is about the gist of it.

Senator KENNEDY. I do appreciate very much that your group could get together with some specific recommendations. I think your audit idea is excellent. I think you probably have a wealth of different suggestions on these areas, and I would like to get them. I am going to write the Secretary and ask if HEW would implement the recommendations that you suggest and then I will talk to my colleagues on the Commitee and see if we can get some reaction from HEW. We will stay in touch with you and work with you on this area.

I just want to indicate to you that we have every intention of staying with this issue.

We are going to stay after HEW in this whole area. It is of great concern to me and I know, to the other members of the committee. We are looking forward to working with you on this.

Ms. ROSE. Thank you very much, Senator.

Senator KENNEDY. We want to thank you. At this point I order printed all statements of those who could not attend and other pertinent material submitted for the record.

[The prepared statements of Ms. Rose, Mr. Ashford, Mr. Anderson, and Mr. Crimm and the material referred to follows:]

STATEMENT OF MARILYN G. ROSE TO THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON LABOR AND PUBLIC WELFARE, U.S. SENATE, NOVEMBER 25, 1974, ON THE NATIONAL HEALTH POLICY PLANNING AND RESOURCE DEVELOPMENT ACT OF 1974

I would like to thank the Subcommittee for this second opportunity to testify on the subject of Federal regulation and health facility construction. My name is Marilyn Rose. I am an attorney with the Center for Law and Social Policy in Washington, D.C., and have worked for several years in the area of health problems of the poor. I am accompanied by three other persons who have extensive experience in the same area and familiarity with the issues of concern to this subcommittee. Mr. Jerome Ashford is Executive Director of the National Association of Neighborhood Health Centers and previously served in various executive capacities with primary care facilities providing comprehensive health service to poverty populations in Boston, Massachusetts. Dr. Leroy Anderson is the Director of the Franklin C. Fetter Family Health Center, a project funded under section 314(e) of the Public Health Service Act to serve low income persons in Charleston, South Carolina. Mr. Allan Crimm is with the Southern Governmental Monitoring Project of the Southern Regional Council. During the summer of 1974 he supervised an investigative project inquiring into the compliance of the Hill-Burton facilities in eleven southern states with the "free service" requirements of the HEW regulation.

In June 1974 I testified before this subcommittee on similar subjects as now in issue. At that time I raised two serious deficiencies in the administration of the legal obligations of the Hill-Burton Act. One involved the implementation of the 1970 Amendments to the Hill-Burton Act relating to the priority for construction monies for outpatient facilities to serve residents of poverty communities. The other related to the continued failure of State Hill-Burton Agencies to enforce the "free service" obligations of the Hill-Burton Act. These allegations have been confirmed by our continued program monitoring as well as by the investigation and report of the General Accounting Office.

POVERTY PRIORITY FOR OUTPATIENT MONIES

In 1970 Congress amended the Hill-Burton Act by giving a priority to poverty areas to receive outpatient monies. The legislative history makes it clear that Congress intended to help remedy the shortage of primary health care services to residents of poverty areas, and that the neighborhood health centers which had been developed by OEO and similar comprehensive health service centers were the principal potential grantees for such monies. I have attached to this statement a summary of that history (Exhibit A).

However, the vast share of the outpatient monies was granted to facilities not organized to deliver primary health care to large numbers of poor people unable to pay for such services.

Our monitoring of the program led to a lawsuit challenging various actions of HEW officials permitting and sanctioning those actions by State officials.* The GAO report to the Subcommittee, as well as the information developed through the lawsuit, confirms our allegations.

The GAO report contains a number of findings and conclusions with which we agree.** Information which we have received via Answers to Interrogatories and examination of project files confirms and amplifies on a nation-wide basis the findings and conclusions which GAO reached with the States it surveyed. I have attached two charts, the first of which was supplied by HEW on November 5, 1974 as part of supplemental answers to interrogatories (still not complete). This first chart (Exhibit B), lists grantees of outpatient monies on a state-by-state basis,

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* NANHC v. Weinberger, USDC DC, Civ.Act.No. 74-52.

** GAO found: (1) that there has been a lack of outreach activities by the State Agencies to apprise and assist poverty communities in obtaining Hill-Burton monies (p. 2); (2) that State Hill-Burton plans lack any explanation how special consideration is to be given to poverty areas for outpatient monies (p. 3); (3) that monies were illegally transferred to new hospital construction in some states after a sham double-transfer through the modernization category (p.11, pp. 19-24); (4) that in the States surveyed by GAO large amounts were awarded to nonpoverty areas (pp. 7-8) and/or were transferred out of the outpatient category (pp. 9-10); (5) that the Hill-Burton Act does not authorize HEW to give priority to nonpoverty outpatient projects over poverty outpatient projects based solely on the relative needs of the service areas for outpatient facilities (p. 27); (6) that a memorandum issued in 1971 by HEW to the States authorizing a dispensation with the statutory requirement for designating poverty areas before awarding outpatient monies was improper (p. 29).

and designates which grants were made to projects located in poverty areas. Location, however, does not mean that the facilities were designed to treat poverty area residents unable to pay for services.

The second chart (Exhibit C) lists on a state-by-state basis various extractions from Answers to Interrogatories, i.e., monies as appropriated by Congress for fiscal years 1971 and 1972, monies remaining in the outpatient category after transfer to other categories of some sums, and monies granted to projects in poverty areas and nonpoverty areas. Then, after examination of project files, we categorized those projects which HEW characterized as granted to projects in poverty areas based upon evidence of intent to provide comprehensive health services to persons unable to pay.

Please note the distinction which is made between projects in poverty areas and projects designed to serve poverty area residents. Despite the location of all those projects in so-called poverty areas, in fact a great number of them were not designed to serve residents of poverty areas unable to pay, in contrast with the neighborhood health centers which this subcommittee considered the model grantee for the monies. Thus, aside from States which admitted transferring monies out of the outpatient category and then granting the remaining monies to nonpoverty area grantees (e.g., Alabama, Tennessee, Louisiana, North Carolina, South Carolina, Minnesota, Kansas, Nebraska, Utah, North Dakota, South Dakota, etc.), other States made grants

to facilities within designated poverty areas, but not to projects serving poverty residents unable to pay. In most instances the grant was made for ancillary outpatient services as part of a hospital. For example, Mississippi received a total of $2,913,607 for fiscal years 1971 and 1972, transferred all but $518,500 out of the outpatient category, and granted the remaining $518,500 to a hospital outpatient facility, located in a poverty area according to the State plan, but not designed to serve a poverty population unable to pay for services. California did likewise with the outpatient funds it did not transfer out of the outpatient category for fiscal year 1971. I refer you to Exhibit C to see the disposition for each State.*

Although the information is still not complete, it clearly demonstrates that a vast portion of the outpatient monies was not in fact granted to projects designed to serve poverty residents. This result was triggered by some serious misconceptions of the intention of Congress as well as a misinterpretation of the effect of the 1970 Amendments on the existing Hill-Burton Act.

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* HEW files were not complete enough in many instances to determine categorically whether facilities restricted services to the paying population. Many facilities in our IV - D category on Exhibit C may, in fact, serve persons unable to pay without restriction on number. But such information was not deemed necessary despite the grant of monies to the facility as a poverty area grantee.

A critical factor was the perpetuation of the simplistic notion that need for outpatient services is determined simply by counting physical facilities in whatever service area system the State chose for determining bed need in hospitals. Neither HEW nor the State Agencies reviewed the "service area" designations in State plans to reflect the lack of primary health care facilities to the poor. The GAO report notes that the State plans either do not indicate how outpatient facility needs are determined, or limit determination of need by showing a relationship of outpatient facilities to population or to hospitals or service areas. In every State plan which I have examined, I have yet to see any consideration of the availability of physicians providing health care to segments of the population within an area unable to pay as an element in determining the need of an area for outpatient facilities. Personnel in the Office of Health Affairs of OEO knew, as the present personnel in the Bureau of Community Health Services in HEW know, that there is a high correlation between the lack of physicians, the poverty of the population, and the need for comprehensive health services through ambulatory centers. Beverly Hills does not need the same number of outpatient facilities as does Watts, and certainly not the same number (if any) comprehensive health care centers. When the Hill-Burton Agencies failed to recognize these distinctions, the existing State plans were perpetuated as inadequate or indeed defective documents for the determination of need for outpatient services in poverty areas.

This failure need not have been a fatal defect had the Hill-Burton agencies and HEW recognized that the poverty priority superceded the nonpoverty determination of need for outpatient facilities. HEW persists, however, in taking the legal position that the critical issue is the need between service areas (however determined) without regard to the need of poverty populations for primary health care. The GAO concluded that the Hill-Burton Act, as amended,

> "does not authorize HEW to give priority to nonpoverty outpatient facilities projects over poverty projects of the same type based solely on the relative needs of the service areas for outpatient facilities." (p. 27).

We agree with the GAO conclusion, and believe that it reflects the intention of Congress in this regard.

ENFORCEMENT OF FREE SERVICE REQUIREMENTS

In June 1974 I testified extensively in the continued failure of HEW and the State Agencies to enforce the "free service" regulation. I reiterate my contentions set forth in that testimony that the enforcement activities of State Agencies have been minimal but in most cases non-existent. As Mr. Crimm is prepared to testify in depth concerning the investigation by the Southern Regional Council, I shall be brief with my comments.

Obviously because of the constraints in time GAO conducted a limited investigation of this area, visiting only some 20 Hill-Burton facilities out of a potential 6,000. However, GAO did note the limited nature of the evaluation function on the State Agency level, finding that it was one

> "...essentially accomplished by matching the amount of free services required with the amount of free service provided as shown on financial statements submitted by the facilities. None of the State agencies reviewed has an active program for verifying the information submitted by the facilities."
>
> "Officials at three State agencies told us that they did not have sufficient personnel to conduct site visits to determine facility compliance. Most of the State agencies reviewed plan to rely on complaints as an indication of noncompliance." (p. 15).

Our own interviews with HEW Hill-Burton Regional personnel also indicates lack of on-site investigations and audits. Thus, in response to a questionnaire sent by my office, three Regions of HEW (Region I - Boston; Region IV - Atlanta; and Region X - Seattle) indicated that they too engaged in no on-site evaluations because of limited personnel, and relied simply on the reports of the States. In most instances the State reports are simply two page summary letters. Thus, there is no indication that any inspections and audits are being conducted by anyone.

Moreover, many facilities have operated on the assumption that as long as they select the option that they will turn no one away, they need not report their financial statements or projected budgets of free service, an assumption which has validity under a number of State plans which exempt them from so reporting. (E.g., Alabama's plan). According to an HEW report presented at the Federal Hospital Council meeting of November 12, some 136 institutions in Alabama had selected the "open door" option, and reported giving the grand sum of $25,636 in free service.

Although the State agencies interviewed by GAO indicated that they would rely upon complaints, there have been very few complaints filed according to the reports to HEW. In view of the fact that HEW and most State agencies have not required any posting of notice of the possibility of a free service obligation, one might conclude that most poor people do not even know that such an obligation exists and that the particular hospital has an obligation in this regard, let alone know to whom one might complain.*

According to our own investigation as well as reports by HEW at the most recent meeting of the Federal Hospital Council, there are indeed States which have not even instituted a program, or have just completed and approved a "free service" plan, or are just receiving their first reports from hospitals. Note that the implementing regulation was promulgated in the summer of 1972, more than two years ago. Among the States without even the beginnings of a program are California, Connecticut, and Virginia. I have attached copies of a complaint which was filed with the State Agency of Virginia, concerning the actions of two hospitals which have pursued to judgments claims against indigent clients of a legal service attorney. (Exhibit D). Despite the fact that these hospitals have checked the option of turning no one away, the State has refused to process the complaints, referring the legal service attorney back to the hospital administrators on the excuse

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* This situation may soon change, as the Federal Hospital Council recently approved an HEW proposal that would require the posting of notice.

that the State Agency has not "established as yet a criteria for identifying persons unable to pay for service."

We continue to be seriously concerned that there is no enforcement program and that business as usual with regard to free service to the indigent persists.

NATIONAL ASSOCIATION of
NEIGHBORHOOD
HEALTH CENTERS, Inc.

1625 "I" Street, N.W. | Suite 401 | Washington, D.C. 20006
(202) 833 - 9280

TESTIMONY ON THE ISSUE OF

NON-COMPLIANCE WITH HILL-BURON REGULATIONS

PRESENTED TO THE

SENATE
SUBCOMMITTEE ON HEALTH

Senator Edward M. Kennedy, Chairman

by

L. Jerome Ashford
Executive Director
National Association of Neighborhood
Health Centers, Inc.
1625 "I" Street, N.W.
Washington, D. C.

November 25, 1974

Good morning Mr. Chairman. I am L. Jerome Ashford, Executive Director of the National Association of Neighborhood Health Centers, Inc. The Association speaks for the more than 750 community health programs across the nation which provide ambulatory and preventive health care services to America's medically underserved and medically indigent. The programs which we represent include neighborhood health centers, family health centers, migrant health centers, maternal and infant care and children and youth programs, community health networks and other similar programs. While these programs employ different delivery system models and vary in the range of services provided, they possess a universal commonality in that they provide services to a sizeable segment of our population denied access by other components of our national health care delivery system, including private practitioners and public and private hospitals, many of which were built with substantial support from Hill-Burton funds.

I believe my colleagues on this panel and members of earlier panels have dealt sufficiently with the question of non-compliance with Hill-Burton regulations as they relate to requirements for providing services to the medically indigent. With your indulgence I would like to address myself to another area of non-compliance of equal importance, but heretofore of lesser notoriety; funds for the construction of out-patient facilities, especially in medically underserved areas.

In 1970 congress amended the Hill-Burton legislation to establish statutory priority for the construction of out-patient facilities in poverty areas. Our interpretation of those provisions leads us to the conclusion that the intent of congress was to benefit the medically underserved and medically indigent who lacked access to the health system by reason of the absence of ambulatory health services in their communities. The model for potential. grantees under this provision was the neighborhood health center such as those previously identified as represented by the organization I represent. The congressional intent was further manifested by an earmarking of funds for this specific purpose.

One of the major problems which still exists for the centers is that of inadequate facilities. Approximately 85 to 90% of the centers are in need of modernization or totally new construction to provide the facilities to provide the services for the population they are designed to serve. Although some centers have received construction moneys from the Hill-Burton program in a few states, many centers have been discouraged from submitting formal applications in other states, told that money has been "frozen" in some cases, transferred out of the out-patient facilities category, or simply not responded to or encouraged or assisted in applying for such moneys. As a result, many of the centers have long since given up on the possibility of obtaining out-patient facilities construction or modernization funds. In addition, it is well-known that, in most cases, fundable applications will not be forthcoming from centers without considerable technical assistance from the Hill-Burton program agencies being made available to them. All the

centers would be greatly assisted if a conscious effort was made to encourage applications and assist in the technical "grantsmanship" game to obtain such moneys.

Despite the clear intent of congress on this matter the Department of Health, Education and Welfare and its representatives in Hill-Burton agencies in the 50 states have knowingly diverted funds from this intended purpose to inappropriately provide additional support for urban and suburban hospitals which do not provide the required services to the medically indigent.

The 1970 amendment became law on June 30, 1970 and mandated the promulgation of regulations to implement the poverty priority. However, regulations were not even proposed until July 29, 1971; thirteen months later. Not unitl January 6, 1972, 18 months after enactment did DHEW issue regulations. In the interim no precautionary measures were taken to insure compliance with the congressional intent.

As a consequence of this negligence by DHEW millions of dollars intended for the construction of out-patient facilities in poverty areas were intentionally diverted away from such institutions, in clear violation of the legal obligation of HEW. From fiscal 1971 through fiscal 1973 over 280 million dollars were illegally diverted or impounded.

America's medically underserved and medically indigent have been caused additional suffering by these illegal acts. Millions of the nation's indigent are still denied access to basic ambulatory and preventive care because of the absence of proper ambulatory fa-

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cilities. The growth of the community health center movement has been critically hampered by the inability to secure construction funds, not provided under other health services legislation.

In 1973 the National Association of Neighborhood Health Ceners, Inc. in cooperation with other plaintiffs initiated legal action to recover all or a portion of the funds misappropriated thru the illegal actions of DHEW and its representatives in the Hill-Burton Agency. That suit is still under consideration. However, in the course of preparing for that action we have generated substantial detailed documentation of the basic charges I have made here today. With your permission, Mr. Chairman, rather than belabor you with those details at this time, I will make pertinent portions of that data available to the Subcommittee.

I would also like to recommend specific actions which might be taken by the Subcommittee to remedy the problems which we have discussed here this morning.

1. I recommend that the Department of Health, Education and Welfare be required to conduct or have conducted by an independent auditor an audit of the records of the Hill-Burton Agency. The purpose of this audit would be to determine (a) how much money was diverted from the outpatient category to other categories and which of those transfers were inappropriate, (b) to identify those outpatient facilities which formally applied for the Hill-Burton funds, or made informal inquiries about the availability of funds, (c) to identify which applications were funded and (d) to identify which applications were rejected and why.

2. I recommend that the Department of Health, Education and Welfare be required to restore to the proper account (out-patient facilities) funds which are shown to have been inappropriately transferred out of that category and that such funds be made available to qualified out-patient facilities for the period originally mandated by the 1970 amendments.

3. I recommend that the difinition of "out-patient facility" be revised and clarified such that it is more consistent with the congressional intent as manifested in the committee reports and the legislation itself.

4. I recommend that the Department of Health, Education and Welfare be required to adopt an improved procedure for notifying potential applicants of the availability of funds and further that DHEW be required to provide, where necessary, technical assistance to aid otherwise eligible applicants to apply for funds.

5. I recommend that the Department of Health, Education and Welfare be required to establish a monitoring mechanism to insure that each state Hill-Burton Agency fully complys with the requirements of the established legislation, rules and regulations.

Mr. Chairman, you and your colleagues on the Subcommittee are perhaps more aware than most that we are now at a critical point in the history of our national health care delivery system. The issues which confront us are complex and their resolution will be equally complex, I am sure. But one fact which appears abundantly clear is that if we are to be successful in our effort to revitalize our national health care delivery system we must have meaningful legislation which deals with the planning for health services, the organization of health services, the provision of health care facilities and the financing of health services. We cannot solve the problem by addressing only some of the issues, we must address all of them.

But more important, Mr. Chairman, we must insist on total compliance with the spirit and letter of the law as determined by congress. I encourage you and your colleagues to take every necessary action to see that this is done.

Mr. Chairman, I commend you and your colleagues for addressing this critical issue and offer you the full support and assistance of the National Association of Neighborhood Health Centers. This concludes my prepared remarks and I will be pleased to answer any questions you may have.

STATEMENT OF LEROY F. ANDERSON TO THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON ALBOR AND PUBLIC WELFARE, U.S. SENATE, NOVEMBER 25, 1974, ON THE NATIONAL HEALTH POLICY PLANNING AND RESOURCE DEVELOPMENT ... ACT OF 1974

Good morning Mr. Chairman and members of the Subcommittee. Thank you for permitting me to appear this morning. I am Leroy F. Anderson, Ed.D., Project Director of the Franklin C. Fetter Family Health Center, 417 Meeting Street, Charleston, South Carolina.

At the outset please let me establish the position that because of my staff position at the Medical University of South Carolina, I will make no statements involving the Medical University of South Carolina. Though our relationship most probably will change in the near future, I do not wish to jeopardize this existing relationship.

BACKGROUND OF THE HEALTH CENTER

Funded through Charleston County Economic Opportunity Commission and delegated to the Medical University of South Carolina by the Office of Economic Opportunity in 1967, the Center became operational in late 1968; was transferred to 314(e) HEW in July 1972. We are presently occupying a series of six rented buildings and operating, since November 1970, our clinical services in a modular temporary configuration of trailers at 51 Nassau Street, with a life span of six years. This is the heart of Charleston's worst ghetto areas. See Attachment I for the rest of the Demographic and Utilization Statistics.

HILL-BURTON

In 1971 and 1972 I spoke with Mr. Eugene Harris, Bureau of Health Facilities & Services, Columbia, S.C. All Hill-Burton funds were committed.

October 29, 1974 letter from E.F. Bleakley, Assistant Chief, Bureau of Health Facilities & Services; Coney, Chief, and Malcolm U. Dautzler, Deputy Commissioner for Medical Care.

> "The Franklin C. Fetter Family Health Center has always been a part of the Medical University of South Carolina (see our letter of October 8, 1974, to Mr. Leroy F. Anderson concerning this matter), and as a part of State Government, the poverty area priority does not apply to this facility. In that our State plans have been prepared to give consideration on a county and statewide basis for outpatient health facilities, it must be pointed out that Charleston County is not considered a poverty area in this document, and that this in itself would not benefit the Center, even if it was a separate entity.
>
> In reply to your questions, we must point out that the Hill-Burton funds are appropriated yearly by the Congress and while the State Plan establishes the priority it does not contain these funds per se. [Attachment II].

