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The Hill-Burton Act, 1946-1980: Asynchrony in the Delivery of Health Care to the Poor

THE HILL-BURTON ACT, 1946-1980: ASYNCHRONY IN THE DELIVERY OF HEALTH CARE TO THE POOR

The Hospital Survey and Construction Act, better known as the Hill-Burton Act, was adopted by Congress in 1946.[1] The Act, which was the federal government's first health care initiative,[2] was intended to stimulate public and nonprofit hospital construction and modernization.[3] The device chosen to attain this goal was the provision of federal grants to individual hospitals for capital construction and modernization projects.[4] As a condition of funding, recipient facilities contracted to be available to "all persons residing in the territorial area" of the facility and to make available "a reasonable volume of hospital services to persons unable to pay therefor."[5] These two obligations have been termed, respectively, the "community service" and "uncompensated care" components of the Act.[6]

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1. Title VI of the Public Health Service Act, Pub. L. No. 79–725, 60 Stat. 1040 (1946) (codified, as amended, at 42 U.S.C. §§ 291–291o (1976)) [hereinafter referred to as the Act or Title VI]. In 1975 Congress enacted Title XVI of the National Health Planning and Resources Development Act of 1974 to supplant the original Hill-Burton Act. Pub. L. No. 93–641, 88 Stat. 2258 (codified at 42 U.S.C. §§ 300o–300t (1976)) [hereinafter referred to as the new Act or Title XVI].

2. Rose, *Federal Regulation of Services to the Poor Under the Hill-Burton Act: Realities and Pitfalls,* 70 Nw. L. Rev. 168, 169 (1975). Prior to Hill-Burton, federal involvement in health care was limited to the provision of medical services to military personnel and their dependents. *Id.*

3. The Congressional Declaration of Purpose of the 1946 Act stated:

> The purpose of this title is to assist the several States—
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> (a) to inventory their existing hospitals . . . [,] to survey the need for construction of hospitals, and to develop programs for construction of such public and other nonprofit hospitals as will, in conjunction with existing facilities, *afford the necessary physical facilities* for furnishing adequate hospital, clinic, and similar services to all their people; and
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> (b) *to construct* public and other nonprofit hospitals in accordance with such programs.

Pub. L. No. 79–725, § 601, 60 Stat. 1041 (emphasis added) (codified, as amended, at 42 U.S.C. § 291 (1976)). Although Hill-Burton funds also became available to other public and nonprofit facilities such as out-patient clinics, this Comment focuses on the Act's application to private, nonprofit in-patient hospitals.

4. *Id.* § 621, 60 Stat. 1042 (codified, as amended, at 42 U.S.C. § 291a (1976)).

5. *Id.* § 622(f)(1)–(2), 60 Stat. 1041 (codified, as amended, at 42 U.S.C. § 291c(e)(1)–(2) (1976)). The relationship between grantee hospitals and the federal government was understood by grantees to be contractual, given the government's right of recovery of funds in certain circumstances. *See* note 43 *infra.* The relationship was later held to be contractual by the United States Court of Appeals for the Tenth Circuit in Euresti v. Stenner, 458 F.2d 1115, 1118 (10th Cir. 1972). *See* note 64 *infra.*

6. These terms will be used throughout this Comment to refer to the Hill-Burton obligations. The Department of Health, Education and Welfare refers to the "uncompensated services" and "community service" obligations. *See* 42 C.F.R. §§ 124.501–.607 (1979).

For over twenty-five years these obligations remained undefined. The first regulations drafted under the Act paraphrased the vague statutory terms without attempting to quantify them.[7] It was not until 1970 that indigent persons who had been denied services at a Hill-Burton hospital filed suit charging the facility with failing to fulfill its uncompensated care obligation under the Act.[8] Subsequent years brought a number of uncompensated care and community services actions, which, in addition to seeking to compel hospital treatment of poor people, charged that the Department of Health, Education and Welfare (DHEW), the Act's federal regulatory agency, and various state health departments, which also had a supervisory role under the Act, had failed to enforce the hospitals' Hill-Burton obligations. Between 1972 and 1978, prodded at virtually every step by new decisions of federal courts, DHEW effected numerous changes in the Hill-Burton regulations. The general language of the initial regulations grew progressively into a body of specific rules that set forth quantifiable standards for hospital compliance with the uncompensated care and community service obligations. Even as the regulations evolved, however, Hill-Burton plaintiffs continued to charge that DHEW was not enforcing its various new regulations and that, despite pressure from the courts, hospital compliance remained inadequate.

In 1979, again at federal court instigation, DHEW issued the most recent Hill-Burton regulations.[9] In contrast to the piecemeal changes of the 1972-1978 period, these regulations are a comprehensive redraft. The result is a highly structured, technical compliance document that incorporates the major changes of the previous generations of court-shaped regulations and, in addition, imposes new requirements on Hill-Burton facilities. Coupled with these important changes is DHEW's new and enthusiastic enforcement posture.[10]

This new beginning represents a victory for Hill-Burton plaintiffs, who have litigated for this result for ten years. DHEW has now adopted a plaintiff's perspective on compliance and has armed itself with a powerful new enforce-

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7. 12 Fed. Reg. 6,176, 6,179 (final regulations of Sept. 16, 1947, codified at 42 C.F.R. §§ 53.62–.63 (Supp. 1947)). For regulatory provisions no longer in effect, this Comment provides a *Federal Register* citation with specific characterization of the regulation, its date, and, for final regulations, its parallel citation in the last *Code of Federal Regulations* in which it appeared before being superceded by a new issuance. For regulations that did not survive to codification in the *Code of Federal Regulations*, and for uncodified agency commentary, only a *Federal Register* citation is provided. Current regulations are cited to the 1979 *Code of Federal Regulations*. This method is employed so that the reader may better understand the chronology of regulatory change.

8. *See* Cook v. Ochsner Foundation Hosp. (*Cook I*), 319 F. Supp. 603 (E. D. La. 1970) (defendants' motion to dismiss denied). *Cook I* was not the first case in which a hospital's obligation under Hill-Burton was litigated, *see, e.g.*, Stanturf v. Sipes, 224 F. Supp. 883 (W.D. Mo. 1963), *aff'd*, 335 F.2d 224 (8th Cir. 1964) (grantee hospital's refusal to admit individual did not constitute denial of equal protection), but it was the first in the line of cases that affected the development of the regulations that is the subject of this Comment.

9. 44 Fed. Reg. 29,372 (final regulations of May 18, 1979, codified at 42 C.F.R. § 124.501–.607 (1979)).

10. *See* note 311 and accompanying text *infra*.

ment weapon designed to assure that poor persons will receive medical care under the Act. From a contractual and equitable standpoint, this result might appear to be long overdue; after all, the provision of uncompensated care and community service is presumably what hospitals bargained for when they accepted Hill-Burton funds.

Closer examination, however, reveals that the new regulations are neither contractually nor equitably sound. The new compliance standards bear no relationship to the original purpose of the Hill-Burton Act. They alter dramatically the nature of the original obligations incurred by Hill-Burton grantees when they accepted federal funds under the program and impose unexpected and often financially burdensome new requirements upon some Hill-Burton facilities. Even more important, however, is the fact that the 1979 regulations are fundamentally unsound from a health policy perspective. The regulations will have little more than a negligible impact on the plight that they purport to remedy, the access of indigents to adequate medical care; at the same time they impose inordinate administrative burdens and costs upon Hill-Burton facilities and their patients.

The 1979 regulations are the unfortunate culmination of Hill-Burton's aberrant development since 1972. In some respects, the current dilemma has been unintentionally begotten by a series of related events involving a diverse chorus of actors, principally a number of hospitals, DHEW, Congress, and the federal courts. The sequence of development makes an intriguing study of how government loses control of a well-intentioned program to the point that the program works at cross-purpose to the original desired end.

This Comment examines the policy issues raised by the development of the Hill-Burton program from 1946 to date. Part I outlines the legislative history of the Act and its operation through 1972. Part II traces the complicated course of Hill-Burton litigation and the resultant changes in its regulations through 1979. In Part III the serious health care issues raised by the new regulations are discussed, and Hill-Burton is shown to be an exceedingly expensive and highly inefficient vehicle for the provision of needed medical care to the poor.

PART I: LEGISLATIVE HISTORY AND OPERATION, 1946-1972

Legislative Intent

In 1929, with the onset of the Depression, nearly all privately financed hospital construction in the United States came to a halt. Not only did building cease, but between 1928 and 1938 nearly eight hundred hospitals closed.[11] As the American population grew, the problem of hospital availability and accessibility was compounded.

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11. DIVISION OF HOSP. AND MED. FACILITIES, PUBLIC HEALTH SERVICE, U.S. DEP'T OF HEALTH, EDUCATION AND WELFARE, TWO DECADES OF PARTNERSHIP FOR BETTER PATIENT CARE 6–9 (Public Health Service Pub. No. 930–F–8, 1966). Although some public works programs undertook hospital building, these efforts were directed primarily at unemployment problems and did not result in any notable increase in the number of hospitals. *Id.*

In response to this problem, the Commission on Hospital Care was organized in 1941. The Commission, which was sponsored by the American Hospital Association with the assistance of the United States Public Health Service,[12] completed a nationwide survey that showed the number of hospitals to be inadequate and their distribution haphazard.[13] This information, in addition to testimony on health needs gathered in hearings by the Senate Subcommittee on Wartime Health and Education,[14] provided the impetus for Senate consideration of a federal program to improve hospital and health facilities.[15]

Two possible approaches to this problem emerged. The sponsors of the Hospital Survey and Construction Act, Senators Lister Hill of Alabama and Harold Burton of Ohio, chose what might be termed a conservative activists' approach, in direct contrast to the Truman administration's broad proposal for a national health insurance program.[16] Both bills recognized a need for federal intervention in the health care field and cited the inadequacies of medical services,[17] but the Hill-Burton program called for a much more narrow and modest preliminary step toward solution of the problem.[18] Senator Hill's opening statement in committee hearings on his bill summarized his intent in sponsoring the legislation:

> The first purpose [of Senate Bill 191] is to assist the States in making a careful State-wide survey of hospitals and health care facilities . . . in order to determine where additional facilities are needed and to prepare a

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12. The Commission was supported by grants from several private foundations, and the Public Health Service supplied staff assistance. *See Proposed Amendments to the Public Health Services Act: Hearings on S. 191 Before the Senate Comm. on Education & Labor*, 79th Cong., 1st Sess. 19 (1945) [hereinafter cited as *1945 Hearings*].

13. TWO DECADES OF PARTNERSHIP, *supra* note 11, at 9.

14. *See Investigation of the Education and Physical Fitness of Civilians: Hearings on S. Res. 74 Before the Subcomm. on Wartime Health & Education of the Senate Committee on Education & Labor*, 78th Cong., 1st & 2d Sess. (1943–44).

