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SEP 25 1974

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

RELEASED

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.

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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

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.

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.

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 non-poverty 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.

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).

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

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

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.

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
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	*
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	*
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	0.0
FY 72	4,852,446	0	185,333	4,667,113	3.8

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
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	*
FY 72	200,000	355,508	271,890	283,618	*

*indicates an increase in funds after transfers

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.

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.

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.

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.

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).

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

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:

"(e)(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(e)

In summary, 42 U.S.C. 291b(e) 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:

"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,

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;

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.

* * * * *

§53.84 Outpatient facilities (new 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 §53.129 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 limited 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 absense 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

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.