Franklin C. Fetter
Family Health Center

Projected Activities for Year - 03

Registrants as of October 31, 1974	15,187
Utilization Factor (Annual)	80%
Registrant-Users	12,000
Utilization Factor for Medical Visits	67%
Estimated Medical Visits	35,600
Estimated Physician Visits	32,000
Ratio of Laboratory Tests to Physician Visits	2.2:1
Estimated Laboratory Tests Performed	70,400
Ratio of X-ray to Physician Visits	1:5.2
Estimated X-rays Performed	6,154
Ratio of Prescriptions Filled to Physician Visits	2:1
Estimated Prescriptions Filled	64,000
Utilization Factor for Dental Users	20%
Estimated Dental Visits	10,000
Utilization Factor for Counseling & Therapy Services Users	5.3%
Estimated Counseling and Therapy Visits	8,400
Utilization Factor for Home Health Users	10%
Estimated Home Health Visits	15,630
Estimated Social & Homemaking Services	4,836

Budget Requirement for Year - 03

Total Personnel Cost	$1,951,541
Total Non-personnel Cost	819,855
Total Budget Requirement	$2,771,396
Estimated Revenues other than HEW	250,000
To be Requested from HEW (PHS)	2,521,396
Total Staff Requirement (FTE)	168.5

Registrants According to Payment Status as of October 31, 1974

Payment Status	Number	Percent
Medicaid	3,651	24.04
Medicare	930	6.12
Private Insurance*	838	5.52
Partial Payment**	3,094	20.37
Non-Paying Patients	6,674	43.95
Total	15,187	100%

* Private insurance patients covers in-hospitalization only

**Partial paying patients are on a sliding fee scale based on 10% increment. 50% fee under the 30% payment category.

N.B. Reimbursement Rate

a) Medicare — $20.00 per visit after deductible and co-insurance

b) Medicaid

1) Physician Visits — 13.50 per visit
2) Laboratory Tests — 4.94 per test
3) X-ray Tests — 28.16 per test
4) Prescription — variable

Routine check up not covered for reimbursement.

OFFICE OF THE VICE PRESIDENT & TREASURER
(803) 792-3691

Medical University of South Carolina
80 BARRE STREET / CHARLESTON, SOUTH CAROLINA 29401

September 23, 1974

Mr. John T. McNeely
Acting Director
Division of Planning & Programs
Bureau of Health Facilities & Services
S. C. Department of Health & Environmental Control
J. Marion Sims Building
2600 Bull Street
Columbia, South Carolina 29201

Dear Mr. McNeely: Re: Construction of a new facility to replace the Franklin C. Fetter Family Health Center

In accordance with your recent request for information concerning ownership and operation of the Franklin C. Fetter Family Health Center, I wish to advise that the Medical University of South Carolina has the full responsibility for operation of the Center. The ownership is a question which will have to be settled by HEW, since they have replaced OEO as Granting Agency. A meeting will be held in Charleston on October 25, 1974, at which time this question of ownership will be determined.

All property acquired for the new facility has been acquired in the name of the Health Sciences Foundation of the Medical College of South Carolina. However, in our opinion, it has not been determined that the Health Sciences Foundation has complete ownership or rights appertaining thereto.

I hope this information will be of some help in making your decision related to the construction application.

Sincerely yours,

John E. Wise
Vice President

JW/mam

SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

October 8, 1974

Re: Construction of a new facility to replace the Franklin C. Fetter Family Health Center

Mr. Leroy F. Anderson, Ed. D.
Project Director
Franklin C. Fetter Family Health Center
417 Meeting Street
Charleston, South Carolina 29403

Dear Mr. Anderson:

We apologize for our tardiness in replying to your letter of September 4, 1974, however this was due to questions which arose concerning the ownership of the Fetter Center.

In attempting to resolve this, Mr. John E. Wise, Vice President, Medical University of South Carolina was contacted. We are enclosing for your information a copy of our letter and Mr. Wise's reply.

As indicated in Mr. Wise's letter, a meeting will take place on October 25, 1974 to resolve the ownership question. At such time as the question is resolved we will contact you regarding your request.

If you have any questions please feel free to contact Mr. John T. McNeely at 758-5594.

Sincerely,

John McNeely

John T. McNeely, Acting Director
Division of Planning and Programs
Bureau of Health Facilities and Services

J. Richard Gerry, Chief
Bureau of Health Facilities and Services

Malcolm C. Dantzler, M.D.
Deputy Commissioner for Medical Care

File

JTM:mca

cc: Mr. Richard Gerry
Col. C. S. Campbell

SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

E. KENNETH AYCOCK, M.D., M.P.H., COMMISSIONER
J. MARION SIMS BUILDING — 2600 BULL STREET
COLUMBIA, SOUTH CAROLINA 29201

October 29, 1974

Re: Franklin C. Fetter Family Health Center
Charleston, South Carolina

Reverend Henry L. Grant, Chairman
Charleston County Economic Opportunity Commission
1000 King Street
Charleston, South Carolina 29403

Dear Reverend Grant:

In reply to your letter of October 23, 1974, this Agency must point out the following basic facts:

The Franklin C. Fetter Family Health Center has always been a part of the Medical University of South Carolina (see our letter of October 8, 1974, to Mr. Leroy F. Anderson concerning this matter), and as a part of State Government, the poverty area priority does not apply to this facility.

In that our State plans have been prepared to give consideration on a county and statewide basis for outpatient health facilities, it must be pointed out that Charleston County is not considered a poverty area in this document, and that this in itself would not benefit the Center, even if it was a separate entity.

In reply to your questions, we must point out that the Hill-Burton funds are appropriated yearly by the Congress and while the State Plan establishes the priority it does not contain these funds per se.

The outpatient facilities funds were encumbered as follows:

Fiscal Year 1971

Project SC0318 - Medical University of South Carolina Hospital (Rehabilitation Medical Treatment and Diagnostic Center Addition) in the amount of $329,912.53.
Project SC0319 - Clinical Science Building, Medical University of South Carolina in the amount of $1,092,608.14.

Fiscal Year 1972

Project SC0319 - An additional $1,317,840.00.

Fiscal Year 1973

Project SC0320 - Williamsburg County Memorial Hospital Outpatient Facility, Hemmingway in the amount of $553,500.00.
Project SCL-4 - Tuomey Hospital, Sumter in the amount of $588,276.00.

Fiscal Year 1974

Project SC0321 - McLeod Memorial Hospital, Florence in the amount of $815,521.37.
Project SC0322 - York General Hospital, Rock Hill in the amount of $257,394.63.

The 1974-1975 State Plan has been drafted by this Agency and is now at the printer. This plan also programs Outpatient Facilities on a county and statewide basis. The only source of financing available through this Agency would be for the Congress to extend the Hill-Burton Act, which incidentally has expired, in some form. We will, of course, be most pleased to furnish you with a copy of said plan when it is printed in final form.

If we can be of further assistance, please feel free to contact Mr. E. F. Bleakley at 758-5594.

Sincerely,

E. F. Bleakley

E. F. Bleakley, Assistant Chief
Bureau of Health Facilities and Services

J. Richard Coney

J. Richard Coney, Chief
Bureau of Health Facilities and Services

Malcolm U. Dantzler, M. D.

Malcolm U. Dantzler, M. D.
Deputy Commissioner for Medical Care

EFB/snp
Enclosure
cc: Mr. Leroy F. Anderson
Mr. John Wise

FHA INSURED PROJECTS TRANSFERRED TO HEW

OEO GRANT NO.	PROJECT NAME	LOCATION	FHA NO.	GROSS SIZE SF	CONSTRUCTION CONTRACT COST	FHA REPLACEMENT COST	DATE TRANSFERRED TO HEW	STATUS AT TIME OF TRANSFER
8963	Wayne Miner NHC, Inc. Kansas City, Mo.	9th Euclid Ave.	084-51001-R	48,958	$1,589,000 Initial const. contract	$2,072,827	Dec. 1, 1970	Initial closing & contract award April 9, 1970. Mortgage $1,750,000. 84 monthly payments of $26,842 (8.5% interest rate) starting 19 months after mortgage dated. Const. 16% complete as of Nov. 30, 1970.
8718	St. Louis Comprehensive NHC, Inc., St. Louis, Mo.	5441-71 Easton Avenue	085-51002	45,250	1,999,421	3,378,987	Aug. 1, 1971	GP-2 submitted May 26, 1971, still being processed at time of transfer. Design completed & submitted to K. C. HEW Regional Office, Sept. 1, 1971. Mortgage requested $2,973,[illegible]
40573	Franklin C. Fetter Family Health Center Charleston, S. C.	432-442 Meeting Street		35,000	1,400,000		July 1, 1972	Site purchased ($258,545). Feasibility Study Architect Contract in effect for planned health center to be insured by FHA. GP-1 not submitted at time of transfer.
39707	Homewood-Brushton NHC Pittsburg, Pa.	7227 Hamilton Avenue	033-51001-EC	23,000	906,622	1,567,582	July 1, 1972	Project complete. Mortgage $1,410,[illegible]. Monthly payment $22,640. Closing Feb. 3, 1971.
8935	Meharry Neighborhood Health Center Nashville, Tennessee	1501 Herman St	086-51001 NPR	40,465	1,027,319 Initial Constr. Contract	1,612,022	Dec. 1, 1970	Project complete. Mortgage $1,450,[illegible] 120 monthly payments of 16,659 (6.75% interest rate) starting 15 months after mortgage is dated.
8743	Nicetown-Tioga NHC Philadelphia, Pa.	3450 North 17th St.	034-51001NP	30,000	1,452,740	1,709,780 (Estimate)	Dec. 14, 1970	Initial closing & contract award Oct. 23, 1969-Mortgage 1,535,[illegible] principal repaid in 7 equal annual installments 1970 thru 1976 incl. interest at 7½% on unpaid principal balance monthly beginning March 1, 1970, construction approx 70% comp

TESTIMONY OF

Allan Crimm
Southern Governmental Monitoring Project
Southern Regional Council
Atlanta, Georgia

BEFORE THE

HEALTH SUBCOMMITTEE

OF THE

SENATE COMMITTEE ON LABOR & PUBLIC WELFARE

November 25, 1974

Good morning, Mr. Chairman. I am Allan Crimm, health consultant with the Southern Governmental Monitoring Project. With me is Joe Tom Easley, Director of the Project. We appreciate your invitation to give testimony on this important piece of legislation now before your committee.

As you know, a section of the original 1948 legislation required all Hill-Burton-funded facilities to provide a "reasonable volume of free service" to people who could not pay for such medical care themselves. Just over two years ago, HEW issued regulations to implement those long unnoticed requirements. Responsibility for enforcement of these indigent care obligations was delegated by HEW to the state agencies.

During this past summer, our project employed field researchers in 25 cities and small towns in eleven Southern states. Their job was to interview the administrator of each Hill-Burton hospital and nursing home in their locality in order to assess compliance with the "free service" regulations. Staff from three state agencies and one regional HEW office were later contacted to evaluate their role in enforcement.

During the summer our investigators talked with staff at 44 hospitals, evenly divided between public and private, non-profit facilities. They attempted to meet with people at 11 more facilities but were refused interviews. With a few exceptions, the staff they contacted were contemptuous of their legal obligation to

provide free service and hostile to inquiries about compliance. A Miami hospital administrator, for example, refused to grant an interview until our investigator's credentials were approved by a hospital industry organization. Requests for even the most basic financial information about hospitals were met with refusal time and time again. However, a number of administrators were willing to talk openly and candidly about the lack of compliance.

I have for each member of the committee a copy of the report documenting our findings of widespread abuse of the regulations and denial of medical treatment to indigents in Hill-Burton facilities. I would like to summarize briefly our findings for you.

In our meetings with hospital administrators and conversations with state agency and HEW regional officials, the following six findings emerged:

1. Some facilities use loopholes to avoid accountability for specific dollar amounts of free service.

2. Highly questionable expenses are accounted for in such a way that hospitals appear to be in compliance.

3. The obligation of all Hill-Burton facilities to provide indigent care is one of our health care system's best kept secrets. No one except hospital administrators seems to know about it.

4. Eligible people are turned away from hospital doors because they either do not live in the right area or do not need the type of medical treatment that the facility has decided to give to indigents.

5. In spite of these abuses, the state agencies do little more than collect paper which purportedly documents compliance. Several staff admitted that they are simply taking facilities at their word.

6. The regional HEW offices condone this lack of effective evaluation and enforcement. Inadequate state plans are approved, and failure by state agencies to submit annual reports is overlooked.

As a result of these unauthorized and deceptive practices and the lack of enforcement, poor Southerners are being denied the medical treatment they need and are entitled to receive.

I would like to deal with each of our major findings in more detail in the time remaining.

Each Hill-Burton facility is required to select annually one of four methods by which the amount of free service obligation is calculated. However, some facilities use a variety of illegal practices and loopholes to avoid accountability for a specific dollar amount of indigent care. 39 facilities, or almost 15% of the hospitals and nursing homes in Alabama, Georgia and Louisiana, have not chosen one of the four options. Based on documents contained in the state agency files, we found that one Georgia hospital system has miscalculated by a third the amount of free service which it is required to give under the option it selected.

Selection of the so-called "open door" option is the means by which many facilities avoid accountability for a specific amount of free care. Under this option, hospitals certify that they will not refuse service to anyone because of his inability to pay. More than 45% of the hospitals and nursing homes in 6 states -- Alabama, Arkansas, Georgia, North Carolina, Tennessee and Texas -- chose this option. In none of these states have such facilities been required

to document precisely how much indigent care they did, in fact, provide. Evidence indicates that some hospitals, although agreeing to serve everyone in need of treatment, actually provide less indigent care than if they had chosen either of the other options available to them. A Baton Rouge, Louisiana hospital, admittedly not in compliance under one of the other options, is anticipating a change to the open door method with the concurrence of the state agency staff in order to avoid accountability for such a high dollar amount of free medical care.

Many facilities appear to be in compliance but are actually including highly questionable expenses as "free service." The administrator of a Winston-Salem, North Carolina facility admitted that bad debts are used to meet the obligated level of service although this is specifically prohibited by the regulations. A Fort Smith, Arkansas hospital administrator, dissatisfied with the allegedly low amount which his facility received from Medicare and Medicaid, is writing off the difference between the "reasonable cost" it gets and the reported actual cost of providing the care. HEW regional officials and Alabama, Arkansas, and Georgia agency staff see nothing wrong with this practice. However, many hospitals can account for all their "free service" without giving medical treatment to a single indigent person for whom they are not already receiving compensation from a government program.

Southerners are denied needed medical care because of both

arbitrary geographic restrictions and limitations on the types of medical care to be given to people who cannot afford to pay. A Memphis, Tennessee facility, for example, will not admit residents of the county in which it is located. The administrator contends that indigents are supposed to go to the county-operated hospital for the medical care they need. A North Georgia hospital registered as an "open door" facility will not admit obstretical cases unless the physician will certify that the life of either the mother or child is in danger. Routine deliveries by indigent mothers do not ordinarily get the benefit of hospital care.

Public notification of the availability of free service is a farce. Most administrators we talked to in both public and private, non-profit facilities contend that the public is aware of the possibility of obtaining free or below cost care. The case files of Georgia Legal Services offices we contacted belie this assertion. The regulations require that notices be published in local papers informing the public of the free service obligations. The administrator of one Alabama facility told us that he would not voluntarily do so, but that if he were forced to publish a statement, he would "hide" it in the paper. That is exactly what happens to most of the notices that are published. The one attached to this testimony was published in the legal notices section of the paper and is characteristic of the efforts employed to inform the public. Of the 44 hospitals visited, only one, the University of Virginia Medical Center, has a notice conspicuously posted that informs people that

free service is available.

The state agencies are not performing adequate annual evaluations to check the compliance of every Hill-Burton hospital as required by the free service regulations. Our investigators found one instance of collusion between the Louisiana agency and a Baton Rouge facility not in compliance but seeking to change its option so as to avoid accountability for a high level of free service.

The Virginia state agency refused to give our investigator a list of the facilities receiving Hill-Burton money although such information is clearly public. As for the evaluation responsibility, a direct examination of the files at the Alabama, Arkansas, and Georgia state agencies reveals that few facilities are separating free service and uncollectible accounts in their financial statements. The majority do not submit financial information at all. Without this as a minimum, there can be no adequate evaluation of compliance. Not a single state agency has conducted an audit of a facility to verify its documentation of compliance in spite of the variety of highly questionable expenses we found written off as free service.

The regional HEW offices condone this lack of effective state agency evaluation and enforcement of the indigent care requirements. Virginia has not yet submitted a state plan some two years after the regulations took effect. Others that have been approved by HEW do not contain adequate information on evaluation procedures. Alabama's permits facilities to write off as "free service" unauthorized Medicare costs. Although required by the regulations, annual reports by state agencies to HEW have not been submitted by Georgia,

Tennessee, and Virginia. Alabama's report did not contain the easily verifiable information that over 20% of its facilities have not yet chosen an option and yet no objections were raised by the regional staff.

The health needs of the South's poor are not met. The requirements of these regulations, if enforced, would make a significant contribution toward meeting that goal. Hospitals have a legal obligation to provide free service, but the state agencies and HEW have thus far shirked their responsibility for enforcement. The justification for such lack of diligence seems to be the contention that many facilities are in severe financial difficulties. However, the regulations themselves allow that such a hospital may be granted a variance from the requirements of providing a higher dollar amount of free care. The financial troubles of some hospitals do not excuse widespread avoidance of responsibility by others. It is time for HEW and the state agencies to stop the devious practices facilities use to escape serving the poor.

Fort Smith Southwest Times Record, July 24, 1974

NOTICE
SERVICES TO PERSONS UNABLE TO PAY THEREFOR
ST. EDWARD MERCY HOSPITAL
FORT SMITH, SEBASTIAN, ARKANSAS

The Arkansas State Department of Health has established the sum of $40,915.00 as the level of uncompensated services to be made available by the St. Edward Mercy Hospital, Fort Smith, Arkansas in the period July 1, 1973 to June 30, 1974. This determination has been made pursuant to the requirements of the regulations of the Public Health Service, U. S. Department of Health, Education and Welfare, (42CFR paragraph 53.111) and the applicable provisions of Arkansas Medical Facilities Construction Plan. "Uncompensated services" mean services available in the facility which are made available to persons unable to pay therefor without charge or at a charge which is less than the reasonable cost of such services. The level of such services is measured by the difference between the amount charged such persons for the services and the reasonable cost thereof. The level set out above meets the presumptive compliance guideline of the Federal regulations and is ten (10) per cent of all Federal assistance provided the facility under the Hospital and Medical Facilities Construction Act. Copies of the criteria used for identifying persons unable to pay for services may be obtained from Arkansas State Department of Health, Division of Hospitals and Nursing Homes, 4815 West Markham, Little Rock, Arkansas. The records and documents on the basis of which the above level of uncompensated services was established are available for public inspection at Arkansas State Department of Health, Division of Hospitals and Nursing Homes, 4815 West Markham, Little Rock, Arkansas, between the hours of 8:00 A.M. and 4:30 P.M. on regular business days.

Eugene C. Spratt, Director
Bureau of Health Facility Services

SERVICES TO PERSONS UNABLE TO PAY THEREFOR
CERTIFICATION
METHODIST NURSING HOME
FORT SMITH, SEBASTIAN, ARKANSAS

The Methodist Nursing Home, Fort Smith, Arkansas has certified that it will not exclude any person from admission on the ground that such person is unable to pay for needed services, and that it will make available to each person so admitted services provided by the facility without charge or at a charge which does not exceed such person's ability to pay therefor, as determined in accordance with criteria established in the Arkansas Medical Facilities Construction Plan. This certification has been made pursuant to the requirements of the regulations of the Public Health Service, U. S. Department of Health, Education and Welfare, (42CFR paragraph 53.111), and the applicable provisions of Arkansas Medical Facilities Construction Plan. The Arkansas State Department of Health has, therefore, established the foregoing level of services as the level of uncompensated services to be made available by by said facility in the period May 1, 1973 to April 30, 1974. The level of services set out meets the presumptive compliance guideline of the Federal Regulations. Copies of the criteria used for identifying persons unable to pay for services may be obtained from Arkansas State Department of Health, Division of Hospitals and Nursing Homes, 4815 West Markham Street, Little Rock, Arkansas.

Eugene C. Spratt, Director
Bureau of Health Facilities Services

ACCESS BY THE POOR TO HEALTH CARE IN SOUTHERN HILL-BURTON HOSPITALS

Allan Crimm
Southern Governmental Monitoring Project
52 Fairlie Street
Atlanta, Ga. 30303
November 25, 1974

Almost two and a half years ago in July 1972, the Department of Health, Education and Welfare issued regulations concerning the implementation of the "free service" section of the Hill-Burton Medical Facilities Construction Act. Senate discussion prior to the drafting of the legislation in 1948 shows that the origins of the provision lay in a desire to ensure that both the indigent and medically indigent would be able to get medical care at the facilities constructed under the act. By accepting federal Hill-Burton funds, hospitals, nursing homes and other facilities acknowledged a continuining legal responsibility to "provide a reasonable volume of service to those unable to pay."