15. *See 1945 Hearings, supra* note 12, at 7 (statement of Sen. Lister Hill). Another factor in the timing of legislation was the impending return to civilian life of thousands of Army physicians. It was believed that the improved distribution of adequate hospital facilities would encourage doctors to locate in underserved areas. *See id.* at 195.

16. *See Proposal for a National Health Program: Hearings on S. 1606 Before the Senate Comm. on Education and Labor*, 79th Cong., 2d Sess. (1946) [hereinafter cited as *National Health Program Hearings*]. The administration offered a five-part proposal, consisting of programs to: (1) construct facilities; (2) develop public health services and maternal and child care; (3) expand medical research and professional education; (4) expand the existing compulsory social security system to encompass mandatory health insurance; and (5) provide for comprehensive disability insurance. *Id.* at 1–8 (message from President Truman).

17. *See 1945 Hearings, supra* note 12, at 6–9; *National Health Program Hearings, supra* note 16, at 1–8.

18. The Hill-Burton proposal called, in effect, for enactment of the first item of the five-part Truman proposal. *Compare* text accompanying note 19 *infra with* note 16 *supra*.

> State-wide program for new construction so that all people of the State may have adequate health and hospital service.
>
> . . . .
>
> The second purpose . . . would be to assist States, counties, cities and communities to provide for themselves modern hospitals and health centers
>
> . . . .
>
> The third purpose . . . is to assist and encourage the States to correlate and integrate their hospital and public-health services and to plan additional facilities when and where needed . . . .
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> . . . .
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> No great increase in either [*sic*] public health, hospital, or medical services can be expected unless we have a much better distribution of modern hospital and health-center facilities.[19]

This statement indicates that the bill was intended to increase and improve health care facilities in the expectation that more and better hospitals and health centers would mean more and better health care. In committee hearings, the building and modernization program was characterized repeatedly as a "necessary preliminary" to other government programs to assist in actual service delivery, and it is clear from witness testimony and from many of the exchanges between Senators and witnesses that further health care enactments were expected to take up where Hill-Burton was to leave off.[20]

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19. *See 1945 Hearings, supra* note 12, at 8–9 (statement of Sen. Lister Hill).

20. For example, Dr. Donald C. Smelzer, President of the American Hospital Association, said:

> We believe that the steps provided in this legislation are a necessary preliminary in the better distribution of hospital and medical care. I am also frank to say that it is our hope that this step will be followed by, first, a more adequate provision of hospital and professional care for the medically indigent, those now unable to pay for such care, and, second, a thoroughly active and aggressive support by the Government of voluntary prepayment hospital and medical plans.

1945 Hearings, supra note 12, at 10. *See id.* at 31 (Sen. Pepper's characterization of bill as a "first step and merely a part of a whole program"); *id.* at 63–65 (exchange between Sens. Smith and Ellander and witness, in which bill characterized as "first step in a national health program," limited to the provision of physical facilities); *id.* at 80 (exchange between Sen. Taft and witness, in which bill characterized as one factor in a general health program). *See also id.* at 90, 173, 188, 194, 208, 301.

Dr. Thomas Parran, who was then Surgeon General, was an important witness in the hearings. In response to questioning during his testimony, he noted:

> S. 191 is silent on the whole question of medical care for people of low incomes. Apparently this was a deliberate omission on the theory that the first and most necessary step is to plan for constructing the most-needed facilities, which facilities will be required no matter what the plan may be that is adopted for providing for the payment for hospitals and other medical care.
>
> In other words, it will require a long time to make the surveys and plans, to draw the actual blueprints on the most-needed facilities, to secure appropriations, and to arrive at the stage when you have a finished hospital. By that time I assume the thinking of the sponsors is that there will have been some further action taken by the State or by the Federal Government.

Id. at 64.

Questions concerning the actual provision of services through Hill-Burton facilities were the subject of discussion during the hearings;[21] however, reading of the transcripts overall shows that the committee's focus did not broaden to include the provision of services as a coequal goal with construction.[22] Attention to the issue of access to federally financed hospitals was expressed primarily through the committee's concern that the hospitals would not at some later date be taken over by restrictive interests that would exclude some segments of the population.[23] Moreover, the committee was concerned that new hospitals should not be distributed according to the ability of surrounding community residents to pay for services; instead, hospital locations should be determined by community need and according to a rational state-wide plan.[24]

This attitude was reflected in the text of the Hill-Burton Act as it was reported out of committee and passed by Congress.[25] The uncompensated care and community service provisions were inserted in the original draft *not* as

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21. *See, e.g., id.* at 63–65, 70, 190–91. Such discussion proceeded in a non-conclusory fashion, with the various Senators and witnesses making vague suggestions as to how the financing of services might be handled. In contrast, many other less comprehensive and less financially complicated topics arose, which committee members discussed in much more detail because of their understood relevance to the bill. *See, e.g., id.* at 193, 235–38, 301–02 (inclusion of hospital maintenance and operating funds); 70–76, 153, 259 (allocation and amount of federal/state funding shares); 140–46, 156–59, 199, 231 (authority of Surgeon General and Federal Advisory Council); 91–92 (division of federal/state agency authority).

22. *See* notes 20 & 21 *supra*. This interpretation of the Act's legislative history is shared by another student commentator, who provides a more detailed recitation of the Committee hearings. *See* Note, *Due Process for Hill-Burton Assisted Facilities*, 32 VAND. L. REV. 1469, 1475–80 (1979) [hereinafter cited as *Hill-Burton Facilities*]. Other commentators have taken a contrary view, concluding that the legislative history of the Act at least implies congressional intent to provide services. *See* Rose, *supra* note 2, at 169–70; Rose, *The Duty of Publicly-Funded Hospitals to Provide Services to the Medically Indigent*, 3 CLEARINGHOUSE REV. 254, 261–62 (1970); Rosenblatt, *Health Care Reform and Administrative Law: A Structural Approach*, 88 YALE L.J. 243, 267–68 (1978); Comment, *Provision of Free Medical Services by Hill-Burton Hospitals*, 8 HARV. C.R.-C.L. L. REV. 351, 354 (1973). As is explained in *Hill-Burton Facilities, supra*, at 1477 n.72, however, "such a conclusion may be drawn from the quoted fragments of the colloquy, [but] the testimony when read in context and in toto refutes this result."

23. It may be that the Committee was concerned that certain racial, religious, or fraternal groups might place restrictions on access to a Hill-Burton facility and thought that federal dollars should not be used to assist such facilities. This, apparently, was the thrust of the language of the Act's purpose clause, which said that facilities in each state should be available "to all their people," *see* Pub. L. No. 79–725, § 601, 60 Stat. 1041 (1946) (codified, as amended, at 42 U.S.C. § 291 (1976)), and of the community service clause (which was not a part of the bill as introduced), which stated that facilities should be "made available to all persons residing in the territorial area," *id.* § 622(f)(1), 60 Stat. 1043 (codified, as amended, at 42 U.S.C. § 291c(e) (1976)).

24. *See 1945 Hearings, supra* note 12, at 189–90.

25. *See* H.R. REP. No. 2519, 79th Cong., 2d Sess., *reprinted in* [1946] U.S. CODE CONG. & AD. NEWS 1558; H.R. REP. No. 2697, 79th Cong., 2d Sess., *reprinted in* [1946] U.S. CODE CONG. & AD. NEWS 1571; Title VI, Pub. L. No. 79–725, 60 Stat. 1040 (1946).

additional substantive components of the Act, but as checks on the inappropriate use of federal funds, *i.e.*, the provisions were preventive, not affirmative.[26] The additions directed the Surgeon General to issue regulations prescribing:

> (f) That the State plan shall provide for adequate hospital facilities for the people residing in a State, without discrimination on account of race, creed, or color, and shall provide for adequate hospital facilities for persons unable to pay therefor. *Such regulation 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 (1) such hospital or addition to a hospital will be *made available to all persons residing in the territorial area* of the applicant, without discrimination on account of race, creed, or color . . . and (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.*[27]

There is no apparent indication in the hearing transcripts that Congress' purpose in the addition of these obligations was other than to ensure that the hospital building program would proceed in an equitable fashion as a "first step" toward improved health care for Americans.[28]

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26. *Cf.* Perry v. Greater Southeast Community Hosp. Foundation, Civ. No. 725–71 (D.D.C. June 28, 1972), at 5 (community service requirement appears to be negative prohibition against discrimination that cannot be considered an affirmative mandate). *See* text accompanying note 68 *infra*.

27. Title VI, Pub. L. No. 79–725, § 622(f), 60 Stat. 1042–43 (codified, as amended, at 42 U.S.C. § 291c(e) (1976)) (emphasis added). This section specified an exception to the equal access provision, however, by allowing separate facilities for "separate population groups, if the plan [made] equitable provision on the basis of need for facilities and services of like quality for each such group." *Id.* This portion of the statute was deleted in response to the court's holding in Simkins v. Moses H. Cone Memorial Hosp., 323 F.2d 959 (4th Cir. 1963), *cert. denied*, 376 U.S. 938 (1964), that found the provision unconstitutional. *See* Pub. L. No. 88–443, § 603(e)(1), 78 Stat. 448 (1964). The *Simkins* case was a civil rights action, not a compliance challenge, per se.

28. Further evidence of the Act's purpose is found in reading the entire bill, which goes into great detail concerning many other provisions, *e.g.*, factors to be considered in determining the allotment formulae by which federal funds would be distributed among the states, the manner and method of approval of projects and payments for construction, the procedure for amendment of a facility's application for funds, the factors prompting withholding of facility certification. *See* Title VI, Pub. L. No. 79–725, 60 Stat. 1040. By this detailed drafting, Congress left little doubt as to the precise manner of the Act's implementation. In contrast, the uncompensated care and community service provisions are very brief and extremely general. *Id.* Although use of Congress' failure to provide the same detail in these provisions as it did in others, as with any interpretation based on what a legislature has not done, is necessarily inconclusive, an obvious inference to be drawn from this contrast is that Congress did not intend that the obligations would be a major financial factor in the program. Other discussion in committee hearings shows that the Senators understood that the financing of medical services for the indigent was a complicated financial problem. *See* note 24 *supra*. It is therefore difficult to reconcile the Act's general and superficial treatment of these issues with an intent to provide any substantial volume of medical services to the poor.