In the first 26 years following the passage of the act, more than $3.25 billion in federal funds were appropriated to stimulate the construction of units to accommodate over 470,000 inpatient care beds. During this same period, however, the pledge to provide service for indigents was little more than a pro-forma statement since no one had bothered to define what constituted "a reasonable volume," determined what "service(s)" were to be included, or identified who were "person(s) unable to pay." Only after successful litigation against eight New Orleans Hill-Burton hospitals in 1970 did HEW issue regulations implementing the "free service" commitment.

But despite the court ruling and the extensively delineated guidelines, facilities throughout the South are still not meeting their legal obligation to provide free medical service. Based on the experiences of field investigators in twenty-five cities and small towns in eleven Southern states, and from follow-up investigations of the operations of the state agencies and the HEW regional offices, it is clear that the regulations are little more than empty words on Federal Register paper as far as poor people, hospitals and nursing homes, and state agencies are concerned.

Throughout the South access by the poor to medical care in Hill-Burton facilities is restricted in a variety of ways. Eligible people are refused service through vagaries of both geographic location and limitations on the types of medical care provided to indigents. Some people who would be eligible

for free service, having never been informed of such a possibility, are harrassed for payment after receiving medical care. Others have no way of knowing that their local hospital has an obligation to treat people such as themselves unless they read its legal notice in the newspaper, assuming, of course, that one is printed. Very few facilities determine a person's eligibility for free service before admission. Consequently many people do not attempt to get needed medical care, preferring to remain untreated because of a fear that they will have to pay the bills themselves. Because of such factors, it is primarily the medically needy rather than the truly indigent who benefit from the "free service" requirements.

Many facilities are distorting the amount of their free service obligations by setting their quotas at levels far below the presumptive guidelines although such a variance is not specifically approved by the state agency.[1] The dollar level of indigent care is grossly undercalculated for some facilities. Although they pledge to accept every patient without consideration of his ability to pay, some "open door" hospitals are actually providing less free service than would be required had they chosen one of the other presumptive guidelines. At least one facility unable to meet its established quota is contemplating a change to the "open door" system so that it will not be held accountable for a specified dollar amount of indigent care.

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[1]Each facility selects one of the following four methods of fulfulling its annual uncompensated service obligations:

- -- provide 3% of the operating costs after first subtracting the Medicare and Medicaid reimbursements;
- -- provide 10% of the total Hill-Burton grant and loan money received during the previous twenty years;
- -- certify that no person will be turned away from the facility because of an inability to pay (hereinafter referred to as the "open door" option); or
- -- petition the state agency to allow the facility to provide, due to financial hardship an amount less than that required under any of the above options (hereinafter referred to as the "less than presumptive guideline" option).

Across the South, facilities are writing off many types of questionable expenses in order to give the impression that they are meeting their uncompensated service quotas. The methods employed differ widely from hospital to hospital, and the regulations themselves are the subject of much misinterpretation. Some facilities are including uncollectible accounts and bad debts in order to meet their predetermined dollar level. Several larger hospitals do not participate in the Medicaid reimbursement program, and yet they maintain that they are meeting their obligated free service quotas. It is not clear if, in fact, they are writing off as free service the medical care they give to Medicaid eligibles.[2] Other facilities apparently include as uncompensated services the difference between the actual charge to paying patients and the "reasonable cost" reimbursement made under the Medicare and Medicaid programs.

Inpatient hospital care of longer duration than that covered under state Medicaid plans is also being written off in spite of the fact that many of these state plans allow coverage for additional days on a "preauthorization" basis. The effect of such practices is to decrease the amount of free service given to those poor people not covered by Medicaid or Medicare -- a significant proportion of the Southern population. Thus the obligated free service is not increasing access by poor people to hospital care but is rather subsidizing the deficiencies in the reimbursement levels of state Medicaid plans.

Although the HEW regulations charge the state agencies with the responsibility of enforcing the free service requirement, the widespread abuses uncovered in our investigations indicate that this enforcement authority is not exercised conscientiously. Some of the state plan amendments covering the free service provisions are inadequate; several are hardly more than a restatement of the HEW regulations in slightly different language. Some state agencies do not gather adequate financial information that would enable them to evaluate each facility's performance in meeting its indigent care quota. In spite of the abuses described here, to our knowledge, no audits have been conducted. Our investigators found only one instance where a complaint mechanism was used.

[2]This practice is specifically prohibited in 42 CFR 53.111 (f) (2).

The extreme difficulty in gaining access to pertinent information is a major contributing factor to the lack of formal complaints.

In some cases political considerations are cited as reasons why state agencies fail to enforce the regulations more diligently. HEW apparently suffers from the same malady because it provides little supervision of the state agencies' enforcement responsibilities. Failure of state agencies to turn in annual reports is apparently condoned, or at least ignored, and amendments to state plans seem to be approved with only a cursory examination. To our knowledge, the Secretary's authority to convene a hearing to examine alleged lack of compliance by an individual facility has never been used.

Before some of the background to these problems is discussed, an examination in greater detail of each is warranted.

I. WHO IS ELIGIBLE TO RECEIVE FREE SERVICE?

According to the HEW free service regulations, each state agency must establish criteria, including family size, financial resources of various types, and health insurance coverage, which identify persons unable to pay. The medically indigent are also to be provided services on a part-pay basis. The free service plans of seven state agencies -- Alabama, Florida, Georgia, Mississippi, North Carolina, South Carolina and Tennessee -- were examined. Five contain guidelines considering the above factors but specifically delegate the responsibility for identifying those eligible for free service to the individual facilities themselves. The Georgia, Florida, South Carolina, and Alabama plans leave much discretion to the individual hospitals cautioning that each case is different and must be evaluated on its own merits. The desirable flexibility allowed each facility has in many cases, however, been abused. Criteria other than the financial ones outlined in the HEW regulations and the various state plans are effectively restricting some eligible people's access to hospital care.

Geographical Restrictions

Geography is one limiting criteria used by some facilities.

- Hall County Hospital, is a 271-bed general hospital in North Georgia which serves paying patients in a ten county rural area. Although the hospital has selected the "open door" option for meeting its federal obligations, it expressly limits free medical service to Hall County residents.

A Memphis, Tennessee hospital maintains the opposite geographic limitation on patients from that imposed in the previous example.

- Mr. C. Henry Hottum, Director of 910-bed Methodist Hospital in Memphis, reported that his facility will not accept indigents from Shelby County (where the hospital is located) since "they are the responsibility of the City of Memphis Hospital"[1] which receives funds from the county to provide indigent service.

Both of the above policies employ a very narrow interpretation of the hospital's "territorial area" and ignore "the need within the area served by the applicant."[2]

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[1]Interview with James Camp, Southern Governmental Monitoring Project (SGMP) Field Investigator, July, 1974.

[2]42 C.F.R. 53.111 (h) (2) (iii).

Medical care restrictions

Other facilities investigated restrict eligibility to people who have certain types of medical needs although, as general hospitals, they provide a much wider variety of services to paying or third-party covered patients.[3]

- At Montgomery Baptist Hospital in Alabama, indigent patients needing "elective surgery" are not eligible for free service.[4]

- 71-bed Elberton-Elbert County Hospital in Georgia provides free care only in emergency cases although it has selected the open door option.

- Vanderbilt University Hospital which received approximately $4,000,000 in Hill-Burton money for some ten projects over the last twenty years stipulates that, although employing the Tennessee Means Test to determine eligibility standards for financial assistance:

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[3]There is apparently no federal authorization for such restriction contained in either HEW regulations (which mention only financial criteria) or in explanatory policy memoranda. One District Court (SDNY) in Corum, et al .v. Beth Israel Medical Center, et al., has held that

> The stated purpose of the Act is not merely to enable hospitals to provide emergency services, but "to furnish adequate hospital, clinic, or similar services" (42 U.S.C. 291), which terms, we believe, encompass the whole range of hospital services. Moreover, the Act nowhere indicates an intention to delegate to the recipient of funds the power to determine what constitutes the reasonable volume of services which should flow from the grant, either in terms of amount or kind, and we reject the Beth Israel defendents invitation to interpret the Act in such fashion. (359 F. Supp. 909,917 (1973).

[4]Interview with W. T. Morrow, Administrator, by Michael Johnson, SGMP Field Investigator, July, 1974.

> We may continue to deny treatment for non-emergency conditions of persons who cannot meet our financial requirements by referring such persons to a hospital with a legal responsibility for providing "Free Care" to patients. (Emphasis added)[1]

- Hall County Hospital, the only hospital in this Georgia county, stipulates that for patients served at county expense, the only obstetric cases eligible for free service are those for which a doctor certifies that there are complications which may endanger the life of the mother or child. And although it does not include cases of minor surgery that can normally be provided outside the hospital, it does specifically authorize sterilization performed at county expense.[2]

Deposit

At some facilities, indigents face another major obstacle before they can get medical care--the deposit. Although they may qualify for free care, they may have to pay a fee before they can even be considered for admission.

- At 136-bed Martha Jefferson Hospital in Charlottesville, Virginia, a deposit is required of all patients who do not have insurance. Mr. Donald Sandridge, Assistant Administrator, reports that if the deposit cannot be paid, the patient must see him and at that time, he tries to explain to the potential patient the importance of paying such a fee.

Our investigator did not determine during this interview how many indigents are allowed to waive this down payment. Curiously enough, both Mr. Sandridge and Mr. Norman Carpenter, Administrator, reported

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[1]"Criteria for use in identifying persons unable to pay," enclosed in a October 29, 1973 letter from D. Gene Clarke, Acting Director, Vanderbilt University Hospital, to Mary Jane Livingston Gunter, Tennessee Department of Public Health, Health Care Facilities Unit.

[2]From Hall County Board of Commissioners "Resolution designating the Hall County Department of Family & Children's Services as the sole agency to certify indigent sick and poor for admittance to the Hall County Hospital at County expense..."

that, including bad debts, the amount of indigent care provided totals less than 2% of the hospital's operating expenses. Both agreed that if audited, they would not be found in compliance.[1] Evidently those indigents not receiving care at Martha Jefferson Hospital are directed to University of Virginia Hospital which has a reputation of providing charity care.

II. HOW DO INDIGENT PEOPLE FIND OUT IF THEY QUALIFY?

Public access to criteria

Although HEW regulations require that facilities make available to any patient or person seeking services a copy of the eligibility criteria they employ,[2] several of the surveyed hospitals do not do so, evidently for fear of being deluged with potential patients.

- At 464-bed Memorial Medical Center, Savannah, Georgia's public hospital, a request for a copy of the sliding scale eligibility figures was denied by the Director of Social Services on the grounds that they are "confidential."[3]

In many legal notices announcing the level of free service set for a particular facility, a reader is informed that he may get a copy of the criteria for eligibility not from the hospital itself, but from an agency in the state capital many miles away. Two notices for Fort Smith, Arkansas facilities, for example, explain that a copy of the criteria "may be obtained from Arkansas State Department of Health, Division of Hospital and Nursing Homes, 4815 West Markham Street, Little Rock, Arkansas."[4]

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[1] Interview with Dick Wall, SGMP Field Investigator, July 3, 1974.

[2] 42 C.F.R. 53.111(g).

[3] Interview with Connie Speidel, SGMP Field Investigator, June 18, 1974.

[4] See bottom of Page 12.

The time at which eligibility is established for free or below cost care directly affects poor people's access to medical treatment.

The actual procedures employed for certifying eligibility for free service vary from facility to facility. Some use hospital staff to determine each case's merits; many public hospitals make arrangements with the local welfare departments to certify eligibles. In some cases this involves a trip to an office across town from the hospital

Eligibility determination

Unfortunately the HEW regulations require only that determination be made "prior to any collection effort other than the rendition of bills."[1] This section has effectively invalidated the entire purpose of the free service requirement as far as poor (as opposed to medically indigent) people are concerned. As a result of allowing facilities enough flexibility to include cases of medical indigency (which would usually require that bills be computed) eligibility determination is delayed until after admission. This procedure discourages poor people who have neither health insurance nor deposit fees from seeking medical care.[2]

- At Texas' Midland Memorial Hospital, Mr. Wayne E. Ulrich, the administrator, picks out those eligible for below cost care by scanning each morning a computer printout listing the diagnosis and financial resources of each inpatient.[3]

- Memorial Hospital of Martinsville and Henry County, Virginia, apparently delays determination of eligibility for free service until after the bills are computed. At that time, financial resources are considered, and a reduced billing figure is tabulated. Thus it is, primarily, the medically indigent who benefit.[4]

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[1] 42 C.F.R. 53.111 (f)(1).

[2] As a result of arguments such as these, the Court, in Corum v. Beth Israel Hospital, Cir. No. 72-2654 (SDNY, January, 1974), held the above clause invalid. HEW is presently developing a new regulation making clear that determination of eligibility before the provision of service is to be the rule rather than the exception.

[3] Interview with Danny Tsevat, SGMP Field Investigator, August 6, 1974.

[4] Telephone interview with Ed Belcher, Comptroller, Memorial Hospital of Martinsville & Henry County, by Alice Ratliff, SGMP Field Investigator, July 3, 1974.

If as in the above cases, eligibility is not normally determined until after admission, many poor people do not attempt to get needed medical care, fearing that they will be billed afterwards for treatment they cannot pay for themselves.

Evidence from the Gainesville office of the Georgia Legal Services Program indicates that this fear is justified. Its attorneys are asked to defend Hall County residents eligible for free service who are being harrassed by the local "open door" hospital to pay for medical care they received there. Two such examples follow:

- Lucille B_____has no known income and is living in the back seat of a friend's car. She received outpatient service from the hospital and has subsequently been threatened with legal action although, as yet, no suit has been filed. The balance due on her account is $31.00. By the hospital's own admission, the collection costs alone can amount to $40.00. Lucille B_____was never advised of the possibility of receiving free services.

- Mary G_____'s income is approximately $100 per month. At the time she received emergency care from the hospital, she told them that she was unable to pay for it. Since then, she has been continuously dunned by the hospital and threatened with legal action. Her debt is $22.00.

With a personal awareness of examples like these, it is not surprising that many poor people tolerate their physical ills in silence rather than seek out the medical care they need and are entitled to, but cannot pay for themselves.

- Carrie C_____is a 2½ year old encephalitis victim who will be in and out of hospitals as long as she lives. With the 20% coinsurance requirements and the charges beyond those covered by the 110-day hospitalization limit of their Blue Cross-Blue Shield policy, the C___'s now have a bill of almost $4,000. A fund established to raise money for the child's medical needs has collected $500. With a balance of $3,467 remaining, the account was given to a Missouri collection agency. Although the C_____ family would qualify as medically indigent, they were never informed by any hospital staff of the Hill-Burton requirement that St. Edward's Mercy Hospital in Ft. Smith, Arkansas must provide a certain amount of free and part-pay care.[1]

[1]Reported by Will Godwin, SGMP Field Investigator, July, 1974.

These medically indigent people did not know that they might be eligible to have some of their financial burden lifted, although their local hospital has a legal obligation to help people such as themselves. It is not an altogether uncommon occurrence. In fact the free service obligations of Hill-Burton facilities seem to be a well-kept secret as far as the general public is concerned.

Public notice

The HEW regulations require that the state agency "publish as a public notice in a newspaper of general circulation within the community served by the applicant the rate [level] of uncompensated services that has been established"[1] for each facility. Many hospitals in the South do not meet even this minimal requirement. Staff of the Georgia Hill-Burton agency maintains that the agency does not have the well over $1,000 needed annually to pay for some 130 legal notices for Georgia's Hill-Burton facilities. Consequently, each facility is "strongly encouraged" to make its own arrangements to publish a notice. Several sample wordings are provided. This approach has admittedly had little success. Georgia is not the only state agency leaving this responsibility up to the individual facilities, and the small number of published notices is an indication of this procedure's ineffectiveness.

As for the adequacy of the notices themselves, many administrators seem to share the attitude of Mr. O. D. McClusky at Druid City Hospital in Tuscaloosa, Alabama.

> • • Mr. McClusky said that he knew he was required to advertise free health care but that he did not intend to do so. He further maintained that the facility was more than meeting its legal obligation for free service; any more would "break" the hospital. If forced to advertise, he would "hide" it in the newspaper.[2]

Not surprisingly, that is almost literally what happens with most of the notices that are published. On the left side of the following page are two typical examples which were published in the Ft. Smith, Arkansas Southwest Times Record in the legal notices section. Our field investigators, unfortunately, found such examples

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[1] 42 C.F.R. 53.111(h) (4)

[2] Interview with Newman Strawbridge, SGMP Field Investigator, August, 1974.

Ft. Smith Southwest Times Record

NOTICE
SERVICES TO PERSONS UNABLE TO PAY THEREFOR
ST. EDWARD MERCY HOSPITAL
FORT SMITH, SEBASTIAN, ARKANSAS

The Arkansas State Department of Health has established the sum of $440,000 as the level of uncompensated services to be made available by the St. Edward Mercy Hospital, Fort Smith, Arkansas, in the period July 1, 1973 to June 30, 1974. This determination has been made pursuant to the requirements of the regulations of the Public Health Service, U.S. Department of Health, Education and Welfare, (42CFR paragraph 53.111) and the applicable provisions of Arkansas Medical Facilities Construction Plan. "Uncompensated services" means services available in the facility which are made available to persons unable to pay therefor without charge or at a charge which is less than the reasonable cost of such services. The level of such services is measured by the difference between the amount charged such persons for the services and the reasonable cost thereof. The level set out above meets the presumptive compliance guideline of the Federal Regulations and is 10 per cent of all Federal assistance provided the facility under the Hospital and Medical Facilities Construction Act. Copies of the criteria used for identifying persons unable to pay for services may be obtained from Arkansas State Department of Health, Division of Hospitals and Nursing Homes, 4815 West Markham, Little Rock, Arkansas. The records and documents on the basis of which the above level of uncompensated services was established are available for public inspection at Arkansas State Department of Health, Division of Hospitals and Nursing Homes, 4815 West Markham, Little Rock, Arkansas between the hours of 8:00 A.M. and 4:30 P.M. on regular business days.

Eugene C. Spratt, Director
Bureau of Health Facility Services

SERVICES TO PERSONS UNABLE TO PAY THEREFOR
CERTIFICATION
METHODIST NURSING HOME
FORT SMITH, SEBASTIAN, ARKANSAS

The Methodist Nursing Home, Fort Smith, Arkansas has certified that it will not exclude any person from admission on the ground that such person is unable to pay for needed services, and that it will make available to each person so admitted services provided by the facility without charge or at a charge which does not exceed such person's ability to pay therefor, as determined in accordance with criteria established in the Arkansas Medical Facilities Construction Plan. This certification has been made pursuant to the requirements of the regulations of the Public Health Service, U. S. Department of Health, Education and Welfare, (42CFR paragraph 53.111), and the applicable provisions of Arkansas Medical Facilities Construction Plan. The Arkansas State Department of Health has, therefore, established the foregoing level of services as the level of uncompensated services to be made available by by said facility in the period May 1, 1973 to April 30, 1974. The level of services set out meets the presumptive compliance guideline of the Federal Regulations. Copies of the criteria used for identifying persons unable to pay for services may be obtained from Arkansas State Department of Health, Division of Hospitals and Nursing Homes, 4815 West Markham Street, Little Rock, Arkansas.

Eugene C. Spratt, Director
Bureau of Health Facilities Services

Montgomery Advertiser
March 8, 1974

NOTICE

SERVICES TO PERSONS UNABLE TO PAY THEREFOR

Montgomery Baptist Hospital
Montgomery, Alabama

The Alabama State Department of Public Health has established the sum of $44,000.00 as the level of uncompensated services to be made available by the Montgomery Baptist Hospital, Montgomery, Alabama, in the period July 19,1973 to June 30, 1974. This determination has been made pursuant to the requirements of the regulations of the Public Health Service, U.S. Department of Health, Education, and Welfare, (42 CFR & 53.111) and the applicable provisions of Alabama Master Hospital Plan.

"Uncompensated services" means services available in the facility which are made available to persons unable to pay therefor without charge or at a charge which is less than the reasonable cost of such services. The level of such services is measured by the difference between the amount paid by such persons for the services and the reasonable cost thereof.

The leve set out above meets the presumptive compliance guideline of the Federal regulations and is 10 per cent of all Federal assistance provided the facility under the Hospital and Medical Facilities Construction Act.

Copies of the criteria used for identifying persons unable to pay for services may be obtained from Bureau of Health Facilities Construction, State Office Building, Room 657, Montgomery, Alabama 36104.

The records and documents on the basis of which the above level of uncompensated services was established are available for public inspection at State Office Building, Room 657, Montgomery, Alabama, between the hours of 8:00 A.M. and 5:00 P.M. on regular business days.

VARIETY CHILDREN'S HOSPITAL

DEDICATED TO THE CARE OF CHILDREN OF OUR MANY COMMUNITIES

STATEMENT OF OPERATIONS — 6/1/73 through 5/30/74

6125 S.W. 31st ST. MIAMI, FLA. 33155

Patients treated for the year	46,323
Hospitalized patients	7,699
Ambulatory patients	38,624
Patients who have received uncompensated services	11,401
Private patients	34,922
Surgical patients	3,007
Ear, Nose and Throat Admissions	1,435
Patients treated for dental problems	1,906
Average daily census	142.0
Average daily ambulatory patients	106.0
Average daily recipients of uncompensated services	31.2
Invested in the children of our community	$1,637,403.82
(uncompensated charges from 4/1/73 through 3/31/74)	

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THERE ARE 437 ACTIVE PRACTICING PHYSICIANS AND DENTISTS ON THE STAFF OF THE HOSPITAL

Miami Herald, Sunday, July 28, 1974

(reduced for convenience from a half page -- 11" x 14", -- advertisement)

to be the rule rather than the exception.[1] With print so small, they are almost impossible to read without a magnifying glass if one is fortunate enough to notice them at all. Even if the HEW regulation is followed verbatim, it is unlikely that it will benefit a poor person needing free medical care.

Hospital Sign indicating free service available

If a poor person is not to learn from the paper that a nearby hospital might provide him with free medical care, then where can he find out? Strangely enough, our investigations show that he very well might not discover such a requirement at the facility itself unless he has the temerity to ask. Of the forty-four hospitals visited, only one, University of Virginia Medical Center in Charlottesville, prominently posted a sign indicating the possibility of obtaining free service. When asked about the lack of such notice, administrators at other facilities usually maintained that "everyone" in the community knew that they provide some charity care. The instance cited on page 10 and those like it occurring throughout the South indicate otherwise.

IV. WHAT LEVELS OF UNCOMPENSATED SERVICES ARE FACILITIES PLEDGING TO PROVIDE?

In deciding how much uncompensated service they will give to indigents annually, facilities have four options:

--provide 10% of the total Hill-Burton grant and loan money received during the previous 20 years;

--provide 3% of the operating costs after first subtracting the Medicare and Medicaid reimbursements;

--certify that no person will be turned away from the facility because of an inability to pay (open door); or

--petition the state agency to allow the hospital, for reasons of financial hardship, to provide less than the amounts required under any of the above options.

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[1] It is instructive for comparison to examine only two exceptions to the above rule found by our investigations. They are contained at the right of page . and on page . (The latter example was a half-page advertisement which has been reduced for convenience.)

A comparison of the alternatives chosen reveals a great deal of variation from one state to another. In the course of the field investigations a number of abuses were uncovered. The discussion below is based on material received from the following nine states --Alabama, Arkansas, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, and Texas.

10% option

The 10% quota is selected with relatively low frequency in all nine states -- 10 - 25%.

3% option

In two states, Mississippi and South Carolina, more than 50% of the facilities chose to use the 3% method to compute the level of their free service obligation. 43% of Louisiana's hospitals chose this option while in the six other states, between 25-35% of the facilities selected this alternative.

In the case of at least one hospital authority, however, budgetary information submitted by the facility to the state agency suggests that the dollar level established was far too low if the accounting methods outlined above were followed.

- In FY 1974 the three general hospitals of the Gwinnett County Hospital System in Georgia pledged under the 3% option, to give $95,200 in indigent care "providing patients of this financial class present themselves for treatment." With projected FY 1974 operating expenses of $4,889,371, and Medicare and Medcaid reimbursements of $38,164 and $32,104 respectively, the three hospitals would be expected to provide $144,573 of care to indigents.

This latter amount is almost 50% greater than the level established by the state agency as fulfilling their legal obligations. From further examination of the hospital system's current year budget, one finds two line items pertaining to uncompensated service -- $74,244 to be paid by the county for care of its indigent patients and an additional $11,580 labelled "free service." The sum of these two amounts does not even equal the figure which the hospitals themselves agreed to provide. In spite of these discrepancies, the 3% option and insufficient dollar amount was apparently approved by the Georgia state agency.

"Open door" option

In six of the nine states, the "open door" option is the one most frequently chosen by hospitals and nursing homes. More than 45% of the Alabama, Arkansas, Georgia, North Carolina, Tennessee, and Texas facilities agreed to certify that no one would be refused service because of an inability to pay--that everyone would be given medical care. Evidence from Georgia and Tennessee suggests that a very high percentage of the rural hospitals with fewer than 70 beds selected this open door option. All the reasons for this pattern were not determined, but some evidence indicates that the open door option was chosen because it involves virtually no accountability.

Facilities choosing either the 3% or 10% option are required to submit supporting budgetary information to the state agency. But in only one of the six states mentioned above are those selecting this open door assurance required to provide financial data indicating how much free service is actually given. And that state, Arkansas, has only recently instituted such a requirement. Although such information is not routinely sent to the state agency responsible for monitoring compliance, evidence suggests that, in some cases, the "open door" assurance has the effect of enabling some facilities to avoid the obligation of providing the higher amounts of indigent care that would be required if the 3% or 10% option were chosen. Hospitals simply maintain that they accept as indigent patients anyone who meets the eligibility standards. HEW regulations provide that the "open door" facility is presumed to be in compliance[1] even though some hospitals are avoiding accountability for the free service they are supposed to give.

According to the prospective budgetary figures summarized in the table below, two Georgia hospitals were expected to provide far less indigent care in FY 1974 than would have been required of them under the 3% or 10% options.

Hospitals	$ actually budgeted for free service	$ expected under: 3% option	10% option
Monroe County Hospital	3,340	14,587	12,941
Rockmart-Aragon Hospital	2,967 (in charity discounts)	c.20,000	12,080

[1] 42 C.F.R. 53.111(d).

If the budgets submitted to the state agency are followed, Monroe County and Rockmart-Aragon Hospitals will each give approximately 25% of the amount of uncompensated services that would be expected if they had selected one of the other two guidelines. Although located in counties where more than one out of every five families lives on an income below the poverty line established by the U.S. Census Bureau,[1] these two facilities are in effect providing medical care to indigents as if the state agency had approved a petition for a level below the presumptive guidelines.

The two rural hospitals discussed above are very small, each having less than 50 beds. But some larger hospitals have discovered this method of avoiding accountability for a high level of uncompensated services.

- Women's Hospital in Baton Rouge, Louisiana is a 135-bed maternity facility which had pledged to provide $165,000 of free service under the 3% option this past year. Mr. James F. Hightower and Mr. Rod Baker, Administrator and Assistant Administrator at the facility, said that Women's Hospital will have a very difficult time meeting this level of free service. When in need of medical care, most indigent Baton Rouge patients reportedly go to Earl K. Long Hospital, one of Louisiana's state-run charity facilities. It was not determined, however, what efforts have been made by Women's Hospital to ensure that local physicians will admit more indigent patients there so that the compliance guidelines may be satisfied. Instead the hospital administrators are reportedly seriously considering a change to the "open door" option next year so as to be in compliance since they "never refuse service to anyone."[2]

Although our investigators found other facilities in the South not meeting their legally required free service levels, it was not determined if they too are contemplating a similar change.

Less than presumptive guidelines

In spite of the implications of the evidence discussed in the previous section on the "open door" option, Louisiana is the only state agency approving a significant number of formal petitions by hospitals to provide free service at levels below those presumptive guidelines discussed above. Fourteen, or 20% , of its 70 facilities

[1] General Social & Economic Characteristics, PC(1)-C Series, 1970, U.S. Census Bureau.

[2] Interview with Carol Rose, SGMP Field Investigator, August 12, 1974.

have taken advantage of this option.

Three of these facilities, East Jefferson, Flint-Goodridge, and Hotel Dieu, were among the original defendents in the 1970 litigation which prompted HEW to establish regulations whose implementation is discussed in this report. In June 1974 the U.S. District Court conducted hearings to determine if any of these six facilities should be held in contempt for failing to meet the free service quotas. Although a formal ruling has not been issued, three facilities were found at this hearing to be providing less than the required amounts of indigent care. One of them, Hotel Dieu, was able to convince the court that it could afford no more since its first year of operation in a new building has resulted in a large loss, forcing rates to be increased twice. East Jefferson Hospital and one other facility were not so persuasive and were found on a preliminary basis to be in contempt for non-compliance. Thus one of these facilities has made virtually no attempt to raise the low level of free services the state agency has allowed them to provide although HEW regulations require such action of all facilities granted an exception to the presumptive guidelines.[1]

No decision

In Louisiana, in addition to the fourteen facilities approved for service levels below the presumptive guidelines, three more--Glenwood Hospital in West Monroe, Natchitoches Parish Hospital in Natchitoches, and Slidell Memorial Hospital in Slidell--had, as of August 21, 1974, reached no decision as to how much indigent care they will provide.[2]

Although Louisiana is the state most easily documented in this regard, it is by no means the only one not forcing facilities to commit themselves to an option. Mr. Oliver Kyle, Jr., Deputy Director of Alabama's Bureau of Health Facilities Construction, said that 19 Hill-Burton facilities had not selected an option by the

[1] 42 C.F.R. 53.111(e)(2).

[2] August 21, 1974 letter from J. Ben Meyer, Jr., Chief of Engineering and Consulting Services, Louisiana Health & Human Resources Administration, to Wayne A. Clark, SGMP.

end of July 1974.[1] A perusal of the state agency files on more than 130 Georgia hospitals and nursing homes, 17[2] or 13% have evidently discovered this method of avoiding accountability as far as their free service obligations are concerned. In addition to hospitals that have never chosen an option, several more selected one during FY '73 but have not done so since, evidently assuming that there is no need to once again inform the state agency.

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[1]Interview with Allan Crimm, SGMP, November 18, 1974.

[2]As of August 22, 1974, the following seventeen Georgia facilities had not informed the state that an option had been selected:

City	Facility	#Beds
Atlanta	Holy Family Hospital	125
Augusta	University Hospital	690
Bainbridge	Memorial Hospital	50
Camilla	Mitchell County Hospital	51
Cedartown	Polk General Hospital	66
Cordele	Crisp County Hospital	70
Griffin	Griffin-Spalding Hospital	163
Jasper	Pickens General Hospital	40
Pelham	Pelham Parkway Nursing Home	Undetermined
Sandersville	Memorial Hospital of Washington Co.	115
Soperton	Treutlan County Hospital	27
Statesboro	Bulloch County Hospital	133
Thomaston	Upson County Hospital	121
Valdosta	South Georgia Medical Center	236
Vidalia	Dr. John Meadows Memorial Hospital	48
Washington	Wills Memorial Hospital	51
Waycross	Memorial Hospital	218

V. WHAT ARE THE FACILITIES INCLUDING AS "UNCOMPENSATED SERVICES"?

In 1948, long before Medicare and Medicaid, the language of the original statute required that facilities receiving Hill-Burton money "provide a reasonable volume of service to those unable to pay." During the process of writing implementing regulations some 26 years later, the words "uncompensated services"[1] were inserted to make provision for the various third-party medical care payment programs, both private and public, which had proliferated during the interim. Many hospitals are interpreting the phrase "uncompensated services" in a variety of discretionary ways that violate the intent of the regulations. The determination of exactly what may be written off to fulfill a facility's legal obligation is the subject of widespread confusion among hospitals as well as state agencies.

Uncollectible accounts and bad debts

HEW regulations state that the only services which may be included in meeting the hospital's predetermined level of uncompensated services are those provided to an individual for whom the hospital has determined eligibility "prior to any collection effort other than the rendition of bills."[1] Three of the seven state plans examined paraphrase this language,[2] and one, that of Florida, includes the injunction that "bad debts, per se, shall not be included."[3]

In spite of these directives, however, some hospitals are writing off bad debts in order to meet their compliance level.

- Mr. Lynn Pressler, Vice President of 572-bed North Carolina Baptist Hospital in Winston-Salem, admitted that bad debts are being used to cover the more than $150,000 in free service which that facility is obligated to provide. He could not, however, document what percentage of the total this represented.[4]

Vanderbilt Hospital in Nashville, Tennessee apparently makes little effort to distinguish the "pikers" from those who are genuinely in need of reduced cost care since a copy of their criteria used in identifying those unable to pay states:

> Any balance (remaining after third-party or cash payments which is) not paid within reasonable time following date of service or discharge may be classified as "Free Care"

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[1] 42 C.F.R. 53.111 (f)(1)

[2] The state plans of Alabama, Florida, and South Carolina include such stipulations; those of Georgia, Mississippi, North Carolina and Tennessee do not.

[3] "Rules and Regulations Governing Services for Persons Unable to Pay." Section 6a, Florida Department of Health & Rehabilitative Services, Division of Planning & Evaluation.

[4] Interview with Harold Kennedy, SGMP Field Investigator, August 19, 1974

and charged off the accounts receivable listing.[1]

Lafollette Hospital in Tennessee has apparently been unable to document its compliance except through reliance on the fact that, historically, at least 12% of its accounts receivable have been uncollectible.[2]

Although Mr. William Green, Deputy Director of the HEW Region IV Division of Resource Development, suggests that one of the main effects of the 1972 regulations has been to stimulate the establishment of separate accounting procedures for bad debts and free service[3] The lack of evidence[4] contained in the files of the Georgia Hill-Burton agency suggests otherwise. 39 facilities were selected at random. Of the 16 hospitals choosing the 3% or 10% option and submitting a budget to support their claim of compliance, eight contained no evidence of a separation of free service and uncollectible accounts. In Alabama, 27 files were selected. Of the nine containing financial statements, four did not separate the two categories. Similarly, five of the fourteen audited statements in the 35 Arkansas files examined did not separate free service and uncollectible accounts. It is not known, however, if accounting procedures have simply not caught up with more recent changes in budgeting strategies.

Care provided to indigents in Hill-Burton facilities not participating in Medicaid program.

Under the 1972 "free service" regulations, a hospital not registered as a Medicaid provider is not permitted to write off as uncompensated service the "reasonable cost" reimbursement which it would have been unable to receive had it participated to the Medicaid program.[5]

Our investigations uncovered three general hospitals which do not participate in the Medicaid program and one which received

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[1] See Note 1, Page 7, supra.

[2] Interview with Bill Allen, SGMP Field Investigator, August, 1974.

[3] Interview with Allen Crimm, SGMP and Marilyn Rose, Center for Law and Social Policy, Washington, D. C., September 5, 1974.

[4] Availability of such documents for public inspection is required by HEW regulations at 42 C.F.R. 53.111 (h)(4).

[5] 42 C.F.R. 53.111 (f)(2).

reimbursement for only two inpatients.[1] The following table provides pertinent information about each of these facilities:

TABLE 1

Hospitals	Beds[2]	Inpatient Admitted[2]	Inpatients for which Medicaid reimbursed (FY 1974)	% poor families in hospital's county (1970 census)[3]	Hill-Burton received	Hill-Burton free service obligation
Abernathy Memorial Hospital; Flomaton, Alabama	39	756	2	25%	$ 221,256	undetermined
Methodist Hospital Memphis, Tennessee	910	36,939	0	16%	1,056,988	$105,699
Mobile Infirmary Mobile, Alabama	568	26,841	0	19%	1,484,479	undetermined
Parkview Hospital Dyersburg, Tennessee	160	7,070	0	22%	852,365	"open door"

All four facilities are located in counties in which more than one out of every six families has an income below the U. S. Census poverty line. Abernathy Memorial and Parkview Hospitals, the two smaller facilities, are county run. Mobile Infirmary and Methodist Hospital, which admitted 26,841 and 36,939 inpatients respectively during FY 1974, are private non-profit facilities. Neither of these two facilities accepts Medicaid patients, reportedly because of the low level of reimbursement and the large amount of paperwork involved in the program. Methodist Hospital is, however, trying to get approval from the Mid-South Medical Center Council to plan a new 174-bed facility near Memphis. According to a report in the Memphis Press-Scimitar[4] the hospital would put up $5 million for construction, money that would come from a fund taking 10¢ from every dollar of current patient revenues.

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[1]At the time of our investigation during the summer of 1974, a Hill-Burton facility was free, like any other hospital, to choose not to participate in the Medicaid program. However, according to the new "community service" regulations issued by HEW in August 30, 1974 (Federal Register, Vol. 39, No. 170), all recipients of Hill-Burton monies must register for the Medicaid program.

[2]Guide to the Health Care Field: 1974, American Hospital Association.

[3]General Social and Economic Characteristics, PC(1)-C Series, 1970.

[4]See page 23.

Memphis Press-Scimitar, July 24, 1974

PAGE 8

Raleigh-Bartlett Satellite Hospital Recommended

By PEGGY BURCH
Press-Scimitar Staff Writer

A committee of the Mid-South Medical Center Council has recommended MMCC approve a Methodist Hospital plan to build a satellite hospital in the Raleigh-Bartlett area.

The hospitals and related health facilities committee voted yesterday after a public hearing for two separate hospital proposals by Methodist and by Drexel Toland and Associates, Inc.

MMCC, regional health planning agency, has stated there would be a need for a 200- to 400-bed hospital in the Raleigh-Bartlett area by 1980. MMCC's board of directors will vote on the issue, then make a recommendation to the Tennessee Health Facilities Commission, which must approve all certificates of need for construction of new facilities.

Methodist's plan for a 174-bed satellite would cost an estimated $9.3 million for the hospital and professional building. Construction would be completed by December, 1980.

L. M. Stratton III, president of the Methodist board of trustees, said Methodist would put up $5 million to build the satellite. He said that money would come from a fund set aside for purchase of equipment and expansion by taking 10 cents from every patient dollar.

Stratton said the rest of the money would come from loans.

Drexel Toland and Lewis R. Donelson III, attorney, presented an opposing plan for what they called "a community hospital with a grassroots point of view."

Toland said 40 per cent of the board of trustees at his proposed hospital would be Bartlett residents.

The group would build a 150-bed facility a mile and a half north of I-240, west of the Covington Pike-Stage Road intersection. It would cost $14 million to build and construct the hospital and professional building.

Stratton, arguing for the Methodist satellite, said it was "almost impossible to get doctors to swear allegiance to a small community hospital because of the 70 per cent rule." He said doctors don't receive "active staff privileges" unless they admit at least 70 per cent of their patients at one hospital.

The committee voted against an amendment to require Methodist to accept Medicaid patients at the satellite.

Stratton said Methodist does not accept Medicaid patients because 30 per cent of the patient load at Methodist is Medicare patients and Medicare pays only 18 per cent of the operating budget.

Dr. Colin Threlkeld, a member of the committee, said Methodist and Parkview Hospital, Nashville, are the only hospitals in Tennessee which do not have an agreement with the state to admit Medicaid patients.

Donelson said the group he represented would appeal to the Health Facilities Commission in Nashville if the MMCC approved the Methodist request. If that appeal is turned down, the group could take its appeal to Chancery Court.

It is not known how or if these four hospitals are meeting their obligation to provide a reasonable volume of free services. Several local observers have questioned if the facilities are including service given to patients who are Medicaid eligible in violation of the HEW regulations. Our investigations have not determined if their suspicions are, in fact, true.

Medicare and Medicaid - related costs

The intent of the 1972 "free service" regulations is to place an upper limit on the amount that a facility may claim as its cost of providing service to a patient unable to pay. This cost is apparently fixed, not at actual change, but at the "reasonable cost" figure determined through Medicare formulas.[1] It would thus appear that a facility may not legally claim as part of its "uncompensated service" the difference between the amount reimbursed by Medicare and Medicaid for various services and the actual cost to the facility of providing this care.

But many facilities have complained that the amounts they are reimbursed under Medicaid and Medicare are inadequate. Medicare cost levels, which are established by the individual states, are a source of particular concern. For this reason, the language originally proposed for one section of the 1974 "community service" regulations was altered to provide that hospitals may not refuse to participate in the Medicaid or Medicare programs due to a factual determination of whether or not the reimbursement provided is, indeed, "reasonable."[2] The Social Security Administration of HEW also recently published regulations pertaining to this issue. The new rules provide procedures for the determination of Medicare provider reimbursements and mechanisms to appeal the levels established.[3]

With this background information in mind, Mr. William Green, Hill-Burton Coordinator for HEW Region IV, was asked if he was aware of any memorandum from the Health Services Administration, dealing with the permissibility of a facility writing off as uncompensated service the difference between the "reasonable cost" level and the actual cost or charges established by the hospital. Mr. Green said that, although he was unaware of any such clarifying memo, this procedure would probably be allowed, citing as a hypothetical

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[1] See 42 C.F.R. 53.111(b) (6-8).

[2] Federal Register, Vol. 39, No. 170, August 30, 1974. See discussion on page 31766 relating to proposed language for 42 C.F.R. 53.111(d)(2)(i)(B).