Program Implementation

The original Hill-Burton Act provided for dual federal-state operation of the program.[29] Overall supervision was vested in the Surgeon General, although the statute limited his regulatory authority by the creation of the Federal Hospital Council, an appointed body of hospital experts and consumer representatives that had final and binding power to approve or veto the Surgeon General's regulations.[30] Each state was to designate an agency to plan and administer a state-wide program of hospital construction and modernization.[31] The plans were to be submitted to the Surgeon General, who, upon approval, channeled federal funds through the state agency to individual facilities.[32]

The first regulations under the Act, promulgated in 1947, restated the statutory language concerning the community service and uncompensated care obligations.[33] The community service regulations, entitled "Non-discrimination," provided that the federally funded facility would be available to all community residents without regard to race, creed, or color.[34] No dollar figure or volume minimum defined a "reasonable volume" of uncompensated care, and, in accordance with the Act, the regulation provided for a waiver of this requirement if a hospital was not financially capable of delivering such care.[35] Free or below cost patient care provided by a facility would satisfy the requirement; moreover, hospitals that received reimbursement on behalf of such patients from public or charitable funds could still count such treatment as uncompensated care. The determination of what constituted a "reasonable volume" of uncompensated care would take into consideration the conditions in the hospital's service area, "including the amount of free care that may be available otherwise than through the applicant."[36]

These provisions were consistent with the underlying purpose of the statute: While Congress had expressed concern that Hill-Burton facilities be available to all people, it had not specified the method of funding care to the indigent and had not contemplated prohibiting outside contributions to offset the costs of treating persons unable to pay. The 1947 regulations also carried through the Act's concept of uncompensated care based on area-wide need.[37]

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29. Title VI, Pub. L. No. 79–725, §§ 622–623, 60 Stat. 1041–42 (1946).

30. *Id.* §§ 622, 623(a), 633, 60 Stat. 1042–44, 1048–49.

31. *Id.* §§ 612, 623–625, 60 Stat. 1043–46. The state agency was to submit plans for its construction program, implement the plan, and supervise the participation of grantee hospitals.

32. *Id.* §§ 612, 613, 623–625, 60 Stat. 1041–42, 1043–46.

33. 12 Fed. Reg. 6,176 (final regulations of Sept. 16, 1947, codified at 42 C.F.R. § 53.62–.63 (Supp. 1947)).

34. *Id.* at 6,179 (codified at 42 C.F.R. § 53.62 (Supp. 1947)). As specified by the original Act, Title VI, Pub. L. No. 79–725, § 622(f), 60 Stat. 1042 (1946), however, "separate but equal" facilities were permitted on the basis of race. *See* note 27 *supra*.

35. 12 Fed. Reg. 6,176, 6,179 (final regulations of Sept. 16, 1947, codified at 42 C.F.R. § 53.63 (Supp. 1947)).

36. *Id.*

37. *Id.*

Under these terms, federal financing of hospital construction and modernization began. Between 1947 and 1970, nearly four billion dollars flowed to some seven thousand hospitals and health facilities as the program assisted in the addition of nearly one-half million hospital beds.[38] During this period, as Congress renewed appropriations for the program, the Act was amended a number of times.[39] In 1966 regulatory authority was transferred from the Surgeon General to the Secretary of DHEW, although the authority of the Federal Hospital Council remained intact.[40] By a 1970 amendment, the program was expanded to authorize loans and loan guarantees as well as grants.[41] Throughout these years, the substantive provisions of the statute and the regulations dealing with the community service and uncompensated care obligations remained unchanged.[42]

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38. BUREAU OF HEALTH PLANNING AND RESOURCES DEVELOPMENT, HEALTH RESOURCES ADMIN., U.S. DEP'T OF HEALTH, EDUCATION AND WELFARE, HILL-BURTON PROGRAM PROGRESS REPORT, JULY 1, 1947-SEPT. 30, 1976, at 2 (1976). A number of hospitals received more than one grant during the life of the program, *see, e.g.*, note 229 *infra*, and some 10,000 grants were made during the 1947-1970 period. *Id.*

39. Hospital Survey and Construction Amendments of 1949, Pub. L. No. 81–380, 63 Stat. 898 (authorized Public Health Service to provide grants for research and experiments relating to development of facilities and resources); Medical Facilities Survey and Construction Act of 1954, Pub. L. No. 83–482, 68 Stat. 461 (broadened grant program to include nursing homes, diagnostic centers, chronic disease hospitals); Act of Aug. 1, 1958, Pub. L. No. 85–589, 72 Stat. 489 (gave some facilities the option of long term loan instead of grant); Community Health Services and Facilities Act of 1961, Pub. L. No. 87–395, 81 Stat. 533 (increased nursing home and research appropriations); Hospital and Medical Facilities Amendments of 1964, Pub. L. No. 88–443, 78 Stat. 447 (extended program through 1969, authorized additional funds including those for new modernization and replacement program; deleted "separate-but-equal" provision); Comprehensive Health Planning and Public Health Services Amendments of 1966, Pub. L. No. 89–749, 88 Stat. 1610 (transferred regulatory authority to DHEW, removed demonstration grants for planning); Partnership for Health Amendments of 1967, Pub. L. No. 90–174, 81 Stat. 533 (research and experiment functions of 1949 amendment removed); Act of Oct. 15, 1968, Pub. L. No. 90–574, 82 Stat. 1005 (1968) (extended program through 1970); Medical Facilities Construction and Modernization Amendments of 1970, Pub. L. No. 91–296, 84 Stat. 337 (extended program through 1973; authorized $500 million for loans and loan guarantees). The original Act was later amended by the Health Program Extension Act of 1973, Pub. L. No. 93–45, 87 Stat. 92 (extended program through 1974; authorized additional funds). Then, in 1974, appropriations ceased under Title VI when Title XVI was enacted. *See* note 1 *supra*; note 159 and accompanying text *infra*.

40. *See* Comprehensive Health Planning and Public Health Service Amendments of 1966, Pub. L. No. 89–749, 88 Stat. 1610. *See also* 31 Fed. Reg. 8,855 (final regulations of June 25, 1966) (explaining statutory transfer of regulatory authority); 42 U.S.C. § 291c note (1976) (abolition of the Office of Surgeon General).

41. Medical Facilities Construction and Modernization Amendments of 1970, Pub. L. No. 91–296, 84 Stat. 337. Although some long term loans had been authorized by the 1958 amendment, Act of Aug. 1, 1958, Pub. L. No. 85–589, 72 Stat. 489, the major loan option program was established by the 1970 amendment.

42. *See* note 39 *supra*. By the 1964 amendments, however, the purpose clause of the original Act was amended to omit the phrase "physical facilities." The new declaration provided that the purpose of the Act was

> to assist the several States in the carrying out of their programs for the construction and the modernization of such public or other nonprofit community hospitals and

During this period, the provisions were regarded by federal and state regulatory agencies and Hill-Burton grantees as having no operational effect. Facilities apparently understood the contractual nature of their acceptance of Hill-Burton funds, but regarded it as pertinent primarily in the context of the Act's specification of a twenty-year period during which the government retained a right of recovery of funds in the event of a hospital's sale, transfer, or conversion into a for-profit concern.[43] It apparently was the understanding of the agencies and the grantee hospitals that the uncompensated care provision "required no substantial change or modification in the volume of charity care" that a grantee hospital had dispensed prior to receiving Hill-Burton money, or would have dispensed, according to its financial ability, if it had been built without Hill-Burton funds.[44] The community service obligation was apparently perceived to mean that a facility would not discriminate in allowing access by all persons in its service area.[45]

Other Developments in the Health Care Field

During this period of Hill-Burton quiescence, the federal government made further inroads into the health care area. Most notable of these were the 1965

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other medical facilities as may be necessary, in conjunction with existing facilities, to furnish adequate hospital, clinic, or similar services to all their people.

Hospital and Medical Facilities Amendments of 1964, Pub. L. No. 88–443, § 600, 78 Stat. 447 (codified at 42 U.S.C. § 291 (1976)). *Compare id. with* text of original purpose clause, *supra* note 3. The meaning of this change is characterized accurately by the author of *Hill-Burton Facilities, supra* note 22, at 1471 n.9, who states: "The changes in the declaration of purpose were intended to provide specifically for modernization and renovation of hospital and health facilities and not to change the focus of the Act from providing physical facilities to providing health services themselves." (citing S. REP. No. 1274, 88th Cong., 2d Sess. 1, *reprinted* in [1964] U.S. CODE CONG. & AD. NEWS 2800).

The amendment's omission of the specific language was to cause unforeseen problems, however, as courts, quoting selectively from the text of the 1964 purpose clause, were to find that the Act's purpose was "'to furnish adequate hospital, clinic, or similar services.'" *E.g.*, Euresti v. Stenner, 458 F.2d 1115, 1117 (10th Cir. 1972); Corum v. Beth Israel Medical Center (*Corum I*), 359 F. Supp. 909, 917 (S.D.N.Y. 1973).

43. Pub. L. No. 79–725, § 625(e), 60 Stat. 1046 (1946) (codified at 42 U.S.C. § 291i (1976)). This section provided that the government was entitled to recover one-third of the value of any facility built with Hill-Burton funds if, during any time within 20 years after the completion of construction, the facility were sold or transferred to a party not qualified to file an application under the Act, or ceased to be a nonprofit hospital as defined by the Act. This language was the basis for the parties' understanding that a contract was formed by acceptance of Hill-Burton funds. *See* Complaint for Declaratory and Injunctive Relief, American Hosp. Ass'n v. Harris, No. 79–C–2669 (N.D. Ill., filed June 27, 1979) [hereinafter cited as *AHA District Court Complaint*], appended affidavits of present and former state Hill-Burton agency administrators and hospital administrators. *See also* Euresti v. Stenner, 485 F.2d 1115 (10th Cir. 1972).

44. *See AHA District Court Complaint, supra* note 43, affidavit of Robert C. Kimball, former state Hill-Burton administrator, at 3.

45. *See id.*, affidavit of Joseph Pratschner, Director, Division of Health Facilities, N.D. State Dep't of Health, at 3.

enactments of government health insurance programs, Medicare and Medicaid. Medicare is a federally funded program that finances health care for the aged.[46] The Medicaid program, which funds medical assistance to certain categories of the poor regardless of age, is financed by state and federal matching funds.[47]

These programs were, in some respects, the service-funding mechanisms that had been envisioned by some members of the legislative and executive branches during the 1940's, when Hill-Burton was being considered. Medicare and Medicaid, however, were not coordinated with the Hill-Burton program on important issues concerning the financing of care to indigents. On the one hand, it might be presumed that the enactment of Medicare and Medicaid would supplant the uncompensated care obligation of Hill-Burton hospitals, since many of those who could not afford hospital care would now be eligible for one of the government insurance programs. Congress' failure to address this issue, however, permitted the inference that Hill-Burton hospitals were now to fulfill their uncompensated care obligations by service to people who did not qualify for Medicare or Medicaid, but who were not able to pay for hospital care.[48] The failure of the drafters of the Medicare and Medicaid programs to specify this relationship resulted in their undefined coexistence with Hill-Burton.[49]

Another failure of integration of Medicare and Medicaid and Hill-Burton occurred because of the reimbursement methods that were set up for the new insurance programs. To understand this conflict, it is necessary to know a basic principle of hospital pricing: As in many other businesses, costs are spread. The rate charged for a surgical procedure covers not only the actual costs of the

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46. Title XVIII, Social Security Act of 1965, Pub. L. No. 89–97, 79 Stat. 286 (codified in scattered sections of 26, 42 & 45 U.S.C. (1976)). The elderly are the chief beneficiaries of the program, although persons with certain disabilities and those with end-stage renal disease are eligible regardless of age. Need is not a factor in entitlement to benefits. "Part A" Medicare benefits, which provide hospital insurance, are funded primarily through the Social Security tax. For a synopsis of the Medicare hospital insurance program, see [1979] 1 MEDICARE & MEDICAID GUIDE (CCH) ¶¶ 1100–1172; 1200–1281.