[3] Federal Register, Vol. 39, No. 188, September 26, 1974; pages 34514 ff.

example the case of a children's hospital for which actual charges were $110 per day for a room but for which the facility was reimbursed under "reasonable cost" formulas the sum of only $75 per day. As far as the hospital is concerned, the difference, $35 per day, is "uncompensated services."[1] Mr. Eugene C. Spratt, Director of the Bureau of Health Facilities Service, Arkansas State Department of Health, agrees with this interpretation. The Alabama state plan specifically authorizes facilities to include in its calculations for compliance purposes:

> the difference between Medicare reimbursements and the actual operating cost of the entire facility as determined in accordance with applicable rules under Title XVIII of the Social Security Act.[2]

For hospitals with many Medicare patients, this can amount to a sum large enough to cover their entire free service obligation.

Although the HEW regulations apparently prohibit hospitals writing off this difference, there is quite a bit of misinterpretation of the rules by the HEW and state agency staff who are responsible for enforcing these sections of the provisions. And hospitals are evidently taking advantage of this confusion.

- Washington General Hospital in Fayetteville, Arkansas apparently includes in its computation of free service the difference between the actual charge and the "reasonable cost" portion for which they are reimbursed by Medicaid and Medicare.[3]

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[1]Telephone conversation with Allan Crimm, SGMP, September 18, 1974.

[2]Amendment to Alabama state plan; Section O - Services for Persons Unable to Pay, Paragraph 115.9 (A)(2). Approved by HEW Region IV office, May 14, 1974.

[3]Interview with Mr. Eugene C. Spratt, Director of Bureau of Health Facility Services, Arkansas State Department of Health, by Allan Crimm, SGMP, November 15, 1974.

Most Southern state Medicaid provisions place relatively low limits on the days of hospitalization covered under their plan. In Louisiana, for example, 15 days is the maximum number for which a hospital may ordinarily be paid. Some states, however, assure that additional days may be reimbursed on a "pre-authorization basis."[1] In some cases, hospitals are not taking advantage of this option to apply for an extension of the allowable number of days but are instead writing this off as part of their uncompensated service. Mr. J. D. Price, Assistant Administrator at St. Edward's Mercy Hospital in Fort Worth, Arkansas, told our investigator that many of the Hill-Burton "charity cases" were Medicaid related. Some involve patients who have exhausted their maximum day limit but for whom the Utilization Review Committee does not request extensions from the state Medicaid agency because of the latter's alleged reluctance to grant them.[2]

Thus, in some cases, Hill-Burton facilities are using proscribed procedures to account for the required amount of free services. The effect of such practices is, of course, to decrease the amount of free care given to those poor and medically indigent people not covered by Medicaid or Medicare programs -- the same people for whom these regulations were intended to provide.

VI. HOW IS COMPLIANCE ASSURED?

Under the provisions of the HEW regulations, the state Hill-Burton agencies are charged with enforcement, including the following specific responsibilities:

-- establishment of criteria for determining who is eligible for free service (42 C.F.R. 53.111(g));

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[1]The Southern state's Medicaid plans cover hospitalization with the following limitations:

	Limits
Alabama	30 days per year; extensions if preauthorized
Arkansas	26 days per year; extensions if preauthorized
Florida	45 days per year; extensions if preauthorized
Georgia	No limits
Louisiana	15 days per year; extensions if preauthorized
Mississippi	40 days per year
North Carolina	No limits
South Carolina	40 days per year
Tennessee	20 days per year
Texas	30 days per Title XIX - "spell of illness"

[2]Interview with Will Godwin, SGMP Field Investigator, July 11, 1974.

-- determination of the level of free service each facility must provide (42 C.F.R. 53.111(h)); and

-- annual evaluation of each facility's performance in meeting its service level, investigation of complaints, and enforcement, through the application of sanctions, of the free service obligations (42 C.F.R. 53.111(i)).

The instances cited in previous sections dealing with overly restrictive eligibility criteria, abuses of the "open door" option, misreporting of figures pertinent to calculation of obligations under the 3% and 10% options, failure to select any option at all, and the variety of prohibited procedures being employed to write off the "uncompensated services" level--all indicate that the state agencies are not conscientiously exercising their enforcement authority.

State plans

As a result of the new free service provision issued by HEW in 1972, all state agencies were forced to write amendments to their existing plans in order to outline what procedures they would employ in insuring that Hill-Burton facilities will provide "a reasonable volume of free service." Since these amendments are, in effect, the state agencies' action plans, it is instructive to examine them to see exactly what procedures they provide.

Some two years after the interim regulations were published, at least one state, Virginia, has not yet submitted such an amendment to its HEW regional office.[1] Some of those which have written are little more than a restatement of the HEW regulations in slightly different language. Those of Alabama, Florida and South Carolina are rather detailed explanations of the responsibilities of the agency and the facilities, but in some cases even they include portions which are not in keeping with the HEW regulations. Alabama's state plan provides, for example, that the difference between the Medicare reimbursement costs and the "actual cost" of providing service may be included by the facility in meeting its "uncompensated service" level.[2]

Financial statements submitted to state agencies

The crux of enforcement is the assurance that adequate information on each facility will be received by the state agency. But many of the state plans do not specify what information should be submitted by facilities in support of either the indigent care level for the upcoming year or proof of compliance with the quota estab-

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[1]Letter from John P. Morrison, Chief of Health Facilities Branch, HEW Region III, Philadelphia, Pennsylvania, to Allan Crimm, SGMP; September 25, 1974.

[2]This provision is apparently in conflict with the intent of the regulations. See pages 24-25 above.

lished for the previous year. Of the eight state[1] plans examined, only those of Florida and South Carolina require that all facilities, including those choosing the open door option, submit financial statements for both the current and previous fiscal year specifying the amount of free service both anticipated and actually provided. Arkansas has only recently instituted such a requirement. The Georgia and North Carolina plans mention nothing about information to be submitted by facilities to support their assurance of compliance. It was not determined if such a requirement is made in other memoranda from the state agency to the facilities. Tennessee's plan provides only that the facility's proposed budget need be submitted "in some instances"[2] which are left unspecified. Florida is the only state requiring separate accounting of "no-pay" and "part-pay" services provided. None of the other states can monitor the extent to which poor, as opposed to medically indigent, people are benefitting from these provisions.

But even assuming that such requirements are spelled out elsewhere, a direct examination of the files of three state agencies[3] reveals the inadquacy for evaluation purposes of the system presently employed. Of the 39 Georgia facility reports randomly chosen, almost 25% included no financial statement either for the current or past fiscal year. Of the remaining 28 folders containing some type of financial information from the hospital, 13 failed to indicate any separation between uncollectible accounts and bad debts. Thus almost 60% of the files examined contained no information that would have enabled the state agency to evaluate accurately a facility's performance in meeting its obligated free service level. At the Alabama and Arkansas state agencies, 70% of the files examined were found to contain insufficient documentation of compliance.

Without accurate record-keeping by the facilities themselves and without submission to the state agency of financial statements which include separate line items for uncollectible accounts and "free service", a state agency cannot effectively evaluate facilities' annual compliance.[4]

Audits

To our knowledge, no state agency has conducted an audit to verify that no prohibited expenses such as bad debts are being included in the computation of indigent care actually provided. Officials at the Alabama, Arkansas and Georgia state agencies said that they are now doing no more than taking facilities at their word. All three maintain that investigations would be difficult because of a lack of manpower and auditing capability. Arkansas, however, is reportedly planning to conduct some audits during the next year.

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[1] Alabama, Arkansas, Georgia, Florida, Mississippi, North Carolina, South Carolina and Tennessee

[2] Amendment to the Tennessee State Plan for Construction of Hospitals and Medical Facilities, Fiscal Year 1972-1973; Chapter I, Section X, Reasonable Volume of Free Care (Page I-39)

[3] Availability of such documents for public inspection is required by HEW regulations at 42 C.F.R. 53.111(h)(4).

[4] 42 C.F.R. 53.111(i)(1).

Complaint system

If abuses are not uncovered through routine state agency evaluations of facilities' compliance, the complaint mechanism offers a means by which objections can be raised.

Under the HEW guidelines, state agencies are required to establish procedures for the investigation of complaints against individual facilities' compliance with the free service assurance.[1] But at only one point in the entire process of setting a dollar amount of free service and evaluating past performance is a public citizen guaranteed entry with a complaint. The interim regulations required (at 42 C.F.R. 53.111(h)(4)) that public notice was to include a statement that anyone wishing to object to the level of free service established by the state agency could do so.[2] In the revisions of June 22, 1973, however, this section was changed so that this statement was to be included only if the level set was below the presumptive guidelines. Thus, individuals wishing to object to a miscalculation of the quotas under the 3% or the "open door" option[3] are provided no mechanism for doing so.

Considering the barriers to filing a complaint, it is not surprising that so few persons have taken advantage of these procedures to voice an objective. From annual reports filed by six states[4] with the HEW Region IV office, it appears that not a single objection has been lodged through a state agency's regular complaint mechanism against a facility for either its quota for the current year or its compliance in past years. In these six states, only one law suit has been filed on issues related to the Hill-Burton free service requirement.[5] In these six states, only one complaint for non-payment of a medical bill has been received and adjudicated by a state agency with reference to the free service requirement.[6]

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[1] 42 C.F.R. 53.111(i)(1)(ii).

[2] Federal Register, Vol. 37, No. 142, July 22, 1972.

[3] For a discussion of the abuses of these options, see pages 15 ff. above.

[4] Alabama, Florida, Georgia, Mississippi, North Carolina and South Carolina

[5] Saine v. Hospital Authority of Hall County et al., No. 73-3054; 5 Cir. (Oct. 11, 1974).

[6] This particular incident in Alabama involved an indigent patient who was transferred from one facility to another in order to receive more specialized care. From the information given to the HEW regional office, it is not entirely clear whether this complaint was initiated by the indigent patient who had been mistakenly billed or by the latter hospital asking the former to pay for the care that it had provided under a pre-established agreement.

The complaint record in the other five states was not determined, but in only one, Louisiana, has any litigation been initiated to force hospitals to come into compliance with the Hill-Burton free service provisions. With the number of abuses of the regulations discussed in this paper and the number of people going without needed medical care every day, such a dearth of complaints is an indictment of the present procedures.

Public access to information

In considering the adequacy of a complaint system, the most crucial aspect is the ability of an individual to have access to information on which to base a well-documented objection. Without this access to information on finances and admissions and billing procedures, a private citizen cannot gather data to substantiate contentions of non-compliance. The incredible lack of formal complaints described above is largely the result of an inability of public citizens to get the information they need. In many cases, our field investigators were refused interviews as soon as the topic was explained to the administrator. Some were simply "out of the office" for weeks at a time. Others just did not return calls. Most of our investigators found that showing up at the office turned out to be the best strategy for getting an interview.

Once at a hospital, many were grilled about "credentials". Public citizens evidently have to "be with somebody" and not just be "off the street" to exercise their right to have access to even the most simple information. At Sparks Manor Nursing Home in Fort Smith, Arkansas, our investigator was told that he could not have an interview since he "had no government authority."[1] In the Miami area, Susan Alper ran into even more bizarre organizational barriers involving the South Florida Hospital Association when she attempted to arrange an interview with Mr. Sidney Golden, Administrator at Mt. Sinai Hospital. She was told that a meeting would not be granted until he received word from Mr. Ivan Hannah of the Hospital Association that her credentials had been formally confirmed. When Mr. Hannah was contacted, he attempted to prohibit her from talking with any of his member hospitals until she had been cleared by him. An explanation of the program and the nature of the research was sent to Mr. Hannah from the Atlanta office in August 8, but apparently this was not in time for him to lift the ban on interviews before Ms. Alper left Miami to go to law school on August 24, 1974.

Through Mr. Glenn Hogan, Executive Director of the Georgia Hospital Association, the Hill-Burton monitoring project was "checked out" by facilities in Birmingham and Little Rock who wanted a confirmation of credentials offered by our field investigators in those cities. Apparently the administrators at three hospitals contacted in Little Rock had discussed the matter of

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[1]Telephone conversation with Mr. Knight by Will Godwin, SGMP Field Investigator, June 27, 1974.

granting an interview because each asked for credentials and then stipulated that only questions submitted in writing would be answered. None granted face-to-face interviews. Of the three--University of Arkansas Medical Center, Baptist Medical Center, and St. Vincent's Infirmary--only the latter actually did respond although all the conditions outlined by these facilities were met.

In Tampa, this restriction to questions submitted in writing was required by Tampa General Hospital. Only after Florida's Freedom of Information Act was cited prominently did the administrator complete and return the questionnaire.

Of these facilities which did respond, and there were some which did so graciously, more than 25% refused to give any budgetary figures. In most cases, those which did give figures cited only summary information, refusing to let our field investigators see the documents themselves. Some administrators said that they would have to get approval from their boards of trustees, but in no case where this condition was given was the information finally supplied.

Apparently such information is not to be gained excepted by resort to the expensive and time-consuming process of litigation. Without public access to information relevant to filing a complaint, the whole process is ineffective.

HEW's role

The regional offices of HEW enable the Secretary to ensure that programs are implemented in accordance with his intent. Apparently the lack of diligence on the part of the state agencies has his approval, because the regional offices do not seem to be overly zealous about requiring state agencies to enforce the provisions of the HEW regulations.

At least one state--Virginia--has not yet submitted an amendment dealing with free service to its state plan. Those submitted seem to receive only cursory review before approval. Alabama's contains provisions which contradict the intent of the regulations.[1] Others seem merely inadequate.[2] Each state agency is required under the regulations[3] to submit an annual report outlining its evaluation of each facility's compliance. In practice such reports include only summaries of the options chosen by the facilities in that state and a statement outlining the status of any complaints received. Of the eleven states, at least three--Georgia, Tennessee and Virginia--apparently have not submitted this information to their regional HEW offices.

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[1] See pages 24-25 above.

[2] See page 27 above.

[3] 42 C.F.R. 53.111(j).

Furthermore, Mr. William Green, Deputy Director of the Division of Resource Development in the Region IV HEW office, admitted that he had neither the manpower nor the auditing capacity to initiate spot checks of individual facilities' compliance. If a complaint were received, however, he asserted that an audit would be done by his office.[1] The problem is, of course, that no formal objections have been made.

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[1]Interview with Allan Crimm, SGMP, and Marilyn Rose, Center for Law and Social Policy, Washington, D. C., September 5, 1974.

VII. SUMMARY AND CONCLUSIONS

What have been the major effects of the Hill-Burton free service regulations? From the information gathered during the course of our investigations, it is clear that in the South they are enforced neither widely nor consistently. Some abuses are apparently overlooked; many more, because of the lack of an effective complaint mechanism, are never brought to light.

Who is getting the free service?

The intent of the regulations is to provide an access to medical care for at least some of those people previously denied treatment because of an inability to pay and a lack of eligibility for present governmental programs. Some of the intended beneficiaries are those "medically indigent" people who are otherwise self-supporting but who cannot pay the full charge for hospital care.

The regulations include special provisions to insure that people other than those currently benefitting from the Medicare and Medicaid programs would benefit by these new free service requirements.[1]

In spite of such stipulations, it does not appear that new groups of people previously excluded from hospital care are receiving the benefits intended by the regulations. It is rather the medically indigent and those eligible for Medicare and Medicaid who have probably gained the most. Some evidence indicates that their gains have come at the expense of people not eligible for these programs.

Access to primary care is good predictor of access to hospital care. Hospitals admit patients only on the orders of a physician, and it is the indigent who are least likely to have the money to pay either a private doctor or the staff of an outpatient clinic or an emergency room. People who are ordinarily self-supporting--the medically indigent--and those who are eligible for Medicare and Medicaid are far more likely to get the doctor's attention which precedes hospitalization. The families of seasonal workers, rural unemployed fathers, and working but still impoverished parents are those who run the greatest medical risk but who are least likely to get the care they need.

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[1] 42 C.F.R. 53.111(j)(2) states that the computation of uncompensated services may not include any amount that the facility is entitled to receive from any third-part insurer or governmental program.

Geographic restrictions and limitations on the types of medical care given to those unable to pay make it more difficult for poor people to get into hospitals. If one does not live in a county providing money specifically for indigent medical care, his medical condition is likely to remain untreated. The same is true if care is needed that is not included on the list of services provided to indigents.

Indigent people are not likely to benefit when hospitals delay the determination of eligibility until after the patient is admitted. Few people have the courage to get admitted knowing that they might be held responsible for large medical bills they cannot pay. Such procedures favor the medically indigent and those covered under various governmental programs. Much of the money for free service is apparently being used to write off costs not covered under the various state Medicaid plans. In many instances, "free service" apparently covers any additional costs. Uncollectible accounts are widely employed to write off free service. Some of the people benefitting from such procedures undoubtedly are indigent. But for the reasons discussed in the paragraphs above, it is far more likely that they are not.

With so much competition for the same few "uncompensated service" dollars, the people who have no way to pay for medical care are the ones most likely to be denied services. In spite of the intentions of the regulations, it seems that those who already have some resources--those ordinarily self-supporting people and those eligible for Medicare and Medicaid--who are benefitting most.

Why has there been little enforcement?

Lack of state agency staff, lack of adequate financial information on individual facilities, lack of effective complaint mechanisms, and lack of public access are among the reasons discussed in previous sections. The reason most often cited by staff in hospitals, state agencies, and HEW regional offices, however, is the desperate financial pressure felt by many facilities. In this light, the free service requirements are seen as a serious threat to the financial stability of many hospitals--particularly the small, rural ones which predominate throughout the South, and upon which the state agencies depend for political support. It is this consideration which is most often voiced as a higher justification for the failure to enforce the guidelines consistently and comprehensively.

The alarmingly low occupancy rates of many of the smaller facilities throughout the South is one indication that they are facing serious financial problems. Rapidly rising costs of supplies, lack of physicians and other medical manpower, lack of medical insurance and ineligibility for government health programs by many rural residents, competition by both proprietary facilities and the larger regional facilities--all place the small rural hospitals under a great deal of financial pressure.

With this background in mind, though, it seems highly unlikely that the survival of hospitals will be determined solely by a factor as small as the free service requirements. The problems involved are indeed large. None of them, however, will be solved by a strategy as simple as ignoring facilities' legal obligations for providing a "reasonable volume of service for those unable to pay." Furthermore, the regulations provide that hospitals such as those described above may be granted an exception to the presumptive guidelines. But the state agencies have excused wholesale abuses rather than make such determination on a case by case basis.

The number of facilities that cannot justifiably cite the above excuses of financial hardship warrants a systematic and thorough re-examination of the methods used to insure compliance with the regulations. For some poor people, especially those in larger cities, enforcement would provide medical care they cannot presently get. Enforcement of the regulations would also help stem abuses by voluntary non-profit facilities by which they send patients unable to pay to the public "charity hospitals."

The health needs of the nation's poor are not being met, although laws exist that, if enforced, would make a significant contribution toward meeting that goal. The federal government has a legal obligation to see that Hill-Burton regulations are enforced. It is time for the government and the state agencies to live up to that obligation.

METHODIST HOSPITALS
Central Unit-1265 Union Avenue Telephone (901) 276-3361 Memphis, Tennessee 38104
Methodist South/John R. Flippin Memorial Hospital-1300 Wesley Drive
Telephone (901) 332-9100 Memphis, Tennessee 38116

C. Henry Hottum
EXECUTIVE DIRECTOR

December 6, 1974

The Honorable Edward M. Kennedy
United States Senator
United States Senate
431 Russell Office Building
Washington, D. C. 20510

Dear Senator Kennedy:

Certain charges were made against the Methodist Hospitals of Memphis, Tennessee, by the Southern Governmental Monitoring Project of Atlanta, Georgia, on Monday, November 25, before your Health Subcommittee of the Senate Committee on Labor and Public Welfare.

This is explained in the enclosed documents. We have asked our Senator Bill Brock to have the Congressional Record corrected and we have apprised Mr. Allen Crimm of the inaccuracy of his report.

We also wanted you and your committee apprised.

Sincerely yours,

Henry Hottum

C. Henry Hottum,
Executive Director

CHH:bn
encl.

THE METHODIST HOSPITALS OF MEMPHIS
1265 Union Avenue
Memphis, Tennessee 38104

POSITION STATEMENT

On Monday, November 25, Allen Crimm of the Southern Governmental Monitoring Project of the Southern Regional Council in Atlanta, Georgia, presented testimony before the Health Subcommittee of the Senate Committee on Labor and Public Welfare. Certain charges contained therein about the Methodist Hospitals in Memphis, Tennessee, are untrue; and we would like to correct the records.

Around July 1, 1974, a young man by the name of James C. Camp, came to my office--unannounced and unidentified--and asked me if it were true that the Methodist Hospitals in Memphis, Tennessee, did not participate in the Medicaid Program. I stated that he was correct, but that we did render free service for the indigents and we frequently took patients that were Medicaid-eligible on our charity service under the care of the House Staff and forfeited filing a Medicaid claim. Our position was based on the fact that the Medicaid claim procedure is complex and costly. There is a limit of 20 days of coverage for any Medicaid-eligible patient in the State of Tennessee and there were insufficient appropriations in the programs in Tennessee to meet all the claims. We understood that the hospitals that did accept Medicaid frequently found themselves filing claims for which no funds were available.

Mr. Camp then asked what care was available to the Medicaid-eligible residents of Shelby County. I answered him that the majority of those patients went to the City of Memphis hospitals where governmental funds were provided for their care. Mr. Camp asked for financial information, at which time I asked him to identify himself and declare for whom he was gathering this information. I made a few estimates of some figures without referring to records to substantiate them. A few days later, he furnished me a letter requesting specific information (Exhibit I), and an identification of the firm for which he was working (Exhibit II). I replied on July 8, 1947 (Exhibit III). You will notice in that letter there was no reference to the disposition of residents of Shelby County.

On Saturday, November 23, a Memphis Press Scimitar reporter telephoned me and informed me that on Monday, November 25, testimony would be presented before the Subcommittee in Washington. I answered a few general questions, but gave her no specific figures. That afternoon, November 23, the Memphis Press Scimitar carried the story shown in Exhibit IV. I denied these charges locally, and a correctional story appeared in the press on November 26. (Exhibit V). I wrote Mr. Crimm on November 26, to protest the inaccuracy of his testimony (Exhibit VI.)

According to Government regulations, we were to select one of four options as to how much free service we would do. The option that we

selected was 10% of the amount of our Hill-Burton Grant received; or $105,699 per year. As the story substantiated, we are doing about 13 times as much as required of us and about one-half of the charity work that we do is for residents of Shelby County. If we were to consider Medicare and other contractural discounts, bad debts, etc., we would show that we are giving nearly $7,000,000 of free service per year. This is about 16% of our total patient income and we believe it is larger than the amount of free service given by most voluntary hospitals and it is a greater amount than required under new regulations.

We are church-owned and have been operating for over 50 years with a commitment of service, regardless of the patients' ability to pay.

We want the records corrected to reflect that we do render service to the indigents of Shelby County, Tennessee.

C. Henry Hottum, Executive Director

EXHIBIT I

James C. Camp
1239 Agnes PL. #5
Memphis, Tenn. 38104
July 5, 1974

Mr. C. Henry Hottum
Executive Director
Methodist Hospital
1265 Union Ave
Memphis, Tenn.

Dear Sir:

Please find enclosed a description of the project. I hope this will be adequate. We feel that the information we are seeking is not of a confidential nature, and I have had nothing but cooperation from other facilities in the area. If you need further assurances, please contact my director, Mr. Wayne Clark, in Atlanta, @ 404-522-8764. I appreciate your time and consideration, and look forward to completing this survey as soon as possible.

Thank you.

Sincerely,

James C. Camp

James C. Camp
Southern Governmental Monitoring
Project

EXHIBIT II

SOUTHERN GOVERNMENTAL MONITORING PROJECT

The Southern Governmental Monitoring Project is a special project of the Southern Regional Council. The Southern Regional Council, founded in 1944, is a research and information agency devoted to the attainment of equal opportunity for all peoples in the South.

The Southern Governmental Monitoring Project was established in 1973 by the Carnegie, Babcock, and Rockefeller Brothers foundations to investigate the effects of the "New Federalism" on minorities and the poor, and to assist community groups to understand and cope with government decentralization. For blacks and other minorities, and for those in poverty, New Federalism has serious implications: federal programs are being discontinued or reduced in funding, forcing states and localities to turn to federal revenue sharing funds or local monies if these programs are to be continued. The Southern Governmental Monitoring Project's purposes are to see how states, cities, and counties are responding and to help local groups understand and take advantage of these developments.

The Southern Governmental Monitoring Project has placed 50 interns in selected cities and towns in 11 southern states. During the 10 week period (mid-June to mid-August) interns will interview mayors, county officials, community leaders, and others to determine the effects of New Federalism on selected governmental activities in that area. They will aid community groups in their own investigations and, where possible, will assist groups in dealing with state and local governments. At the end of the summer the individual reports will be compiled and published.

Southern Governmental Monitoring Project
52 Fairlie Street, N. W.
Atlanta, Georgia 30303

EXHIBIT III

bcc: Mr. S. E. Chambers, Jr.

July 8, 1974

Mr. James C. Camp
Southern Governmental Monitoring Project
1239 Agnes Place #5
Memphis, Tennessee 38104

Office Address:
52 Fairlie Street, N. W.
Atlanta, Georgia 30303

Dear Mr. Camp.

As requested we are happy to furnish you with the following information. You will find the figures I gave you from memory are inaccurate; the following are the correct figures:

	1971	1972	1973
Operating Expenses:	$21,190,164	$23,823,752	$30,855,169

Hill-Burton Grants were as follows:

School of Nursing.	$ 950,000
Out-Patient Clinic:	106,987
Total	$ 1,056,987

Notice of Services to Persons Unable to Pay

Our first notice of services to persons unable to pay appeared in the Memphis Press-Scimitar on April 26, 1973. On May 8, 1973, we received a notice from the State of Tennessee, Department of Public Health, that were in presumptive compliance.

The second notice was in the Memphis Press-Scimitar on April 4, 1974. On April 11, 1974 we received a notice from the State of Tennessee, Department of Public Health we were in compliance with the Hill-Burton charity care regulations.

	1971	1972	1973
Amount of Charity rendered to indigent patients:	$1,083,457	$1,344,751	$1,367,494

Very truly yours,

Executive Director

EXHIBIT IV

MEMPHIS PRESS SCIMITAR
Saturday, November 23, 1974

'Not Meeting Free Service Obligation to Indigents'

Charges Against Methodist Hospital

By PEGGY BURCH
Press-Scimitar Staff Writer

Methodist Hospital in Memphis is included in charges made by a government monitoring project that many Southern hospitals receiving federal funds are not meeting their obligation to provide free medical service to indigent patients.

Allan Crimm, of the Southern Regional Council in Atlanta, has prepared a report on the council's investigation in 25 cities in 11 Southern states to be presented to the health subcommittee of the U.S. Senate Committee on Labor and Public Welfare.

Crimm's report states that "facilities throughout the South are still not meeting their legal obligation to provide free medical service."

Methodist Hospital received $1,056,988 under the Hill-Burton Medical Facilities Construction Act, according to the report, with an obligation to provide $105,699 in free service. Methodist applied for no Medicaid reimbursements for indigents, the report says.

C. Henry Hottum, executive director of Methodist, said today that the hospital does not apply for Medicaid funds because of "complexities in filing for the funds, and inadequate appropriations."

The report charges that Methodist limits its number of indigent patients by using geographical restrictions. Hottum is quoted as saying that indigent patients are not accepted from Shelby County because "they are the responsibility of the City of Memphis Hospital."

Hottum said the hospital "does not refuse indigent patients from Shelby County, but we put emphasis on out-of-county indigent patients because the City Hospital has government funds to treat Shelby County indigent patients."

Southern Regional Council, a non-profit organization established 30 years ago and based in Atlanta, began its monitoring project in 1973. Dr. Philip Caper, medical consultant to the Senate health subcommittee, invited the report by the monitoring project.

Crimm is expected to tell the subcommittee members Monday that project findings were:

- That some facilities use "loopholes" to avoid accounting for specific free service dollar amounts.
- That hospitals include "highly questionable expenses."
- That public notification of free service for indigent patients is inadequate.
- That patients eligible for free service are turned away because of "arbitrary" geographic or service limitations.
- That state agencies do not monitor the hospitals' records on indigent patients.
- That the Department of Health, Education and Welfare regional offices "condone this lack of effective evaluation and enforcement" by approving inadequate state plans.

Facilities receiving Hill-Burton funds are required to choose one of four options to calculate their free service obligation.

Hottum said although Methodist does not record services to Medicaid patients on the Medicaid forms, "our hospital exceeds its obligations in providing indigent patient care and we've not turned away any Medicaid patients."

EXHIBIT V

Methodist Rebuffs Charges on Indigents

By PEGGY BURCH
Press-Scimitar Staff Writer

Methodist Hospital officials today rebuffed charges that they do not treat their share of indigent patients, saying the hospital provides 13 times more free medical services than federal regulations require.

C. Henry Hottum Jr., executive director of Methodist, said the hospital is required only to provide $105,699 in free medical services in 1973 under stipulations of a federal grant, but the hospital actually provided $1,367,494 in free medical services.

Hottum said "If we would put in all our free services, they would exceed $5 million for the year 1973)."

A government monitoring project yesterday submitted a report to a U. S. Senate subcommittee charging that some Southern hospitals, including Methodist, do not provide all the free medical services they agree to provide when they receive federal grants.

Allan Crimm, health consultant to Southern Regional Council in Atlanta, reported to the health subcommittee of the U. S. Senate Committee on Labor and Public Welfare, that Methodist did not account for its free services by applying for federal reimbursement under the Medicaid program.

Harry C. Mobley, an administrator at Methodist, said the number of beds available at the hospital controls the amount of free service the hospital can render.

"We are always running about 99 per cent occupancy, and we review the charity work we've done on a monthly basis." he said.

Hottum said the hospital does not apply for Medicaid funds because the application system is too complex and the funds received for

Turn to Page 3—HOSPITAL

MEMPHIS PRESS SCIMITAR
Tuesday, November 26, 1974

Hospital Says Charges False

From Page 1

reimbursement "are inadequate."

"We have felt we were better off to forfeit the little money we would get from Medicaid, and continue with our present system," Hottum said.

The Southern Regional Council report also charged that the hospital did not treat indigent patients from Shelby County "because the administrator contends that indigents are supposed to use the county-operated hospital."

Hottum said Shelby County residents on Medicaid are not turned away from the hospital. "We have not broken down the dollar value of treatment for Shelby County patients, but 50 per cent of our charity patient days in 1973 were for Shelby County indigent patients," he said.

Hottum said free medical service to indigent patients at Methodist in 1974 will be 25 per cent more than the $1.3 million accounted for last year.

The Methodist officials said they had been reconsidering the hospital's decision not to apply for Medicaid funds prior to publications of Crimm's report.

"We are re-examining the Medicaid program constantly, but we keep coming back to our initial decision and reasoning not to apply," Mobley said.

EXHIBIT VI

METHODIST HOSPITALS
Central Unit-1265 Union Avenue Telephone (901) 726-7000 Memphis, Tennessee 38104
Methodist South/John R. Flippin Memorial Hospital-1300 Wesley Drive
Telephone (901) 332-9100 Memphis, Tennessee 38116

November 26, 1974

Mr. Allen Crimm
Southern Governmental Monitoring Project
52 Fairlie Street, N. W.
Atlanta, Georgia 30303

Dear Mr. Crimm:

We must contest your report to the Health Subcommittee of the Senate Committee on Labor and Public Welfare dated November 25, insofar as your statements concerning Methodist Hospitals of Memphis, Tennessee, in which you state:

> "A Memphis, Tennessee facility, for example, will not admit residents of the county in which it is located. The administrator contends that indigents are supposed to go to the county-operated hospital for the medical care they need."

This is not true. We rendered over $600,000 in free care for indigent residents of Shelby County in 1973.

In July, your agent James C. Camp came unannounced to my office. I saw him on his first visit and answered some of his questions, including our position on the Medicaid program. For several reasons, we had not participated in the Medicaid program; but I told him we did not deny admission to the patients eligible for Medicaid, who chose to come in under the care of our House Staff. He asked for some figures, which I cited from memory. I promised to complete answering his questions and to furnish more specific figures, if he would give me more information about the Southern Governmental Monitoring Project. My reply was dated July 8, 1974, a copy of which is attached.

As you can see by the letter, during the year of 1973, we gave $1,367,494 of free care to indigent patients. This is far in excess of the government's requirement of 10% of our Hill-Burton Grants, which were $1,056,987. (10% thereof is $105,699). We have given as much free care to the indigents during the first 9 months of 1974, as we did in the full year of 1973. The number of patient days of care to residents of Shelby County represents 50% of our total patient days to the indigent. Therefore, your statements about our not servicing the indigent in Shelby County are completely false. These figures are exclusive of Medicare discounts and bad debts.

When all of our free services are computed, we will give this year over $7,000,000 of free service. This represents a larger percentage of our total patient income than the amount given by most voluntary private hospitals.

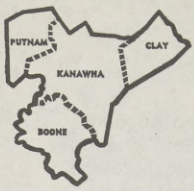
We expect you to correct the false information you are distributing regarding Methodist Hospitals of Memphis.

Sincerely yours,

C. Henry Hottum,
Executive Director

CHH:bn

cc: U. S. Senator Howard Baker, Washington, D. C.
cc: U. S. Senator Bill Brock, Washington, D. C.



HEALTH PLANNING COUNCIL, INC.

FOR REGION 3

1120 KANAWHA VALLEY BUILDING, CHARLESTON, WEST VIRGINIA 25301
Area Code 304-346-0656

Planning to Meet Community Health Needs for:
Boone, Clay, Kanawha, and Putnam Counties

November 27, 1974

Dr. Philip Caper
4228 Dirkson Office Building
Washington, D. C. 20501

Re: Hearings of Subcommittee on Health of the Committee on Labor and Public Welfare; November 25, 1974; regarding the National Health Policy Planning and Resource Development Act of 1974, S-2994.

Dear Dr. Caper,

I regret that I was not apprised of the above hearings until the very day they were held, as I would have preferred that you receive the material I am sending prior to the hearings. Nevertheless, I wish to comment on one aspect of the hearings in which I understand Ms. Marilyn Rose was involved, specifically the failure of both HEW and many of the State Hill Burton Agencies to comply with federal regulations pertaining to the provision of free and below cost care in hospitals receiving Hill Burton funds.

Enclosed you will find some material which shows the apparent disinterest on the part of HEW and the West Virginia State Hill Burton Agency in performing their legal obligations as to establishing and enforcing standards for determining who is unable to pay for health care. I do not know if the actions of the West Virginia State Hill Burton Agency and HEW are typical of other States on this issue, but I feel that this information may be helpful to you in assessing compliance with Section 53:111 of the Federal Regulations (Part 53, Chapter I, Title VI of the Public Health Service Act [42 USC 219 et seq.]) in this state.

Exhibit 1 is the appendix H, (Methods of Administration Services for People Unable to Pay) to the West Virginia State Plan developed in 1974. I believe my letter to the West Virginia Hospital Association (Exhibit 2) dated July 22, 1974, details the manner in which the 1974 Appendix H fails to comply with the regulations as aforementioned. I think it is interesting that almost two years after the regulations became effective, this State Hill Burton Agency had not yet developed criteria for identifying persons unable to pay for services.

Exhibit 3 is the response which I received from HEW, dated August 7, 1974, after HEW received a copy of my letter to the West Virginia Hospital Association, (Exhibit 2). As this letter from HEW indicated that the State Hill Burton Agency had developed a revised Appendix, we obtained the revised Appendix, labeled Exhibit 4. Exhibit 5 is a letter dated August 12, 1974, which I wrote to HEW after receiving the revised Appendix H which also did not conform with the federal regulations. I believe Exhibit 5, my letter, details the problems with the new Appendix H. Exhibit 6 is the letter I wrote to HEW in attempt to receive a reply to my letter of August 12, 1974. I have not to this day received any reply from HEW. To the best of our knowledge, HEW has approved the revised Appendix, Exhibit 4, despite its complete inadequacy.

Twenty-two and two tenths percent (22.2%) of the population in West Virginia are below the poverty level. Twenty-three and one tenth percent (23.1%) of this regions' population are below the poverty level. You will see if you look at the chart at the end of Exhibit 4 that Medicaid in this state does not cover all those below the poverty level. Just one example of this is that Supplemental Security Income is available for those eligible who receive income in excess of the figures shown on the Medicaid chart. It is apparent to me that a number of persons in this state who are not only medically indigent but simply indigent may be suffering unnecessarily as a result of the failure of the State Hill Burton Agency to draft an appendix which complys with the law and the failure of HEW to insist that they do so.

I understand that you want suggestions as to how to ensure that HEW will perform its obligations in this matter. I wish the matter would receive far more publicity nationwide than it has to date. A more concrete suggestion is that HEW regulations should be amended to provide for citizens suits against the facilities, the Hill Burton Agencies, and HEW if any part of the state plan pertaining to free care is not in compliance by a date to be set for all states according to a compliance schedule. It should be required that all parts of the State Plans pertaining to free care be published in the Federal Register, with periods for comment.

Finally I would add that I hope hospitals will comply with new rules to be published in the Federal Register mandating posting of their obligations under the free and below cost care requirement, but without publicity

and enforcement, I am again hesitant to expect compliance, at least in this state.

I hope this letter and the enclosed material will be helpful to you.

Yours sincerely,

D. L. Rodecker

Deborah Lewis Rodecker
Health Law Advisor

Enclosure

DLR/dlj

EXHIBIT 1

W. Va. [illegible]

West Virginia State Department of Health
Charleston, West Virginia 25305
N. H. Dyer, M. D., M. P. H., State Director of Health

Appendix H: Methods of Administration

Services for People Unable to Pay

Procedures for governing the provision of services for persons unable to pay, pursuant to Section 53.111 of the Federal Regulations' (Part 53, Chapter I, Title VI of the Public Health Service Act [42 USC 219 et seq.]), which were printed in the FEDERAL REGISTER (Vol. 37, No. 142, July 22, 1972), became effective for each Facility when its new fiscal year begins after November 4, 1972.

1. PURPOSE

It has been alleged and proven in recent court actions throughout the country that some medical facilities which have received Federal financial assistance in construction were rejecting nonpaying patients contrary to Federal laws and the conditions to which the medical facilities agreed in accepting Federal financial assistance. The Regulations require State Agencies to insure the providing of uncompensated services by establishing levels of uncompensated services on a facility-by-facility basis, taking into consideration the budgets and finances of the facilities, the types of services provided, the need within the area for uncompensated services, and the extent of uncompensated services jointly provided with other facilities in the area.

2. DEFINITIONS

a. FACILITY - Hospitals, long-term care facilities, outpatient facilities, rehabilitation facilities and public health centers which have received or will receive Federal financial assistance under the Federal Act.

b. FISCAL YEAR - The fiscal year of the facility.

c. OPERATING COSTS - The actual operating costs (less Medicare and Medicaid actual and estimated reimbursements) of the facility for a fiscal year as determined in accordance with cost determination principles and requirements under Title XVIII of the Social Security Act. These costs shall be determined for the entire facility and for all patients regardless of source of payment for care received.

d. REASONABLE COST - The cost of providing services to a specific patient determined in accordance with cost determination principles and requirements under Title XVIII of the Social Security Act.

e. UNCOMPENSATED SERVICES - Services which are made available to persons unable to pay therefor without charge or at a charge which is less than the reasonable cost of such services. The level of such services is measured by the difference between the amount charged such persons for such services and the reasonable cost thereof.

f. REASONABLE VOLUME OF SERVICES FOR PERSONS UNABLE TO PAY THEREFOR - A level of uncompensated services which meets a need for such services in the area served by a facility and which is within the financial ability of such facility to provide.

g. STATE AGENCY - The West Virginia State Department of Health, which is the sole agency designated to administer Title VI of the Public Health Service Act in West Virginia.

3. APPLICABILITY

The provisions of the Regulations are applicable to each facility which has received, or will receive, Federal financial assistance under the Federal Act. Time periods during which facilities are committed to provide uncompensated services are:

a. In cases of Federal grants, commitment period is for twenty (20) years after Project completion.

b. In cases of Federal loans or loan guarantees, commitment period is for the life of the loan, which is generally a maximum of twenty-five (25) years.

4. PRESUMPTIVE COMPLIANCE GUIDELINES FOR REASONABLE VOLUME OF SERVICES TO BE PROVIDED

a. A facility is required (unless the requirement is waived under procedures outlined in Section 8 that follows) to provide during each fiscal year a reasonable volume of services under one of the following Options:

(1) Certifies in writing to the State Agency that for the current fiscal year it will not exclude any person from admission on the ground that such person is unable to pay for needed services, and that it will make available for each person so admitted services provided by the facility without charge or at a charge below reasonable cost which does not exceed any such person's ability to pay therefor, as determined in accordance with eligibility criteria in Section 10 that follows.

(2) Budgets for the support of and makes available for the current fiscal year upon request, uncompensated services at a level not less than, the lesser of:

(a) The sum of the Operating Costs (less Medicare and Medicaid reimbursements) times three (3) percent, or

(b) Ten (10) percent of all Federal financial assistance provided to or on behalf of the facility on completed Projects under the Federal Act.

b. A facility unable to meet one of these Options may submit to the State Agency a detailed account of the extent of uncompensated services it is currently providing and proposes to provide. In such cases the State Agency will establish, under procedures outlined in Section 9 that follows, a level of uncompensated services to be provided by the facility.