47. Title XIX, Social Security Act of 1965, Pub. L. No. 89–97, 79 Stat. 343 (codified at 42 U.S.C. §§ 1396–1396k (1976)). Financial need, in combination with other factors, is the primary determinant of eligibility. The federal share of program funding is appropriated annually by Congress from general revenues; the state share is appropriated by state legislatures, who may include local tax revenues as a state funding source. For a synopsis of the Medicaid program, *see* [1979] 2 MEDICARE & MEDICAID GUIDE (CCH) ¶ 14,010.

48. *See* notes 46 & 47 *supra*. Federal law mandates that states provide Medicaid benefits to persons who receive benefits under Title IV-A of the Social Security Act, 42 U.S.C. §§ 601–610 (1976) (Aid to Families with Dependent Children), and either all persons receiving cash benefits under Title XVI of the Social Security Act, 42 U.S.C. §§ 1381–1383c (1976) (Supplemental Security Income), or those who can meet additional, more restrictive eligibility conditions. Eligibility may vary from state to state, as federal matching funds are also available for medical assistance to cover specified optional groups who have incomes higher than the above standards. In any case, however, Medicaid does not cover many people who may be medically needy because of marginal incomes or assets or other circumstances.

49. Not a problem in 1965, when Hill-Burton was dormant, the nature of the relationship became important because of later development.

service, but also a portion of such overhead costs as hospital administration, principal and interest payments on indebtedness for the physical plant, and expenses of non-revenue-generating departments such as social work.[50] And, in almost all hospitals, some portion of total revenues goes to meet the hospital's losses for charity care or bad debts, so that this care is financed by the charges paid by privately insured or cash-paying patients.[51]

In setting the Medicare and Medicaid reimbursement policy, the statutes specified that the government would pay the "reasonable cost" of hospital services provided to beneficiaries.[52] "Reasonable cost" is not the usual charge made to privately insured or cash-paying patients, but is a rate determined to be "reasonable" by the Medicare and Medicaid programs.[53] For example, Medicare might reimburse $75 for a procedure for which a hospital would ordinarily bill $100. The reasonable cost guidelines also described the hospital expenses that could be properly apportioned to the programs. Debt service and interest payments on capital construction loans, for example, are included in Medicare and Medicaid rates;[54] charity care and bad debts are specifically excluded.[55] Although not specified in the enactments, the exclusion of charity care from "allowable costs" was later interpreted by DHEW to mean that Medicare and Medicaid would not share in the cost of providing uncompensated care.[56] By this

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50. *See generally* [1979] II THE HOSPITAL LAW MANUAL 1–8.

51. *Id.* at 23–26. Privately insured and cash-paying patients are differentiated because, in some circumstances, they do not pay identical rates. In most states, for example, Blue Cross/Blue Shield, because of the size of its covered population and its stable payment record, pays a rate somewhat lower than that charged to a cash-paying patient. With only a few exceptions, however, even the discounted rates help to offset charity care losses. Hereinafter, both groups will be referred to as "charge-paying," although the charges made to the respective groups may vary somewhat.

52. *See* 42 U.S.C. § 1395x(v)(1) (1976) (Medicare); *id.* § 1396a(13)(D) (Medicaid). Under both programs, a hospital provider is directly reimbursed for care to beneficiaries.

53. 42 U.S.C. §§ 1814(b), 1833(2) (1976). "Reasonable cost" reimbursement to hospitals is made under the same principles for both programs; the regulations specify that Medicare's hospital reimbursement policies also apply to Medicaid reimbursement. *See* 42 C.F.R. § 442.261 (1979). For a detailed explanation of the reasonable cost concept, see Weiner, *"Reasonable Cost" Reimbursement for Inpatient Hospital Services Under Medicare and Medicaid: The Emergence of Public Control,* 3 AM. J.L. & MED. 1 (1977).

54. 42 C.F.R. §§ 100.101–.109; 405.402–.404; .501–.502 (1979). Debt service is payment to the equity holders of a hospital bond or other debt. Medicare and Medicaid also fund depreciation, *id.* §§ 405.415–.418, *i.e.,* the government pays for depreciation taken by hospitals on their physical plants and equipment.

55. *Id.* § 405.420(a). *Cf.* note 323 *infra* (DHEW's continued insistence that Medicare reimbursement may not contribute to costs of providing Hill-Burton care).

56. DHEW has found that the term "charity care" as employed in the Medicare cost reimbursement regulations applies to uncompensated care delivered under the Hill-Burton Act. *See* note 323 *infra.* A reading of the cost reimbursement regulations, 42 C.F.R. §§ 405.402, .415 (1979), indicates that this is probably an incorrect application of the rule. Hill-Burton uncompensated care is not true charity care, *i.e.,* care rendered as a voluntary philanthropic act for which payment is neither sought nor expected, but is now required by law to be dispensed by a Hill-Burton hospital. *See* 42 C.F.R. §§ 124.501–.607 (1979); Part II *infra.* Rather, the requirement of delivery of uncompensated care is more analogous to

policy, the financial burden of funding uncompensated care was borne by private payors, *i.e.*, charge-paying patients and philanthropy.[57]

At the time of Medicare and Medicaid's enactments, the questions of possible contradictions between these programs and Hill-Burton were abstract. As will be seen, however, the independent development of the Hill-Burton program has transformed these financing questions into practical problems that remain unresolved.

Preliminary Litigation Under the Act

When, in 1970, representatives of the poor began to seek the provision of hospital services via the Hill-Burton Act, they turned to the courts.[58] In *Cook v. Ochsner Foundation Hospital (Cook I),*[59] plaintiffs charged a number of Louisiana Hill-Burton hospitals with failing to fulfill their uncompensated care obligation and asserted that the state health department had failed to enforce the hospitals' compliance. In a preliminary ruling, the court determined that because indigent persons were intended beneficiaries of the Hill-Burton Act they could maintain an action under the statute although the Act contained no specific authorization for private enforcement.[60] In reaching this result, the court stated that it was "not . . . necessary to delve into the legislative history of the Hill-Burton Act . . . [because] the act, by its own terms, makes it plain that persons unable to pay are one of the chief sets of beneficiaries of this legislation."[61] In fact, by this action, the court implied a remedy in the absence of

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interest payments on a capital construction loan: under the Hill-Burton scheme, the Congress determined that it would gather its return on monies dispensed for hospital construction or modernization in the form of the availability of services to the needy rather than by direct repayment. By this analysis, the costs of Hill-Burton uncompensated care should, like ordinary capital construction interest payments, be an allowable cost under Medicare and Medicaid reimbursement.

57. Again, at the time that Medicare and Medicaid were enacted, this problem may have been largely theoretical. As the insurance programs have grown to represent more than 35% of all expenditures for hospital care, *see* Gibson, *National Health Expenditures,* 1978, 1 HEALTH CARE FINANCING REV. 1, 9–12 (1979), and as the Hill-Burton requirements have expanded, *see* Parts II and III *infra,* this lack of coordination has produced financial problems for hospitals.

58. Despite the fact that the Act had been in existence since 1946, compliance litigation did not begin in earnest until the 1970's. *But see* Simkins v. Moses H. Cone Memorial Hosp., 323 F.2d 959 (4th Cir. 1963), *cert. denied,* 376 U.S. 793 (1964) (community service provision permitting "separate but equal" facilities held unconstitutional), *see* note 27 *supra*; Stanturf v. Sipes, 224 F. Supp. 883 (W.D. Mo. 1963), *aff'd,* 335 F.2d 224 (8th Cir. 1964) (Hill-Burton grantee hospital's action in refusing admission to individual did not constitute denial of equal protection).

59. 319 F. Supp. 603 (E.D. La. 1970).

60. This opinion was limited to the consideration of defendants' motion to dismiss on the ground that plaintiffs had no right of action under the statute. *Id.* at 604.

61. *Id.* at 606 (citing 42 U.S.C. § 291(a), *as amended by* Pub. L. No. 88–443, 78 Stat. 447 (1964)).The court analogized the Hill-Burton Act to the Wagner-Peyser Act, 29 U.S.C. §§ 49–49k (1976), which had established a cooperative federal-state program of public employment offices, and had been the focus of a 1969 Florida suit, Gomez v. Florida State Employment Serv., 417 F.2d 569 (5th Cir. 1969). The *Gomez* plaintiffs, who had obtained

any clear statutory language and in the face of unexamined legislative history that was inconsistent with the holding.[62]

Shortly thereafter, a district court in Florida[63] and the United States Court of Appeals for the Tenth Circuit[64] followed the private enforcement ruling of *Cook I*. The community service obligation was challenged for the first time in *Perry v. Greater Southeast Community Hospital Foundation*,[65] in which plaintiffs charged that DHEW, the District of Columbia, and the defendant hospital, in addition to failing to enforce or adhere to the uncompensated care obligation, had ignored the community service obligation. The plaintiffs alleged that the hospital was in violation of the community service regulation because it did not provide sufficient services to residents of southeast Washington, D.C.,[66] a poorer area of the city, and claimed that the supervising agencies should require that

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employment through such a public employment office, had charged that their employer had violated certain regulations under the Act that provided for minimum wages and housing conditions for migrant workers. The Fifth Circuit had looked to the legislative history and regulations to determine that such workers were the expected beneficiaries of the Wagner-Peyser Act, holding that the right of migrant workers to bring a private action under the statute could therefore be implied. *Id.* at 575–76.

62. *See* 42 U.S.C. § 291c (1976); 12 Fed. Reg. 6,176 (final regulations of Sept. 16, 1947, codified at 42 C.F.R. § 53.62–.63 (Supp. 1947)). There were substantial differences in the focuses of the Wagner-Peyser and the Hill-Burton acts, which were not revealed because of the court's failure to probe the legislative history of Hill-Burton. The Wagner-Peyser Act was designed to offer some protections to those workers who moved through the system to various employers, and the regulations promulgated under the act by the Secretary of Labor spoke specifically of required working and living conditions, including sanitation facilities and housing for migrant workers. *See* Gomez v. Florida State Employment Serv., 417 F.2d at 571–73 (discussion of legislative history and regulations).

63. Organized Migrants in Community Action (OMICA) v. James Archer Smith Hosp., 325 F. Supp. 268 (S.D. Fla. 1971). In addition, in this case, DHEW was ordered joined as a party defendant with the hospital and state health agency. *Id.* at 271–72.