5. COMPLIANCE REPORTS BY FACILITY

Not later than 120 days following the end of EACH fiscal year, each facility shall file with the State Agency the following documents:

a. A STATEMENT ELECTING ONE OF THE OPTIONS DESCRIBED IN SECTION 4 OF THESE RULES.

b. A COPY OF ITS ANNUAL FINANCIAL STATEMENT INDICATING THE AMOUNT OF UNCOMPENSATED SERVICES PROVIDED DURING THE YEAR. If the level of services provided was less than the compliance guidelines or a level established by the State Agency, the facility must justify the lesser level of services provided and clearly describe a positive action plan to assure the availability and utilization of the level of uncompensated services to be established for the current year. The positive action plan shall utilize press releases or other means as deemed appropriate by the facility to bring to the attention of the public the availability of and eligibility conditions for the specified level of uncompensated services.

c. A COPY OF THAT PORTION OF THE ADOPTED BUDGET OF THE FACILITY FOR THE CURRENT FISCAL YEAR INDICATING THE LEVEL OF UNCOMPENSATED SERVICES WHICH HAS BEEN BUDGETED. Such portion of the budget for uncompensated services shall be based on the operating costs of the facility for the preceding fiscal year with due consideration being given to probable increases in operating costs. If the budgeted level of uncompensated services does not conform to the presumptive compliance guidelines, the facility shall justify its proposal to provide a lesser level of uncompensated services and the State Agency will establish, under procedures outlined in Section 9 that follows, a level of uncompensated services to be provided.

d. SUCH ADDITIONAL REPORTS related to compliance with the assurances of the facility to provide uncompensated services as the State Agency may reasonably require.

e. Pending the establishment of a level of uncompensated services for any fiscal year pursuant to Section 9 that follows, the facility shall in such fiscal year provide a level of services which is the higher of:

(1) The level established for the preceding year (of if no level has been eatablished for such prior year, the level of services provided in such year), or

(2) The level proposed in its adopted budget for the current fiscal year.

6. QUALIFYING SERVICE

A facility in determining the amount of uncompensated services provided, shall:

a. INCLUDE ONLY THOSE SERVICES PROVIDED TO AN INDIVIDUAL WITH RESPECT TO THE FACILITY WHICH HAS MADE A WRITTEN DETERMINATION, PRIOR TO ANY COLLECTION EFFORT OTHER THAN RENDITION OF BILLS, THAT SUCH INDIVIDUAL IS UNABLE TO PAY THEREFOR (under the criteria stated in Section 10 that follows, except that such collection efforts may be made against a third party insurer or a governmental program. Bad debts, per se, shall not be included.

b. Exclude any amount:

(1) Received, or entitled to be received from a third party insurer or under a governmental program.

(2) That is the reasonable cost of any services for which payment in whole or in part would be available under a governmental program (e.g. Medicare and Medicaid) in which the facility, although eligible to do so, does not participate, but only to the extent of such otherwise available payment.

7. DUTIES OF THE STATE AGENCY

In administering this Program, the State Agency will:

a. Advise facilities, or any person making request, on criteria for identifying persons unable to pay, as set forth in Section 10 that follows.

b. Annually perform evaluations of the amount of the various services provided in each facility to determine whether the assurances submitted by the facility, pursuant to the foregoing Sections 4 and 5, are in compliance. Evaluations of each facility for uncompensated services and financial statements of such facilities filed pursuant to Section 646 of the Federal Act, to show the financial operations of the facility, the costs to the facility of providing health services in the facility and the charges made by the facility for providing such services during the fiscal year. Within sixty (60) days after receipt of these

(1) Accept the proposed plan submitted by the facility, or

(2) Establish, for the facility, a level of uncompensated services to be provided under procedures outlined in Section 9 that follows.

(3) Notify the facility in writing of the level of uncompensated services, which the State Agency has established for the facility for the current fiscal year in accordance with Paragraphs 7b(1) or (2) above. At the time of notifying the facility, the State Agency will also publish as a PUBLIC NOTICE in a newspaper of general circulation within the community served by the facility THE RATE THAT HAS BEEN ESTABLISHED for the facility for the current fiscal year.

c. Establish procedures for the investigation of complaints charging a facility with failure to provide a reasonable volume of uncompensated service.

d. Provide adequate methods of enforcement of the assurance, including effective sanctions to be applied against any facility which fails to provide a reasonable volume of uncompensated services. Such sanctions may include, but are not limited to, license revocation, termination of State assistance, and court action.

e. Annually, report in writing to the Secretary, its evaluation of each facility's compliance with the assurance, the disposition of each complaint received by the State Agency, proposed remedial action with respect to each facility found by the State Agency to be not in compliance with the assurance and the status of such remedial action.

f. Promptly report the institution of any legal action against a facility or the State Agency involving compliance with the assurance to the Regional Attorney and the Regional Health Director of the Department of Health, Education and Welfare.

8. WAIVER PROCEDURES

Any facility which feels that its financial condition will not permit the providing of a reasonable volume of uncompensated services may request a waiver from the requirement to provide such services. Procedures for requesting and obtaining a waiver are, in order:

a. The facility shall submit to the State Agency a request for waiver. Such request shall fully document the financial position of the facility and the reasons why a reasonable volume of uncompensated services cannot be provided.

b. The State Agency will publish in a newspaper of general circulation in the area served by the facility a notice of the request for waiver and invite public comment thereon within thirty (30) days of the date of the notice. All comments received will be available for public inspection, at the State Agency.

c. The State Agency will duly consider the request and comments received from the public in arriving at a decision. Notice of the decision on the request for waiver will be given to all interested persons and to the public.

d. The State Agency will then submit the request and all pertinent documents to the Secretary of Health, Education and Welfare for approval of the determination.

9. PROCEDURES FOR THE STATE AGENCY TO ESTABLISH A LEVEL OF UNCOMPENSATED SERVICES

In the event it becomes necessary for the State Agency to establish a level of uncompensated services to be provided by a facility, the following procedures will apply, in order:

a. Within sixty (60) days after receipt, the State Agency will review and evaluate the annual financial statement, budget, and related documents submitted by the facility pursuant to the foregoing Section 5 and establish a level of uncompensated services, equal to or less than the presumptive compliance guidelines, to be provided by the facility. The level of uncompensated services will be determined by applying the following criteria:

(1) The financial status of the facility, taking account of income from all sources, and its financial ability to provide uncompensated services.

(2) The nature and quantity of services provided by the facility.

(3) The need within the area served by the facility for the provision, without charge or at a charge less than reasonable cost, for services of the nature provided or to be provided by the facility.

(4) The extent and nature of joint or cooperative programs with other facilities providing for uncompensated services and the extent and nature of outreach services directed to the needs of under-served areas.

b. Upon reaching a decision, the State Agency will notify the facility, in writing, of the level of uncompensated services which it has established for the facility for the fiscal year. Concurrently, the State Agency will publish in a newspaper of general circulation in the area served by the facility a Public Notice of the rate that has been established, a statement that the documents upon which the State Agency based its determination are available for public inspection at a location and time prescribed and that persons wishing to object to the rate can do so by writing to the State Agency within twenty (20) days after publication of the notice.

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c. The State Agency will give Public Notice of the receipt of objections rendered by the public and will make the objections and their supporting documents available for public inspection and comment. If it deems the action necessary, the State Agency may set a public hearing on the objections and will give notice of such hearing to all interested parties and to the public.

d. The State Agency will, within sixty (60) days of the expiration of the period within which objections may be filed, rule upon the objections in writing, stating its reason for accepting or overruling them, in whole or part, and establish a final level of uncompensated care to be provided. Notice of the final determination will be mailed to the facility and to all persons who filed objections or who participated in the proceedings leading to the redetermination.

e. Within twenty (20) days of receipt of the written notice of this final determination, the facility or any other interested person or organization may submit to the Secretary of Health, Education and Welfare a written request for review of the final determination of the State Agency.

f. On review, the Secretary may sustain or reject the determination of the State Agency. In case of the latter, the Secretary will establish a level of uncompensated services which he determines appropriate.

g. The level of uncompensated services established for the facility under this Section for any fiscal year shall constitute a reasonable volume of services for persons unable to pay therefor with respect to such facility for such fiscal year.

10. ELIGIBILITY CRITERIA

a. Once a level of uncompensated services to be provided by a facility has been established, it is thereafter the responsibility of the facility administrator to determine HOW, WHEN, and TO WHOM these services will be provided. There are no standards or guidelines which positively identify a person or family as eligible to receive full or partial uncompensated services. Each case must be evaluated on its own merits, as there are numerous persons and families who are otherwise self-supporting but unable to pay the full charge for needed services.

b. The decision on each application for uncompensated services should be based on the following or similar factors:

(1) The health and medical care insurance coverage, personal or family income, size of the patient's family, and other financial obligations and resources of the patient or the family in relation to the reasonable cost of the services.

(2) Generally recognized standards of need such as:

(a) The latest median income statistics per county as obtained from census tracts. (See attached)

(b) Eligibility requirements for the medically needy as obtained from the West Virginia Department of Welfare, "Medical Eligibility Manual." (See sttached)

(3) Any other equivalent measures which are found by the Secretary of Health, Education and Welfare to provide a reasonable basis for determining an individual's ability to pay for needed medical services.

c. It shall be the responsibility of the facility administrator to establish and maintain procedures under which applications for uncompensated services are received, evaluated and approved or denied. A copy of all completed applications (approved or denied) shall be maintained by each facility and available for review by the State Agency upon request. The facility shall provide a copy of the criteria it uses for identifying persons unable to pay, upon request, to any patient or former patient of the facility and to any person seeking services from the facility.

West Virginia Counties 1970 Median Income
Alphabetical Listing

Rank	County	1970 Median Income	Percentile
7	Barbour	$3,749	20th
46	Berkeley	$6,740	90th
28	Boone	$5,164	60th
5	Braxton	$3,560	10th
54	Brooke	$8,379	100th
39	Cabell	$6,095	80th
6	Calhoun	$3,602	20th
4	Clay	$3,488	10th
13	Doddridge	$4,079	30th
20	Fayette	$4,431	40th
1	Gilmer	$2,166	10th
21	Grant	$4,519	40th
27	Greenbrier	$5,035	50th
29	Hampshire	$5,363	60th
55	Hancock	$9,417	100th
15	Hardy	$4,294	30th
44	Harrison	$6,270	80th
49	Jackson	$7,264	90th
36	Jefferson	$5,958	70th
50	Kanawha	$7,382	100th
24	Lewis	$4,714	50th
10	Lincoln	$3,857	20th
35	Logan	$5,917	70th
26	McDowell	$4,857	50th
41	Marion	$6,156	80th
51	Marshall	$7,518	100th
37	Mason	$6,020	70th
32	Mercer	$5,518	60th
43	Mineral	$6,242	80th
12	Mingo	$3,995	30th
8	Monongalia	$3,836	20th
23	Monroe	$4,592	50th
38	Morgan	$6,020	70th
33	Nicholas	$5,626	60th
42	Ohio	$6,162	80th
11	Pendleton	$3,910	20th
48	Pleasants	$7,189	90th
14	Pocahontas	$4,293	30th
25	Preston	$4,838	50th
52	Putnam	$7,539	100th
30	Raleigh	$5,374	60th
16	Randolph	$4,339	30th
22	Ritchie	$4,560	40th
18	Roane	$4,354	40th

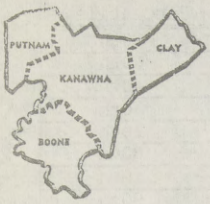
West Virginia Counties 1970 Median Income
Alphabetical Listing

Rank	County	1970 Median Income	Percentile
9	Summers	$3,839	20th
31	Taylor	$5,432	60th
17	Tucker	$4,339	40th
34	Tyler	$5,786	70th
3	Upshur	$3,422	10th
40	Wayne	$6,129	80th
2	Webster	$3,392	10th
47	Wetzel	$6,756	90th
19	Wirt	$4,420	40th
53	Wood	$7,610	100th
45	Wyoming	$6,632	90th

EXHIBIT 2

HEALTH PLANNING COUNCIL, INC.

FOR REGION 3



1120 KANAWHA VALLEY BUILDING, CHARLESTON, WEST VIRGINIA 25301
Area Code 304-346-0656

Planning to Meet Community Health Needs for:
Boone, Clay, Kanawha, and Putnam Counties

July 22, 1974

Mr. Harold Spangler
West Virginia Hospital Association
1219 Virginia Street, East
Charleston, West Virginia 25301

Dear Mr. Spangler:

In accordance with our discussion of recent date, I am writing to point out portions of the West Virginia State Department of Health State Plan, Appendix H, Methods of Administration Services for People Unable to Pay, which in my judgment do not comply with the law.

1. The Federal Regulations clearly state at 53.111(g) (Part 53, Chapter I, Title VI of the Public Health Service Act (42 USC 219 et seq. 1) printed in the Federal Register (vol. 37, no. 142, July 22, 1972):

> "(1) The State Agency shall set forth in its State plan, subject to approval by the Secretary, criteria for identifying persons unable to pay for services, which shall include persons who are otherwise self-supporting but unable to pay the full charge for needed services. Such criteria shall be based on the following or similar factors:
>
> "(i) The health and medical care insurance coverage, personal or family income, the size of the patient's family, and other financial obligations and resources of the patient or the family in relation to the reasonable cost of the services;
>
> "(ii) Generally recognized standards of need such as (a) the State standards for the medically needy as determined for the purposes of the Aid for Families with Dependent Children Program; (b) the current Social Security Administration poverty income level; (c) the current office of Economic Opportunity Income Poverty Guidelines applicable in the area; or

"(iii) Any other equivalent measures which are found by the Secretary to provide a reasonable basis for determining an individual's ability to pay for medical and hospital services."

Pursuant to this mandate, the West Virginia State Department of Health has provided in its State plan, Appendix H, at 10. Eligibility Criteria, the following:

"a. Once a level of uncompensated services to be provided by a facility has been established, it is thereafter the responsibility of the facility administrator to determine HOW, WHEN, and TO WHOM these services will be provided. There are no standards or guidelines which positively identify a person or family as eligible to receive full or partial uncompensated services. Each case must be evaluated on its own merits, as there are numerous persons and families who are otherwise self-supporting but unable to pay the full charge for needed services.

"b. The decision on each application for uncompensated services should be based on the following or similar factors:

(1) The health and medical care insurance coverage, personal or family income, size of the patient's family, and other financial obligations and resources of the patient or the family in relation to the reasonable cost of the services.

(2) Generally recognized standards of need such as:

(a) The latest median income statistic per county as obtained from census facts.

(b) Eligibility requirements for the medically needy as obtained from the West Virginia Department of Welfare, 'Medical Eligibility Manual.'

(3) Any other equivalent measures which are found by the Secretary of Health, Education and Welfare to provide a reasonable basis for determining an individual's ability to pay for needed medical sources.

"c. It shall be the responsibility of the facility administrator to establish and maintain procedures under which application for uncompensated services are received, evaluated, and approved or denied. A copy of all completed applications (approved or denied) shall be maintained by each facility and available for review by the State Agency upon request. The facility shall provide a copy of the criteria it uses for identifying persons unable to pay, upon request, to any patient or former patient of the facility and to any person seeking services from the facility."

It should be readily apparent that the State Department of Health has not set forth in its plan any criteria for identifying persons unable to pay for services. The plan instead delegates to the facility administrator the responsibility to determine how, when and to whom the services will be provided. Rather than setting a standard based on the factors outlined in the regulations, the plan simply states that there are no standards or guidelines which positively identify a person or family as eligible to receive full or partial uncompensated services. The regulations, however, clearly state that the State Agency must set forth standards in its state plan. This has not been done. It has always been my understanding that the purpose of stipulating in the regulations that the State Agency must establish criteria was to take away from facility administrators the discretion to decide on an individual basis who could and could not pay for service. In my judgment, to give such discretion to the facility administrators unlawfully delegates the authority to establish the criteria.

Secondly, the latest median income statistics per county (enclosed), as obtained from census facts, are presented in the plan as indicative of a "generally recognized standard of need." Not only are median income statistics per county not generally recognized standards of need as outlined in the regulations at (g)(1)(ii), but it is difficult to imagine the Secretary of HEW

finding that such statistics are "equivalent measures" for determining an individual's ability to pay for medical and hospital services. [53.111(g)(1)(iii)].

I fail to see how this list meaningfully assists a facility administrator in determining whether or not an individual has the ability to pay. Does an individual living in Clay County who has an income of $4,000 per year have the ability to pay for service because his income is above the Clay County median of $3,488, while an individual who has an income of $7,000 who lives in Putnam doesn't have the ability to pay for service because his income is below the Putnam County median of $7,539?

2. The regulations provide at 53.111(i)(3) that "The State plan shall provide for adequate methods of enforcement of the assurance, including effective sanctions to be applied against any facility which fails to comply with such assurance. Such sanctions may include, but need not be limited to, license revocation, termination of State assistance, and court action."

The West Virginia plan contains no such methods for enforcement. The plan, at 7.d., Duties of the State Agency, merely recites the regulations on this point. But clearly the plan itself must indicate what methods of enforcement have been established. If there is no indication in the plan that the State Agency has established certain enforcement methods, what incentive is there for a hospital to comply with (in this case nonexistent) standards?

3. Finally, I disagree with the wording of the West Virginia State Department of Health Plan in 9. Procedures for the State Agency to Establish a Level of Uncompensated Services. The plan states, "In the event it becomes necessary for the State Agency to establish a level of uncompensated services to be provided by a facility..." It is necessary every fiscal year for the State Agency to establish such a level. [See 53.111(h)]. The State Agency must do so for each facility receiving Hill-Burton (and ARC) funds. This State plan applies to those facilities. In my opinion, therefore, the use of the words "in the event it becomes necessary" is misleading.

In summary, I do not know whether the Secretary of HEW has approved this plan nor do I know whether and/or when the

State Agency has published in the newspaper the rates established for each facility, as required by law. In any event, for the protection of the State Agency, the hospitals involved, and the patients who may be affected by the inadequate State plan provisions, I suggest that the State plan be carefully reevaluated and rewritten to comply with the law.

Yours sincerely,

D. L. Rodecker

Deborah Lewis Rodecker
Health Law Advisor

DLR:npg

Enclosures 2

cc: Mr. Luther Burgess
West Virginia State Dept. of Health

Mr. John P. Morrison
Acting Regional Program Director, HEW

EXHIBIT 3

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
REGION III
3535 MARKET STREET
PHILADELPHIA, PENNSYLVANIA 19101

PUBLIC HEALTH SERVICE

MAILING ADDRESS:
P.O. BOX 13716
PHILADELPHIA,
PENNSYLVANIA 19101

August 7, 1974

Ms. Deborah L. Rodecker
Health Planning Council, Inc.
for Region III
1120 Kanawha Valley Building
Charleston, West Virginia 25301

Dear Ms. Rodecker:

Thank you for sharing with this office a copy of your letter of July 22, 1974 to Mr. Spangler of the West Virginia Hospital Association.

It seems that the material to which you responded was the same original draft submission commented on earlier by this office. Our comments on that draft were very similiar to those made by you in your letter. The State agency has made changes to the original submission and we suggest that you contact them requesting the new revision.

Sincerely yours,

Eulas C. Bartel
for John P. Morrison
Chief, Health Facilities Branch
Health Resources Development Division

EXHIBIT 4

West Virginia State Department of Health
Charleston, West Virginia 25305
N. H. Dyer, M. D., M. P. H., State Director of Health

Appendix H: Methods of Administration

Services for People Unable to Pay

Procedures for governing the provision of services for persons unable to pay, pursuant to Section 53.111 of the Federal Regulations (Part 53, Chapter I, Title VI of the Public Health Service Act [42 USC 219 et seq.]), which were printed in the FEDERAL REGISTER (Vol. 37, No. 142, July 22, 1972), became effective for each Facility when its new fiscal year begins after November 4, 1972.

1. PURPOSE

It has been alleged and proven in recent court actions throughout the country that some medical facilities which have received Federal financial assistance in construction were rejecting nonpaying patients contrary to Federal laws and the conditions to which the medical facilities agreed in accepting Federal financial assistance. The Regulations require State Agencies to insure the providing of uncompensated services by establishing levels of uncompensated services on a facility-by-facility basis, taking into consideration the budgets and finances of the facilities, the types of services provided, the need within the area for uncompensated services, and the extent of uncompensated services jointly provided with other facilities in the area.

2. DEFINITIONS

a. FACILITY - Hospitals, long-term care facilities, outpatient facilities, rehabilitation facilities and public health centers which have received or will receive Federal financial assistance under the Federal Act.

b. FISCAL YEAR - The fiscal year of the facility.

c. OPERATING COSTS - The actual operating costs (less Medicare and Medicaid actual and estimated reimbursements) of the facility for a fiscal year as determined in accordance with cost determination principles and requirements under Title XVIII of the Social Security Act. These costs shall be determined for the entire facility and for all patients regardless of source of payment for care received.

d. REASONABLE COST - The cost of providing services to a specific patient determined in accordance with cost determination principles and requirements under Title XVIII of the Social Security Act.

e. UNCOMPENSATED SERVICES - Services which are made available to persons unable to pay therefor without charge or at a charge which is less than the reasonable cost of such services. The level of such services is measured by the difference between the amount charged such persons for such services and the reasonable cost thereof.

f. REASONABLE VOLUME OF SERVICES FOR PERSONS UNABLE TO PAY THEREFOR - A level of uncompensated services which meets a need for such services in the area served by a facility and which is within the financial ability of such facility to provide.

g. STATE AGENCY - The West Virginia State Department of Health, which is the sole agency designated to administer Title VI of the Public Health Service Act in West Virginia.

3. APPLICABILITY

The provisions of the Regulations are applicable to each facility which has received, or will receive, Federal financial assistance under the Federal Act. Time periods during which facilities are committed to provide uncompensated services are:

a. In cases of Federal grants, commitment period is for twenty (20) years after Project completion.

b. In cases of Federal loans or loan guarantees, commitment period is for the life of the loan, which is generally a maximum of twenty-five (25) years.

4. PRESUMPTIVE COMPLIANCE GUIDELINES FOR REASONABLE VOLUME OF SERVICES TO BE PROVIDED

a. A facility is required (unless the requirement is waived under procedures outlined in Section 8 that follows) to provide during each fiscal year a reasonable volume of services under one of the following Options:

(1) Certifies in writing to the State Agency that for the current fiscal year it will not exclude any person from admission on the ground that such person is unable to pay for needed services, and that it will make available for each person so admitted services provided by the facility without charge or at a charge below reasonable cost which does not exceed any such person's ability to pay therefor, as determined in accordance with eligibility criteria in Section 10 that follows.

(2) Budgets for the support of and makes available for the current fiscal year upon request, uncompensated services at a level not less than, the lesser of:

(a) The sum of the Operating Costs (less Medicare and Medicaid reimbursements) times three (3) percent, or

(b) Ten (10) percent of all Federal financial assistance provided to or on behalf of the facility on completed Projects under the Federal Act.

b. A facility unable to meet one of these Options may submit to the State Agency a detailed account of the extent of uncompensated services it is currently providing and proposes to provide. In such cases the State Agency will establish, under procedures outlined in Section 9 that follows, a level of uncompensated services to be provided by the facility.

5. COMPLIANCE REPORTS BY FACILITY

Not later than 120 days following the end of EACH fiscal year, each facility shall file with the State Agency the following documents:

a. A STATEMENT ELECTING ONE OF THE OPTIONS DESCRIBED IN SECTION 4 OF THESE RULES.

b. A COPY OF ITS ANNUAL FINANCIAL STATEMENT INDICATING THE AMOUNT OF UNCOMPENSATED SERVICES PROVIDED DURING THE YEAR. If the level of services provided was less than the compliance guidelines or a level established by the State Agency, the facility must justify the lesser level of services provided and clearly describe a positive action plan to assure the availability and utilization of the level of uncompensated services to be established for the current year. The positive action plan shall utilize press releases or other means as deemed appropriate by the facility to bring to the attention of the public the availability of and eligibility conditions for the specified level of uncompensated services.

c. A COPY OF THAT PORTION OF THE ADOPTED BUDGET OF THE FACILITY FOR THE CURRENT FISCAL YEAR INDICATING THE LEVEL OF UNCOMPENSATED SERVICES WHICH HAS BEEN BUDGETED. Such portion of the budget for uncompensated services shall be based on the operating costs of the facility for the preceding fiscal year with due consideration being given to probable increases in operating costs. If the budgeted level of uncompensated services does not conform to the presumptive compliance guidelines, the facility shall justify its proposal to provide a lesser level of uncompensated services and the State Agency will establish, under procedures outlined in Section 9 that follows, a level of uncompensated services to be provided.

d. SUCH ADDITIONAL REPORTS related to compliance with the assurances of the facility to provide uncompensated services as the State Agency may reasonably require.

e. Pending the establishment of a level of uncompensated services for any fiscal year pursuant to Section 9 that follows, the facility shall in such fiscal year provide a level of services which is the higher of:

(1) The level established for the preceding year (of if no level has been eatablished for such prior year, the level of services provided in such year), or

(2) The level proposed in its adopted budget for the current fiscal year.

6. QUALIFYING SERVICE

A facility in determining the amount of uncompensated services provided, shall:

a. INCLUDE ONLY THOSE SERVICES PROVIDED TO AN INDIVIDUAL WITH RESPECT TO THE FACILITY WHICH HAS MADE A WRITTEN DETERMINATION, PRIOR TO ANY COLLECTION EFFORT OTHER THAN RENDITION OF BILLS, THAT SUCH INDIVIDUAL IS UNABLE TO PAY THEREFOR (under the criteria stated in Section 10 that follows, except that such collection efforts may be made against a third party insurer or a governmental program. Bad debts, per se, shall not be included.

b. Exclude any amount:

(1) Received, or entitled to be received from a third party insurer or under a governmental program.

(2) That is the reasonable cost of any services for which payment in whole or in part would be available under a governmental program (e.g. Medicare and Medicaid) in which the facility, although eligible to do so, does not participate, but only to the extent of such otherwise available payment.

7. DUTIES OF THE STATE AGENCY

In administering this Program, the State Agency will:

a. Advise facilities, or any person making request, on criteria for identifying persons unable to pay, as set forth in Section 10 that follows.

b. Annually perform evaluations of the amount of the various services provided in each facility to determine whether the assurances submitted by the facility, pursuant to the foregoing Sections 4 and 5, are in compliance. Evaluations of each facility for uncompensated services and financial statements of such facilities filed pursuant to Section 646 of the Federal Act, to show the financial operations of the facility, the costs to the facility of providing health services in the facility and the charges made by the facility for providing such services during the fiscal year. Within sixty (60) days after receipt of these documents, the State Agency will:

(1) Accept the proposed plan submitted by the facility, or

(2) Establish, for the facility, a level of uncompensated services to be provided under procedures outlined in Section 9 that follows.

(3) Notify the facility in writing of the level of uncompensated services, which the State Agency has established for the facility for the current fiscal year in accordance with Paragraphs 7b(1) or (2) above. At the time of notifying the facility, the State Agency will also publish as a PUBLIC NOTICE in a newspaper of general circulation within the community served by the facility THE RATE THAT HAS BEEN ESTABLISHED for the facility for the current fiscal year.

c. Complaints and Investigation: Any person, or any person or organization on his behalf, who believes he has been denied service in violation of an applicant's assurance obligations may file a written statement with the State Agency setting forth the particulars of his complaint and requesting an investigation.

(1) Within 30 days of receipt of such a complaint, the State Agency will undertake an investigation and will, upon the complainant's request, arrange for his personal appearance and permit the presentation of oral or written statements in support of his complaint.

(2) Within 60 days of receiving the complaint, the State Agency will notify the applicant and complainant, or their representatives, in writing of its findings upon the complaint. The applicant shall be advised of his rights to a fair hearing as provided in the State Plan and of procedures for seeking such a fair hearing.

d. Enforcement: When the State Agency finds, either after a complaint or on the basis of its annual evaluation, that an applicant is not complying with its assurance, the facility shall be subject to but not limited to:

(1) License revocation;

(2) Termination of further Hill-Burton or State assistance until the applicant complies;

(3) Court action; and

(4) Any other action deemed appropriate and within the authority of the State Agency.

e. Annually, report in writing to the Secretary, its evaluation of each facility's compliance with the assurance, the disposition of each complaint received by the State Agency, proposed remedial action with respect to each facility found by the State Agency to be not in compliance with the assurance and the status of such remedial action.

f. Promptly report the institution of any legal action against a facility or the State Agency involving compliance with the assurance to the Regional Authority and the Regional Health Director of the Department of Health, Education and Welfare.

8. WAIVER PROCEDURES

Any facility which feels that its financial condition will not permit the providing of a reasonable volume of uncompensated services may request a waiver from the requirement to provide such services. Procedures for requesting and obtaining a waiver are, in order:

a. The facility shall submit to the State Agency a request for waiver. Such request shall fully document the financial position of the facility and the reasons why a reasonable volume of uncompensated services cannot be provided.

b. The State Agency will publish in a newspaper of general circulation in the area served by the facility a notice of the request for waiver and invite public comment thereon within thirty (30) days of the date of the notice. All comments received will be available for public inspection, at the State Agency.

c. The State Agency will duly consider the request and comments received from the public in arriving at a decision. Notice of the decision on the request for waiver will be given to all interested persons and to the public.

d. The State Agency will then submit the request and all pertinent documents to the Secretary of Health, Education and Welfare for approval of the determination.

9. PROCEDURES FOR THE STATE AGENCY TO ESTABLISH A LEVEL OF UNCOMPENSATED SERVICES

In the event it becomes necessary for the State Agency to establish a level of uncompensated services to be provided by a facility, the following procedures will apply, in order:

a. Within sixty (60) days after receipt, the State Agency will review and evaluate the annual financial statement, budget, and related documents submitted by the facility pursuant to the foregoing Section 5 and establish a level of uncompensated services, equal to or less than the presumptive compliance guidelines, to be provided by the facility. The level of uncompensated services will be determined by applying the following criteria:

(1) The financial status of the facility, taking account of income from all sources, and its financial ability to provide uncompensated services.

(2) The nature and quantity of services provided by the facility.

(3) The need within the area served by the facility for the provision, without charge or at a charge less than reasonable cost, for services of the nature provided or to be provided by the facility.

(4) The extent and nature of joint or cooperative programs with other facilities providing for uncompensated services and the extent and nature of outreach services directed to the needs of under-served areas.

b. Upon reaching a decision, the State Agency will notify the facility, in writing, of the level of uncompensated services which it has established for the facility for the fiscal year. Concurrently, the State Agency will publish in a newspaper of general circulation in the area served by the facility a Public Notice of the rate that has been established, a statement that the documents upon which the State Agency based its determination are available for public inspection at a location and time prescribed and that persons wishing to object to the rate can do so by writing to the State Agency within twenty (20) days after publication of the notice.

c. The State Agency will give Public Notice of the receipt of objections rendered by the public and will make the objections and their supporting documents available for public inspection and comment. If it deems the action necessary, the State Agency may set a public hearing on the objections and will give notice of such hearing to all interested parties and to the public.

d. The State Agency will, within sixty (60) days of the expiration of the period within which objections may be filed, rule upon the objections in writing, stating its reason for accepting or overruling them, in whole or part, and establish a final level of uncompensated care to be provided. Notice of the final determination will be mailed to the facility and to all persons who filed objections or who participated in the proceedings leading to the redetermination.

e. Within twenty (20) days of receipt of the written notice of this final determination, the facility or any other interested person or organization may submit to the Secretary of Health, Education and Welfare a written request for review of the final determination of the State Agency.

f. On review, the Secretary may sustain or reject the determination of the State Agency. In case of the latter, the Secretary will establish a level of uncompensated services which he determines appropriate.

g. The level of uncompensated services established for the facility under this Section for any fiscal year shall constitute a reasonable volume of services for persons unable to pay therefor with respect to such facility for such fiscal year.

0. ELIGIBILITY CRITERIA

a. Once a level of uncompensated services to be provided by a facility has been established, it is thereafter the responsibility of the facility administrator to determine HOW, WHEN, and TO WHOM these services will be provided. Each case must be evaluated on its own merits, as there are numerous persons and families who are otherwise self-supporting but unable to pay the full charge for needed services.

b. The decision on each application for uncompensated services should be based on the following factors:

(1) The health and medical care insurance coverage, personal or family income, size of the patient's family, and other financial obligations and resources of the patient or the family in relation to the reasonable cost of the services.

(2) Standards of need are:

(a) Persons who are within the financial standards of the State of West Virginia medical assistance program. An explanation of this program is attached.

(b) Persons whose family income and resources are in excess of the financial standards of the State of West Virginia medical assistance programs but who are found unable to pay for needed services by circumstances creating financial hardships. Each case falling into this category shall be examined on an individual basis.

(3) Any other equivalent measures which are found by the Secretary of Health, Education and Welfare to provide a reasonable basis for determining an individual's ability to pay for needed medical services.

c. It shall be the responsibility of the facility administrator to establish and maintain procedures under which applications for uncompensated services are received, evaluated and approved or denied. A copy of all completed applications (approved or denied) shall be maintained by each facility and available for review by the State Agency upon request. The facility shall provide a copy of the criteria it uses for identifying persons unable to pay, upon request, to any patient or former patient of the facility and to any person seeking services from the facility.

Financial Standards
of the
State of West Virginia
Medical Assistance Program

Eligibility Requirements for
Medicaid for the Medically Needy

Protected Income Level Chart

Number in Medicaid Group	Protected Income	
	One Month	Six Months
1	$158	$ 950
2	175	1,050
3	208	1,250
4	250	1,500
5	275	1,650
6	308	1,850
7	358	2,150
8	400	2,400
9	450	2,700
10 and Over	492	2,950

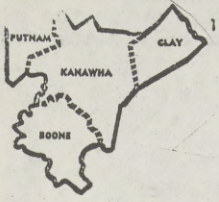
Note: Protected income level of person in an institution with no outside expense is $25.00 per month.

Source: Medicaid Eligibility Manual (12-1-73)
West Virginia Department of Welfare

EXHIBIT 5

HEALTH PLANNING COUNCIL, INC.

FOR REGION 3



1120 KANAWHA VALLEY BUILDING, CHARLESTON, WEST VIRGINIA 25301
Area Code 304-346-0656

Planning to Meet Community Health Needs for:
Boone, Clay, Kanawha, and Putnam Counties

August 12, 1974

Mr. John P. Morrison
Chief, Health Facilities Branch
Health Resources Development Division
Department of Health, Education,
and Welfare
3535 Market Street
Philadelphia, Pennsylvania 19101

Dear Mr. Morrison:

Thank you for your letter of August 7, 1974.

The West Virginia State Department of Health has provided this office with the revision of Appendix H, Methods of Administration Services for People Unable to Pay. The new Appendix H does not comply with the requirements of the federal regulations.

In this new Appendix H, the Department of Health has substituted a new "standard of need" for the list of median income per county, and the Department of Health has altered the manner in which enforcement methods are explained. Such improvements, however, constitute only minor repairs to what remains an inadequate document.

The new Appendix H does not set forth criteria for identifying persons unable to pay for services. The facility administrator has again been delegated the responsibility to determine how, when, and to whom the free or below-cost services will be provided, in spite of the clear requirement in the regulations that the state agency set forth criteria for identifying such persons. The enforcement provision in the Appendix is thus meaningless, for there is no standard to enforce.

While I am confident that HEW has not approved and will not approve this revised document, we are interested in knowing, as I am sure the Hospital Association is also, at what point

after this long delay, the State Department of Health can be expected to come up with a document which complies with the law, for the protection of the State Department of Health, the hospitals, and patients concerned.

Yours sincerely,

D. L. Rodecker

Deborah Lewis Rodecker
Health Law Advisor

DLR:npg

cc: Mr. Harold Spangler
W. Va. Hospital Association

EXHIBIT 6

HEALTH PLANNING COUNCIL, INC.

FOR REGION 3

1120 KANAWHA VALLEY BUILDING, CHARLESTON, WEST VIRGINIA 25301
Area Code 304-346-0656

Planning to Meet Community Health Needs for:
Boone, Clay, Kanawha, and Putnam Counties

September 17, 1974

Mr. John P. Morrison
Chief, Health Facilities Branch
Health Resources Development Division
Department of Health, Education, and
Welfare
Post Office Box 13716
Philadelphia, Pennsylvania 19101

Dear Mr. Morrison:

Enclosed please find a copy of my letter to you dated August 12, 1974. No response to this letter has yet been received. We would like to know what the status is of the revised Appendix H prepared by the West Virginia State Department of Health, which is referred to in this letter, in order that we may determine whether to recommend action to our Board.

I hope to hear from you shortly.

Yours sincerely,

Deborah Lewis Rodecker
Health Law Advisor

DLR:npg

Enclosure

Page Crosland
Southern Regional Council
52 Fairlie Street, N. W.
Atlanta, Georgia 30303
(404) 522-8764

FOR RELEASE NOVEMBER 25, 1974

ATLANTA, November 25--The Southern Regional Council charged today in testimony before the U. S. Senate Health Subcommittee that medical facilities built with Hill-Burton funds in the South are not meeting their legal obligations to provide free medical service to the poor.

The testimony, delivered by Allan Crimm, health consultant to the Council's Southern Governmental Monitoring Project, was based on documentation of "widespread abuse of the HEW regulations and denial of medical treatment to indigents in Hill-Burton facilities."

Investigations of hospitals and nursing homes in 25 cities and towns in the South were conducted last summer by field researchers for the Council's Monitoring Project. According to the testimony, with few exceptions, the hospital officials they contacted were contemptuous of their legal obligation to provide free service and hostile to inquiries about compliance. A Miami hospital administrator, for example, refused to grant an interview until the investigator's credentials were approved by a hospital industry organization. Requests for even the most basic financial information about hospitals were met with refusal time and time again.

Meetings with hospital administrators and staff at 44 Hill-Burton facilities, plus conversations with HEW regional officials and state agency staff responsible for enforcing HEW regulations, revealed that a number of clearly unauthorized and deceptive practices are used to

deny medical care to eligible Southerners.

The more obvious practices that emerged during the Monitoring Project's investigation follow:

1. Some facilities use loopholes to avoid accountability for specific dollar amounts of free service. Each Hill-Burton facility is required to select annually one of four methods by which the amount of free service obligation is calculated. Thirty-nine facilities, or almost 15 percent of the hospitals and nursing homes in Alabama, Georgia and Louisiana, have not chosen one of the four options. Of those hospitals that have selected an option, the "open door" option appears to be the most popular. Under this option, hospitals certify that they will not refuse service to anyone because of his inability to pay. More than 45 percent of the hospitals and nursing homes in six states - Alabama, Arkansas, Georgia, North Carolina, Tennessee, and Texas - chose this option. In none of these states has a facility been required to document precisely how much indigent care it did, in fact, provide. Evidence indicates that some hospitals, although agreeing to serve everyone in need of treatment, actually provide less indigent care than if they had chosen either of the other options available to them.

2. Many facilities appear to be in compliance but are actually including highly questionable expenses as "free service." The administrator of a Winston-Salem, North Carolina facility admitted that bad debts are used to meet the obligated level of service although this is specifically prohibited by the HEW regulations. A Ft. Smith, Arkansas hospital administrator, dissatisfied with the allegedly low amount which his facility

receives from Medicare and Medicaid, is writing off the difference between the "reasonable cost" it gets and the reported actual cost of providing the care. HEW regional officials and agency staff in Alabama, Arkansas, and Georgia see nothing wrong with this practice. However, many hospitals can account for all their "free service" without giving medical treatment to a single indigent person for whom they are not already receiving compensation from a government program.

3. Southerners are denied needed medical care because of both arbitrary geographic restrictions and limitations on the type of medical care to be given to people who cannot afford to pay. A Memphis, Tennessee facility, for example, will not admit residents of the county in which it is located, because the administrator contends that indigents are supposed to use the county-operated hospital. A North Georgia hospital registered as an "open door" facility will not admit obstetrical cases unless the physician will certify that the life of either the mother or child is in danger. Routine deliveries by indigents do not ordinarily get the benefit of hospital care.

4. Public notification of the availability of free service is not effective. Many facilities do not publish notices and those notices which are printed are buried in the paper. Of the 44 facilities visited, only one, the University of Virginia Medical Center, has a notice conspicuously posted that informs people that free service is available. Most administrators who were contacted in both public and private, non-profit facilities contend that the public is already aware of the free or below cost care. The investigators found considerable evidence to the contrary.

5. The state agencies are not performing adequate annual evaluation or enforcement of each Hill-Burton hospital's compliance as required by the free service regulations. An examination of the files at the Alabama, Arkansas, and Georgia state agencies responsible for enforcing health regulations revealed that few facilities are separating free service and uncollectible accounts in their financial statements. Most facilities do not submit financial information at all. Not a single state agency in HEW Region IV has conducted an audit of a facility to verify its compliance in spite of the variety of highly questionable expenses found written off as free service.

6. The regional HEW offices overlook this lack of effective state agency evaluation and enforcement of the indigent care requirements. In the two years since new HEW regulations took effect, Virginia has not submitted a state plan for compliance. Other states that have been approved by HEW do not contain adequate information on evaluation procedures. Alabama's plan permits facilities to write off as "free service" unauthorized Medicare costs. Although required by the HEW regulations, annual reports by state agencies to HEW have not been submitted by Georgia, Tennessee, and Virginia.

The Southern Governmental Monitoring Project was invited to present testimony by Dr. Philip Caper, medical consultant to Senator Edward Kennedy's Health Subcommittee. The subject of the hearing was propsed legislation on health care and hospital construction.

The 30 year old Southern Regional Council, which is non-profit and non-partisan, is the South's oldest bi-racial research and action-oriented organization devoted to the attainment of equal opportunity for

all citizens in the region.

The Monitoring Project was established by the Council in late 1973 to determine the impact of the changes in federally allocated revenues on poor and minorities in the South, to analyze how states, cities, and counties are responding to these changes, and to help local groups understand and take advantage of available resources.

-30-

Senator KENNEDY. The subcommittee will now adjourn.
[Whereupon, at 12:50 p.m., the subcommittee adjourned.]

○