64. Euresti v. Stenner, 458 F.2d 1115, 1119 (10th Cir. 1972), *rev'g* 327 F. Supp. 111 (D. Colo. 1971). The circuit court also reversed the lower court's holding that the Act did not create any contractual relationship between the federal government and a grantee hospital. *Id.* at 1118. Further, it overturned the district court's interpretation of the Act's "non-interference" clause, 42 U.S.C. § 291m (1976), which prohibited the federal government from injecting itself into the operation or administration of a grantee hospital. 458 F.2d at 1119. Although the district court had stated that this provision prevented the federal government from maintaining an action to control a hospital's activities, and reasoned that the plaintiffs could have no greater right to compel the hospital's provision of care, 327 F. Supp. 111, 114–15 (D. Colo. 1971), the Tenth Circuit found that the provision "merely bars the attempts of federal officers to interfere with the daily administration of the hospitals in areas not specifically dealt with in the Act" and did not limit plaintiffs' enforcement rights, 458 F.2d at 1119. Other courts have since found that the Hill-Burton Act allowed a private civil action as a means of enforcing the Act's provisions. *E.g.*, Saine v. Hospital Auth., 502 F.2d 1033 (5th Cir. 1974).

65. Civ. No. 725–71 (D.D.C. June 28, 1972) (defendants' motion for summary judgment granted). The suit was filed against the corporation that owned the hospital, the District of Columbia, and DHEW.

66. *See id.*, bench op. at 2–3.

the hospital admit patients in ratios equal to the characteristics of its service area population.[67] In an insightful ruling that reached the merits, the court determined that the negative prohibition against discrimination contained in the community service regulation could not be construed as an affirmative mandate to the hospital to provide the type of redistribution of services suggested by the plaintiffs.[68] In fact, the legislative history indicated that Congress had contemplated an overall plan for the provision of hospital services and had not directed DHEW to take a "hospital-by-hospital" approach.[69] Although the court was critical of the regulatory agencies' failure to give due attention to these planning provisions,[70] it ruled against the plaintiffs' claims, stating that the Act and the regulations set forth no standards under which it could determine if the hospital and the agencies were performing adequately.[71] The *Perry* court thus reached a question that had not been considered by the courts' preliminary rulings in previous cases.[72] That is, even if the legislative history of the Hill-Burton Act were to be construed to confer an implied private right of action, the question of what relief might be fashioned remained unanswered by the statute and regulations.

PART II: METAMORPHOSIS OF THE ACT, 1972-1979

Initial Regulatory Revision: The Uncompensated Care Obligation

Prompted by the sudden flurry of litigation after more than twenty years of inactivity, DHEW began to develop standards for hospital compliance with the uncompensated care obligation. Although challenges to the community service regulation had been presented in the *Perry* case, the agency chose to defer those issues.[73] Informal initial regulations concerning the uncompensated care obligation were drafted in September 1971[74] and formal proposed regulations

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67. *See id.* at 4.

68. *Id.* at 5.

69. *Id.* at 9.

70. *See id.* at 3, 7, 11–12.

71. *Id.* at 5–6. Without standards, the court said, "there is no way that the Court can function except by considering itself as some kind of administrative agency in a rule-making and administrative process, which is not the role of the Court." *Id.* at 6.

72. *See* notes 60 to 64 and accompanying text *supra*. Of the earlier cases, only Cook v. Ochsner Foundation Hospital (*Cook I*), 319 F. Supp. 603 (E.D. La. 1970), continued to judgment on the merits. The later *Cook* rulings are discussed at notes 120 to 132 and 173 to 187 and accompanying text *infra*.

73. *See* 37 Fed. Reg. 14,719 (preface to binding interim regulations of July 22, 1972) (noting that only the uncompensated care obligation would be dealt with in forthcoming regulations).

74. *See* Rose, *supra* note 2, at 174 n.37.

followed.[75] In July 1972 DHEW published binding interim regulations, which were to be effective until final regulations were issued.[76] The binding interim regulations were finalized in June 1973 in largely the same form in which they had been in effect for the previous year.[77]

The final regulations gave Hill-Burton facilities two options for compliance with the uncompensated care obligation. A facility could elect a percentage minimum option, which in turn offered a choice of two different percentage calculations. Alternately, it could choose to comply by adopting an "open door" policy, *i.e.*, pledging that it would turn away no one because of inability to pay.[78] Under the percentage minimum option, a facility's obligation would be presumed to be fulfilled if it budgeted for and made available uncompensated care[79] at a level that equalled, on an annual basis, either three percent of its operating costs (less that portion of operating costs attributable to Medicaid and Medicare patient care) or ten percent of the Hill-Burton assistance received by it, whichever amount was less.[80] Annual compliance reports were required of facilities,[81] and if a facility's report indicated that it had not met its chosen "presumptive compliance" minimum, it would be obliged to submit a plan to increase its uncompensated care level in future years.[82] Since the Act specified

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75. 37 Fed. Reg. 7,632 (proposed regulations of April 18, 1972). Grant program regulations are not subject to the Administrative Procedure Act, 5 U.S.C. § 553 (1976). DHEW, however, has voluntarily bound itself to promulgate all Department regulations under APA procedures, *see* 36 Fed. Reg. 2,532 (1971); thus, all agency regulations are published in the *Federal Register* in proposed form for public comment before they are made final. *See* Rose, *supra* note 2, at 177 n.57.

76. 37 Fed. Reg. 14,719 (binding interim regulations of July 22, 1972). Apparently, binding interim regulations were issued in lieu of the usual final regulations because, *inter alia*, questions existed concerning the procedural validity of regulations issued by the Federal Hospital Council when it was not fully constituted. *See* Perry v. Greater Southeast Community Hosp. Foundation, Civ. No. 725–71, bench op. at 11 (D.D.C. June 28, 1972). DHEW stated that it was issuing binding interim regulations until such time as questions concerning procedural propriety could be removed. *See* 37 Fed. Reg. 14,720 (preface to binding interim regulations of July 22, 1972).

77. 38 Fed. Reg. 16,353 (final regulations of June 22, 1973). The 1972 binding interim regulations, *see* note 76 *supra*, set forth the full text of the regulations. When the final regulations were issued, the unchanged provisions were not reprinted in the *Federal Register*. Thus, with the exception of a few new provisions that are found only in the final issuance, citation hereinafter will be to the binding interim regulations, 37 Fed. Reg. 14,719 (binding interim regulations of July 22, 1972).

78. 37 Fed. Reg. 14,719, 14,721 (binding interim regulations of July 22, 1972, codified at 42 C.F.R. § 53.111(d) (1978)).

79. This term was defined as services rendered "without charge or at a charge which is less than the reasonable cost of such services," *i.e.*, free or below cost care. *Id.* (codified at 42 C.F.R. § 53.111(b)(7)).

80. *Id.* (codified at 42 C.F.R. § 53.111(d)). These options will be referred to as the 3% of operating costs and 10% of grants presumptive compliance minimums.

81. *Id.* (codified at 42 C.F.R. § 53.111(e)(1)).

82. *Id.* (codified at 42 C.F.R. § 53.111(e)(2)(ii)).

that a hospital could be exempted from providing a reasonable volume of uncompensated care "if such requirement is not feasible from a financial standpoint,"[83] the new regulations provided that a facility could, upon demonstration of financial hardship, make application to its state agency for a prospective waiver or decrease of the presumptive compliance minimum.[84] An exempted facility would be required to submit a plan to increase its uncompensated care level in the future.[85]

If a facility elected the open door option in lieu of a percentage minimum, it certified that it would treat all patients regardless of ability to pay for services.[86] The amount and dollar value of uncompensated care dispensed under this option were not subject to any set minimum, and were essentially unregulated by the government.[87]

Upon determining the uncompensated care rate for a particular facility, the state agency charged with enforcing the Hill-Burton requirements was to publish a public notice of the hospital's obligation in a local newspaper.[88] The regulations also directed state agencies to formulate criteria by which hospitals could determine patient eligibility for Hill-Burton care, listing factors that should be included in such guidelines.[89] In addition, the regulations prescribed the proper method for calculating the amounts a hospital could properly credit toward its Hill-Burton obligation: Services rendered to patients for whom a determination of eligibility had been made prior to treatment could be credited, but hospitals were also allowed to count services to persons who were deemed Hill-Burton eligible after treatment but before collection efforts other than billing were instituted.[90] In determining the dollar amount that could properly be credited toward the obligation, the regulations adopted the Medicare "reasonable cost" guideline.[91] Under this standard, a hospital would receive its Hill-Burton credit based on the rate at which the Medicare program would have

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83. 42 U.S.C. § 291c(e)(2) (1976).

84. 37 Fed. Reg. 14,719, 14,721 (binding interim regulations of July 22, 1972, codified at 42 C.F.R. § 53.111(c)(1) (1978)).

85. *Id.*

86. *Id.* (codified at 42 C.F.R. § 53.111(d)).

87. Under the binding interim regulations, a facility electing the open door option was required to report the amount of uncompensated care rendered, supply a proposed budget for such care for the coming year, and propose plans to increase that level upon a finding by the state agency that the previous level was inadequate. 37 Fed. Reg. 14,719, 14,721 (binding interim regulations of July 22, 1972). This requirement was deleted, however, in the final regulations issued in June 1973. *See* 38 Fed. Reg. 16,353, 16,354 (final regulations of June 22, 1973, codified at 42 C.F.R. § 53.111(e) (1978)).

88. 37 Fed. Reg. 14,719, 14,722 (binding interim regulations of July 22, 1972, codified at 42 C.F.R. § 53.111(h)(4) (1978)).

89. *Id.* at 14,721–22 (codified at 42 C.F.R. § 53.111(g)). DHEW stated that the criteria should require consideration of income, insurance coverage, family size, and other financial obligations or resources in relation to the cost of the hospital services provided.

90. *Id.* at 14,721 (codified, as amended, at 42 C.F.R. § 53.111(f)(1)).

91. *Id.* (codified at 42 C.F.R. § 53.111(b)(6), (7)).

reimbursed for the service rendered, not the usually higher charge that the hospital would have billed to a privately insured or cash-paying patient.[92]

In addition to the substantive requirements for facility compliance, the regulations set forth important new provisions for other aspects of the program. First, state Hill-Burton agencies were required to monitor hospital performance and to institute enforcement mechanisms, including sanctions against noncomplying facilities.[93] Second, at the behest of the Federal Hospital Council, an important limitation was placed on the scope of the uncompensated care obligation. The regulations stated that the obligation, and the attendant new regulations, would pertain to a facility for twenty years after the completion of grant-financed construction, *i.e.*, for only that period of time during which the government retained a right of recovery.[94] At the expiration of that time, a facility would be released from its uncompensated care obligation.[95]

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92. *See* note 53 and accompanying text *supra*. In the preface to the binding interim regulations, the Secretary of DHEW attempted to clarify the terms of the previous proposed regulations dealing with the reasonable cost crediting requirements. In fact, the attempted clarification created more confusion regarding the amount that could properly be credited toward a hospital's Hill-Burton obligation. The explanation read:

> The definition of 'uncompensated services' has been changed [from that contained in the proposed regulations, *see* 37 Fed. Reg. 7,632, 7,633 (proposed regulations of April 18, 1972)] to make clear that the level of uncompensated services is measured by the difference between the reasonable cost of the services provided to persons unable to pay therefor and the amount charged such persons for such services.

37 Fed. Reg. 14,719, 14,720 (preface to binding interim regulations of July 22, 1972). By this, the Secretary obviously intended to disallow a hospital's claim for a *free* service credit when it in fact had provided only below cost service (*i.e.*, the patient had paid some portion of the bill), but the actual effect of the "clarification" was quite the opposite. This led some facilities, and some judges, to believe that it was permissible, when supplying services to Medicare or Medicaid patients, to properly charge against the Hill-Burton obligation the difference between the usually higher charge for the service and the lesser "reasonable cost" reimbursement that was made to the hospital by the government. *See, e.g.*, Newsom v. Vanderbilt Univ., 433 F. Supp. 401, 418 (M.D. Tenn. 1978); note 234 and accompanying text *infra*; Cook v. Ochsner Foundation Hosp. (*Cook III*), Civ. No. 70-1969 (E.D. La. March 12, 1975); text accompanying note 185 *infra*.

93. 37 Fed. Reg. 14,719, 14,722 (binding interim regulations of July 22, 1972, codified at 42 C.F.R. § 53.111(i) (1978)).

94. *Id.* at 14,720 (codified at 42 C.F.R. § 53.111(a)). In the case of a Hill-Burton loan or loan guarantee, the obligation would exist for only the period during which the loan remained unpaid. *Id.* It appears that this limitation was imposed because of the Council's perception that the entire contractual agreement between the government and a funded hospital expired 20 years after the completion of Hill-Burton financed construction. *See* note 43 *supra; accord, AHA District Court Complaint, supra* note 43, affidavit of Pat N. Groner, former member of the Federal Hospital Council, at 1. This provision of the 1972 regulations applied retroactively, so that hospitals that had received Hill-Burton grants from 1947 through 1952 were exempted from the new uncompensated care compliance standards.

95. The preface to the final uncompensated care regulations of 1973 reveals that DHEW attempted, without success, to persuade the Federal Hospital Council to delete this time limitation. *See* 38 Fed. Reg. 16,353 (preface to final regulations of June 22, 1973). DHEW was similarly rebuffed in its attempt to convince the Council that state

The regulations that became effective in 1972 and 1973 satisfied neither indigent plaintiff groups, who had expected more from DHEW,[96] nor hospitals, who had hoped for less regulation.[97] Regardless of the perspective from which they were viewed, however, it is clear that the regulations changed significantly many of the assumptions under which Hill-Burton hospitals had operated. After twenty-five years, the first quantification of the "reasonable volume" of uncompensated care term and the institution of the specific provisions for cost calculation, patient eligibility determination, reporting and enforcement had dramatically altered the nature of the contract under which Hill-Burton hospitals had received federal money. The vague obligation to treat the needy had been transformed into specific requirements. Underlying these changes, however, were more subtle and powerful shifts in the government's conceptualization of the Hill-Burton Act.

First, DHEW had ignored the interpretation of the statute in the *Perry* case, wherein the court had noted that it did not appear that Congress had intended a hospital-by-hospital approach to regulation,[98] and had focused only on individual facilities. That is, the Act's attention to area-wide needs *through* individual hospitals was redefined by the regulations, which were concerned only with the amount of uncompensated care dispensed *by* an individual facility.[99] The regulations compounded this error and further eroded the concept of area-wide needs by setting a uniform compliance standard. The percentage options were

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Hill-Burton agencies should be permitted to demand volumes of uncompensated care higher than the 3% of operating costs or 10% of grants presumptive compliance minimums of hospitals that could afford to meet higher levels of need in their communities. The proposed uncompensated care regulations, *see* 37 Fed. Reg. 7,632, 7,633 (proposed regulations of April 18, 1972), had permitted this action, but the provision was deleted in the binding interim regulations, *see* 37 Fed. Reg. 14,719, 14,722 (binding interim regulations of July 22, 1972, codified at 42 C.F.R. § 53.111(h)(1) (1978)).

96. *Cf.* Rose, *supra* note 2, at 174–78 (chronology of decline in required levels of uncompensated care through the draft, proposed and binding interim regulations preceding final issuance).

97. Although hospitals were subject to less of an uncompensated care burden under the final regulations than they would have borne under previous proposals, the final issuance did set standards for compliance that had not been present before.

98. Perry v. Greater Southeast Community Hosp. Foundation, Civ. No. 725–71, bench op. at 9 (D.D.C. June 28, 1972).

99. It would seem that the recent decisions of the federal courts, which DHEW had acknowledged had prompted its promulgation of regulations, *see* 37 Fed. Reg. 14,719, 14,720 (preface to binding interim regulations of July 22, 1972), may have been influential in this regard, if only because all four suits involved individual hospitals. This may have biased DHEW's selection of the regulatory paradigm of individual hospitals, which was already appealing because of the practicalities of administering the regulations. Hospitals were, after all, the ultimate grantees and contractees under the Act, *see* 42 U.S.C. §§ 291c, f, & j (1976); they had been determined by several federal courts to be proper parties in enforcement actions, *cf.* notes 59 to 72 and accompanying text *supra* (cause of action existed against grantee hospitals); and they were established bureaucracies that could be easily monitored for compliance. In theory, however, this hospital-by-hospital regulatory scheme obscured and undercut the Act's focus on area-wide accessibility of care.

based solely on a facility's operating costs or the size of its Hill-Burton grant,[100] not on the needs of the community surrounding the hospital, much less larger area-wide concerns.

The open door option, which could be selected by a facility as an alternative to a percentage compliance option, could, in theory, have comported with the Act's focus on a need for area-wide care. DHEW's attempt to be responsive, however, left much to be desired. It left the choice of a percentage compliance minimum or open door option in the hands of a grantee hospital, without attempting to coordinate facilities' choices with one another or with area-wide needs.

A second major reinterpretation of the Act occurred in the definition of the term "uncompensated services" and the omission of previous references to the permissible practice of reimbursement by outside sources for services to charity patients.[101] Under the new regulations only expenses for which a hospital was not reimbursed could be properly credited toward its Hill-Burton obligation. Furthermore, the regulations did not address the financing issue that had been raised by the 1965 Medicare and Medicaid enactments; no provision was made whereby the rates paid by the government through these programs would help to pay for the volume of uncompensated care that hospitals were now required to provide.[102] By forbidding both charity reimbursement and government subsidy as a means of financing the required uncompensated services, the regulations placed the entire financial responsibility for uncompensated care on grantee hospitals as a sort of *quid pro quo* for federal assistance that was never contemplated by the statute.[103] In turn, hospitals were faced with the prospect of either finding some way to absorb these costs, or passing them along to charge-paying patients in the form of higher rates for subsidization of an increased uncompensated care obligation.

Thus, the regulations, taken as a whole, began the evolution of the Hill-Burton Act from a "first step" national hospital construction program into the first step toward the establishment of an unfunded national program for the provision of medical services to the indigent. As indicated by the legislative history of the Act, particularly by the relatively small amount of inconclusive discussion in committee concerning a funding mechanism for services to

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100. 37 Fed. Reg. 14,719, 14,721 (binding interim regulations of July 22, 1972, codified at 42 C.F.R. § 53.111(d) (1978)). The only exception to this standard allowed a hospital to seek permission to establish a lower percentage level if compliance was not financially feasible. *Id.* (codified at 42 C.F.R. § 53.111(c)(1)).

101. *Compare id.* (codified at 42 C.F.R. § 53.111(b)(7)) *with* 12 Fed. Reg. 6,176, 6,179 (final regulations of Sept. 16, 1947, codified at 42 C.F.R. § 53.63 (Supp. 1947)). *See also* text accompanying note 35 *supra.*

102. *See* 37 Fed. Reg. 14,719, 14,720–22 (binding interim regulations of July 22, 1972, codified at 42 C.F.R. § 53.111(b) (1978)). *See also* text accompanying note 56 *supra.*

103. As noted, in hearings on the original Act, eventual state or federal funding for indigents' medical care was anticipated. *See, e.g., 1945 Hearings, supra* note 12, at 188–91, 211, 286. *See also* note 20 *supra.*

indigents,[104] and the language of the statute itself, which made only general reference to the issue,[105] this was not the intent of the Act.

Moreover, DHEW's failure to consider the interrelationships of Hill-Burton and Medicare and Medicaid continued the previous lack of coordination between the programs. In the 1972 regulations, the only recognition of the existence of the Medicare and Medicaid programs was the fact that the calculation of the three percent of operating costs percentage compliance minimum exempted those operating costs attributable to Medicare and Medicaid patient care.[106] By implication, however, the 1972 regulations did clarify the other issue raised by the insurance programs' enactments: It was now clear that the uncompensated care obligation had not been supplanted by the Medicare and Medicaid programs, *i.e.*, treatment of patients under these programs did not fulfill a hospital's uncompensated care obligation.

Despite the changes demanded by the 1972 and 1973 regulations, it appears that they precipitated minimal modification of actual program operation. It appears that most state agencies, responsible for supervision and enforcement of the regulations, did not regard the new terms as mandating any major redirection of their previous activities.[107] Most hospitals elected the open door compliance option, apparently with the understanding that this option permitted them to continue whatever charity care policies had previously been in effect.[108] This understanding was, in at least some instances, fostered by the state agencies.[109] In any case, under the open door option regulation such hospitals were freed from reporting the amount of uncompensated care delivered,[110] so the agencies had no means to gauge performance. As a rule, with regard to this and other elements of the uncompensated care regulations, the pre-1972 attitude prevailed and the new requirements were largely ignored.

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104. *See* note 28 and accompanying text *supra*.

105. *See* Title VI, Pub. L. No. 79–725, 60 Stat. 1040 (1946).

106. *See* 37 Fed. Reg. 14,719, 14,721 (binding interim regulations of July 22, 1972, codified at 42 C.F.R. § 53.111(b)(4), (d) (1978)).

107. *See* Rose, *supra* note 2, at 181–94.

108. *Id.* at 190 (citing 1974 report showing that approximately 60% of facilities had chosen the open door option); *AHA District Court Complaint, supra* note 43 (appended affidavits attesting that grantees understood that the 1972 uncompensated care regulations required no substantial change in the volume of charity care that hospitals had been providing prior to the regulation).

109. *See AHA District Court Complaint, supra* note 43 (appended affidavits of present and former state Hill-Burton agency administrators attesting that their state agencies had understood that the uncompensated care regulations required no substantial change or modification in the amount of charity care that hospitals were required to dispense).

110. *See* 38 Fed. Reg. 16,353, 16,354 (final regulations of June 22, 1973, codified at 42 C.F.R. § 53.111(e) (1978)). This waiver from reporting was an additional advantage of the open door option as it accorded hospitals the most administrative flexibility. *See* text accompanying notes 86 & 87 *supra*.

Regulatory Development through Litigation: Judicial Influence on the Uncompensated Care and Community Service Obligations

The 1972 uncompensated care binding interim regulations were attacked by indigent plaintiffs soon after their promulgation. In *Corum v. Beth Israel Medical Center (Corum I)*,[111] plaintiffs contended that the regulations were invalid in their entirety because the veto authority granted by the Act to the Federal Hospital Council was an unconstitutional delegation of legislative power. Alternately, they claimed that several provisions were invalid because of their inconsistency with the Act's purpose.[112] In addition, they contended that Hill-Burton funding for one portion of a facility — in Beth Israel's case, a new rehabilitation clinic — necessarily mandated the provision of free or below cost services throughout the entire hospital.[113] The defendants asserted that the Act required the provision of services only in the federally funded portion of the facility.[114] Deferring the invalidity issues,[115] the court ruled on Beth Israel's motion to dismiss the distribution of services count, holding that the Act required a recipient facility "to provide such services in such portion or portions of its facility as will constitute a reasonable volume in light of the needs of the community and the amount of the grant."[116] From the premise that the Act's purpose was "'to furnish adequate hospital, clinic, or similar services,'" the court declared that grantee hospitals could not designate only one portion of their facility and provide only one type of service.[117] On the other hand, the section of the Act that made reference to the availability of a reasonable volume of charity care "'in the facility or portion thereof to be constructed or modernized'" with federal funds indicated that enforcement agencies "need not require services to be provided in the entire facility."[118]

Corum I was the first instructionary interpretation of the Hill-Burton Act. The ruling implied that the Act permitted but did not require DHEW to demand

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111. 359 F. Supp. 909 (S.D.N.Y. 1973) (class action against hospital and DHEW; defendants' motion to dismiss denied).

112. *Id.* at 911–12.

113. *Id.* at 917.

114. *Id.*

115. The invalidity claims had been made by the plaintiffs while the binding interim regulations, 37 Fed. Reg. 14,719 (binding interim regulations of July 22, 1972), were in effect. Subsequent to the filing, final regulations were promulgated. 38 Fed. Reg. 16,353 (final regulations of June 22, 1973). In the first portion of the opinion the court reviewed plaintiffs' motions to supplement the complaint to reflect these developments. It granted leave to file a new complaint attacking the delegation of authority to the Federal Hospital Council and challenging the substantive validity of the final regulations. 359 F. Supp. at 913–14.

116. 359 F. Supp. at 917. Otherwise, the court said, it would be "impossible to require any services of a facility whose nursing residence, for example, [was] constructed with federal funds." *Id.*

117. *Id.* (quoting 42 U.S.C. § 291 (1976)). The court found that the Act did not delegate this discretion to a recipient facility.

118. *Id.* (quoting 42 U.S.C. § 291c(e)(2) (1976)).

Hill-Burton care throughout the facility. Most important, however, was the court's misconstruction of the statute, which led it to assume that the Act's purpose was to furnish services. This finding marked a further step in Hill-Burton's transformation from a construction and modernization program to a service provision program.

By this time, DHEW was involved in other regulatory changes, which had been precipitated by developments in *Cook v. Ochsner Foundation Hospital (Cook I)*.[119] In *Cook II*,[120] a new charge under the community service obligation[121] attacked the hospitals' admission practices[122] and sought to compel DHEW enforcement of the community service requirements of the Act and the regulations by prohibition of the policy.[123] DHEW's response to this challenge was in sharp contrast to its response to the uncompensated care suits, where it acquiesced readily to general calls for regulation.[124] The agency defended on statutory interpretation grounds and did not contest any of the factual allegations relating to the hospitals' admissions policies. First, DHEW claimed that since promulgation of any community service regulation was discretionary under the Act, enforcement of the existing community service regulation was similarly discretionary.[125] In effect, DHEW argued, the greater power of

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119. 319 F. Supp. 603 (E.D. La. 1970). *See* notes 59 to 62 and accompanying text *supra*.

120. 61 F.R.D. 354 (E.D. La. 1972).

121. The general terms of the original community service regulation, 12 Fed. Reg. 6,176, 6,179 (final regulations of Sept. 16, 1947, codified at 42 C.F.R. § 53.62 (Supp. 1947)), remained in effect, although the regulation had been amended to reflect the deletion of the "separate-but-equal" facilities provision from the statute. *See* 42 C.F.R. § 53.112 (1971); note 27 *supra*.

122. Plaintiffs attacked, as invalid under the requirement of the Act and regulations that Hill-Burton facilities be "made available to all persons residing in the territorial area," the hospitals' admitted discrimination in admissions against Medicaid patients and their requirements that patients be admitted by a private physician with hospital staff privileges. 61 F.R.D. at 358–59 (referring to 42 U.S.C. § 291c(e) (1976)).

In *Cook I*, the plaintiffs had charged the hospital and the state agency with failure to adhere to or enforce the uncompensated care obligations. Cook v. Ochsner Foundation Hosp. (*Cook I*), 319 F. Supp. 603 (E.D. La. 1970) (defendants' motion to dismiss denied). The amended complaint added DHEW as a defendant.

By an interim consent order in August 1973, the uncompensated care claims against the defendant hospitals and the state Hill-Burton agency were settled. 61 F.R.D. at 356–57. The published opinion includes the text of the consent order. By its terms, the defendant hospitals agreed to provide specific dollar amounts of charity care on an annual basis, and to develop programs to increase their participation in the Medicaid program, and the state health agency agreed to supervise hospital compliance.

123. 61 F.R.D. at 359. Implicit in these charges was the plaintiffs' objective of forcing DHEW to draft new community service regulations to supercede the terms of the 1947 regulations.

124. *See* notes 78 to 95 and accompanying text *supra*. *See also* note 156 *infra*.

125. The Act stated that DHEW "*shall* by general regulations prescribe . . . that the State plan *shall* provide for adequate hospitals and other facilities . . . . Such regulations *may also* require that before approval of an application . . . [assurance shall be received that the facility] . . . will be made available to all persons residing in the territorial area . . . ." 42 U.S.C. § 291c(e) (1976).

discretion to issue a regulation included the lesser power of discretion to enforce an existing regulation. The court disagreed, finding that since DHEW had promulgated a community service regulation, it "owe[d] the plaintiffs the obligation" to enforce it.[126]

DHEW then contended that the community service regulation was limited to prohibiting " 'discriminatory admission practices resulting in an absolute exclusion of certain segments of the public,' "[127] *i.e.*, racial discrimination as prohibited by the Act.[128] The court, however, turned that choice of words back on the agency and found that DHEW's failure to issue regulations prohibiting discrimination against Medicaid patients resulted in their absolute exclusion from services, a "clear violation" of the language and intent of the Hill-Burton Act.[129] It ordered DHEW to require "that Hill-Burton recipients participate in the Medicaid Program and refrain from excluding persons on the basis that they are recipients of Medicaid."[130]

The court had thus concluded that the language of the 1946 Act contemplated another federal health program that was not enacted until 1965.[131] The singular focus of this ruling was the community service requirement; the court did not recognize the financial relationship between Medicaid and Hill-Burton's uncompensated care requirement. The court's ruling meant that hospitals were required to participate in a government insurance program the payments under which did not help to offset the costs of providing care to other patients under the Hill-Burton uncompensated care requirement.[132] Although the court accomplished the favorable result of improved access to hospital care by Medicaid patients, its decision was based on faulty analysis of the Hill-Burton Act and was made in isolation from broader questions concerning the relationship of the Hill-Burton program to other health care initiatives. *Cook II*'s activism in ordering a regulatory change was another step in the courts' role in shaping the Hill-Burton regulations, far exceeding the interpretations of the early private enforcement rulings, and going beyond *Corum I*'s interpretation of the Act and the uncompensated care regulations.

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126. 61 F.R.D. at 360.

127. *Id.* (quoting DHEW brief).

128. *See* Title VI, Pub. L. No. 79–725, § 622(f), 60 Stat. 1041 (1946).

129. 61 F.R.D. at 360–61.

130. *See* 39 Fed. Reg. 31,766 (preface to final regulations of Aug. 30, 1974), quoting the decree in Cook v. Ochsner Foundation Hosp. (*Cook III*), Civ. No. 70–1969 (E.D. La. May 29, 1973), which was issued separately from the published opinion.

131. *See* note 47 *supra*. Although one commentator has argued that some of the legislative history of the 1964 Hill-Burton amendments (which had not altered the wording of the 1946 community service obligation) indicated "congressional awareness that . . . the requirement . . . might be interpreted, in later years, to refer to issues other than racial discrimination," Rosenblatt, *supra* note 22, at 280 (citing 1964 Hill-Burton amendments, Pub. L. No. 88–443, § 603(e), 78 Stat. 447 (1964)), even this reasoning provides little justification for the court's finding that the actual text of the Act prohibited discrimination against Medicaid beneficiaries.

132. *See* notes 56 & 57 and accompanying text *supra*.

Nine months after *Cook II*, DHEW issued proposed regulations dealing with the community service obligation.[133] The proposal provided that Hill-Burton hospitals would be required to participate in the Medicare and Medicaid programs and, like the uncompensated care regulations, required a state plan for review, evaluation, and enforcement.[134] The final regulations, binding as of the August 1974 publication date, repeated the proposed regulations and acknowledged the role of *Cook II* in prompting their issuance.[135] The plenary authority of the Federal Hospital Council was again exercised, however, by the addition of a twenty-year time limit on facilities' community service obligation.[136] This provision, like the identical limitation on the uncompensated care obligation, was apparently added over the objection of the Secretary.[137]

Thus, almost three years after the lack of enforcement of the community service obligation had first been raised in *Perry v. Southeast Community Hospital Foundation*,[138] DHEW had promulgated binding regulations concerning the requirement. These regulations, and the court order mandating them, further entrenched the perception of Hill-Burton as a service-provision statute, and reiterated the notion that hospitals could properly be subject to redefinition and expansion of the terms of their original Hill-Burton obligations. Furthermore, issuance of the new court-ordered community service standards set a precedent for judicial regulation under the Act and took the step of linking receipt of Hill-Burton funds with Medicare and Medicaid. The linkage was imperfect, however, because DHEW, like the *Cook II* court, ignored the financial impact of this policy change.

Even before the new community service regulations became effective, however, reargument in the case of *Corum v. Beth Israel Medical Center*[139] had produced another opinion on the uncompensated care issue. In *Corum II*,[140] the court faced the plaintiffs' claims that the uncompensated care regulations were

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133. 39 Fed. Reg. 1,446 (proposed regulations of January 9, 1974).

134. *Id.* at 1,447.

135. *Id.* at 31,766 (preface to final regulations of Aug. 30, 1974).

136. *See id.* at 31,767 (codified at 42 C.F.R. § 53.113(a) (1976)). For facilities that had received a Hill-Burton loan or loan guarantee the community service obligation existed for the period during which the loan remained outstanding.

137. *See id.* (preface to final regulations of Aug. 30, 1974). According to one commentator, "The sole reason given by the Federal Hospital Council for inserting this limitation was consistency with the . . . [uncompensated care] . . . regulation." Rose, *supra* note 2, at 180 n.3. *See also* note 43 *supra*. Like the uncompensated care time limitation, the exemption did not account for a hospital's past service to Medicaid patients or the need in the community. The effect was substantially the same as the previous time limitation in that hospitals built with grants between 1947 and 1954, and hospitals that had repaid their loans were not bound by the regulations to accept Medicaid patients.

138. Civ. No. 725–71 (D.D.C. June 28, 1972). *See* notes 65 to 71 and accompanying text *supra*.

139. 359 F. Supp. 909 (S.D.N.Y. 1974). *See* notes 111 to 118 and accompanying text *supra*.

140. Corum v. Beth Israel Medical Center (*Corum II*), 373 F. Supp. 550 (S.D.N.Y. 1974).

totally invalid because the Act's requirement of Council approval of regulations constituted a delegation of legislative power to a private body not subject to the control of Congress or the Secretary.[141] The motivation for this challenge was undoubtedly plaintiffs' perception that the Council was biased in favor of hospital interests[142] and their cognizance of the dissension between DHEW and the Council on several important provisions of the regulations.[143] The court, although recognizing the Council's veto power, did not agree that the delegation was constitutionally defective. The Council did "not itself make regulations," but held only approval authority.[144]

Thus defeated in their attempt for total invalidation, the plaintiffs argued that several provisions of the uncompensated care regulations were inconsistent with Congress' purpose in enacting the Hill-Burton Act. First, they claimed, the Act did not permit a uniform compliance requirement based on hospitals' operating costs or the amount of the Hill-Burton grant. Rather, the intent in the Act was to predicate the "reasonable volume" determination for a given hospital on the uncompensated care needs of the surrounding community.[145] Alternately, the plaintiffs asserted, even if a percentage compliance concept were valid, the three percent of operating costs or ten percent of grants figures that had been established by the regulations were arbitrary and set an artificial limit on the amount of care that a hospital was required to provide.[146] The plaintiffs also challenged the validity of the time limitation on the uncompensated care

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141. *Id.* at 552.

142. *Cf.* Rose, *supra* note 2, at 168, 176 (regulators may become "captives" of regulated interests). The statute required that 6 of the 12 members of the Council be "persons who are outstanding in fields pertaining to medical facility and health activities" and the remaining 6 members be consumer representatives. 42 U.S.C. § 291k(a) (1976). In another regulatory challenge, it was asserted that some of the regulations should be invalidated because of the conflicts of interest of some Council members who were administrators of grantee hospitals that stood to benefit from the Council's actions. Cook v. Ochsner Foundation Hosp. (*Cook III*), Civ. No. 70–1969 (E.D. La. March 12, 1975). *See* text accompanying note 174 *infra*.

143. It was clear that the Council had forced the Secretary to delete from the final uncompensated care regulations the original provision that would have allowed a level of charity care higher than the 3% of operating costs or 10% of grants figure to be demanded of hospitals that had both greater community needs and the financial resources to meet them. *See* note 95 *supra*. Also, it appeared that the time limitation on both the uncompensated care and community service obligations had been added by the Council over DHEW objection. *See* notes 95 & 137 and accompanying text *supra*. Furthermore, as the *Corum II* court noted, it appeared that the provision allowing hospitals to delay patient eligibility determinations until after treatment and billing had been added over DHEW objection. 373 F. Supp. at 552 (referring to 37 Fed. Reg. 14,719, 14,721 (binding interim regulations of July 22, 1972, codified at 42 C.F.R. § 53.111(f) (1978))).

144. 373 F. Supp. at 553. The court relied on a number of Supreme Court decisions that had approved Congressional action that "'merely placed a restriction upon its own regulation.'" *Id.* (quoting Currin v. Wallace, 306 U.S. 1, 15 (1939)).

145. 373 F. Supp. at 553–55.

146. *Id.* at 556.

obligation and the provision that allowed a hospital to delay patient eligibility determinations until after billing.[147]

At this point the complicated course of Hill-Burton history since 1970 began to limit the options available to the plaintiffs, the defendants, and the courts. The court began by noting that a "long line of cases" commanded judicial deference to agency interpretation of a statute, which was not to be invalidated except in extraordinary circumstances.[148] Further, although the court recognized that community need was one factor in determining the level of uncompensated care, it reasoned that a regulatory scheme based totally on community need, without regard for operating costs, the size of the grant, or a hospital's financial condition, would have the potential to discourage hospitals' acceptance of Hill-Burton funds for expansion and improvement. The court declined to hold that the presumptive compliance guideline would be reasonable in its application to *all* Hill-Burton facilities, but did find it reasonable in its application to Beth Israel.[149]

Again reiterating the narrowness of its holding, the court found that the time limitation as applied to Beth Israel bore a reasonable relationship to the ends of the statute. The plaintiffs had argued that absence of a statutory time limitation on the uncompensated care obligation showed the regulations to be invalid, but the court said that the Act's silence could also be interpreted as consistent with Congressional desire to leave the task of defining the obligation to DHEW and the Federal Hospital Council. Also, the combination of the presumptive compliance guidelines and the twenty-year limitation produced a result that was "reasonable given the size of the grant."[150]

The court sustained plaintiffs' third regulatory challenge, however, striking down the regulation that allowed a hospital to delay determination of a patient's Hill-Burton eligibility until after billing. It noted that the delay might deter poor persons from seeking medical care because of uncertainty about their ability to pay, or might result in a patient's exclusion from eligibility if the hospital's obligation was satisfied by the time of billing. The court concluded that permitting hospitals to count bad debts toward their Hill-Burton obligations was contrary to statutory intent, which it characterized as the provision of services to those who were " 'unable,' not merely unwilling to pay."[151]

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147. *Id. See* 37 Fed. Reg. 14,719, 14,720–21 (binding interim regulations of July 22, 1972, codified at 42 C.F.R. § 53.111(a) and (f) (1978)). The theory for the latter challenge was that delayed determinations violated the Act's purpose by permitting a hospital to count bad debts and uncollectible accounts toward its Hill-Burton obligation. *See* 373 F. Supp. at 557; text accompanying note 151 *infra*.

148. 373 F. Supp. at 554.

149. *Id.* at 556. Beth Israel's grant was relatively new, and a substantial portion of the 20-year time period remained outstanding. It appears that the court did not want to speculate on the validity of the 3% of operating costs or 10% of grants presumptive compliance minimums as applied to older Hill-Burton facilities where only short times remained in the obligation period.

150. *Id.* at 556–57.

151. *Id.* (emphasis in original).

In September 1974, almost nine months after *Corum II*, DHEW sent a memorandum to state agencies informing them that the "billing provision" had been found invalid, and setting forth a revised provision to be enforced until formal rule-making ensued.[152] In March 1975, proposed regulations announced new standards for patient eligibility determination prior to treatment.[153] In conjunction with the prior determination standard, DHEW proposed a requirement that facilities post notices on their premises to inform patients of the availability of uncompensated care.[154]

The *Corum II* decision was thus another step in the process by which certain aspects of the Hill-Burton Act were being defined with increasing precision, but its importance extended beyond the fact that it had prompted another regulatory change. The decision began the process by which the courts, exercising their legitimate authority over DHEW's regulatory interpretations of the Act, shaped the development of a set of regulations that are neither reflective of the Act's original purpose nor sound from a health care policy perspective. In theory, the principles of judicial review of administrative action operate to give deference to agency subject matter expertise, and to check clear instances of agency overreaching.[155] As illustrated by *Corum II*, however, application of these principles was particularly unsuited to Hill-Burton, where DHEW had issued regulations in a haphazard fashion, isolated from other health policy issues, so that the regulations were less the progeny of agency expertise than of chance. The courts' role in interpreting the meaning of the Act only contributed to this problem, as DHEW continued to react to decisions made by judges whose sole focus was the Act because they could not take cognizance of broader policy implications. *Corum II*, like other decisions that would follow it, placed DHEW in the position of reacting to the interpretation of the Act instead of initiating a policy-oriented approach to interpretation by which, ideally, the agency could have coordinated the generation of regulations with the other health care developments and programs under its aegis.[156]

152. Notification Memorandum from Director, DHEW Division of Facilities Utilization, Health Resources Administration (Sept. 5, 1974).

153. *See* 40 Fed. Reg. 10,686 (proposed regulations of March 7, 1975).

154. *Id.* Apparently, DHEW believed that posted notice would make potentially eligible patients seek Hill-Burton information and that this, in turn, would make prior determination an easier task.

155. *See generally* K. DAVIS, ADMINISTRATIVE LAW OF THE SEVENTIES § 29.01–1 (1976).

156. No legal reasons exist for DHEW's repeated deferral to district court interpretations of the Act and its failure to pursue appellate relief in these and later cases. Rather, the explanation probably lies with the political and organizational nature of the agency. DHEW is one of the more political federal agencies, dealing as it does with many human service programs that are subject to rapid change with political shifts. This political malleability may have made DHEW less willing than other agencies to stand by its positions and to pursue further judicial review. Also, DHEW may have been reluctant to appeal in the Hill-Burton cases because of its own "dirty hands," *i.e.*, its failure to promulgate any meaningful regulations until pushed to do so by the courts may account for its defensive stance in subsequent suits. Moreover, because the expenses of compliance were borne by grantee hospitals, the government had little economic incentive to appeal the rulings on the new Hill-Burton regulations; DHEW's costs were limited to those incurred in redrafting and enforcing the regulations.

Congressional Input

While DHEW was reacting to the *Corum II* ruling, another significant development took place with Congress' enactment of Title XVI of the Public Health Service Act,[157] known as the new Hill-Burton Act. The new Act was important to facilities funded under Title VI, the original Hill-Burton Act,[158] because many of the provisions of the new title were made applicable to these older facilities. Although the 1946 Act was not repealed, no appropriations have been made under it since 1974.[159] Title VI retains vitality in that provisions not superceded by Title XVI continue to apply to facilities funded under it.

In authorizing grants and loans to health facilities, Title XVI preserved the uncompensated care and community service obligations. The new Act specified, however, that these obligations would apply "at all times" after the receipt of Title XVI funds.[160] The new statute placed total regulatory authority for *both* Title XVI and the original Title VI with the Secretary of DHEW, and by omission abolished the role of the Federal Hospital Council in Title VI regulation.[161] DHEW's authority to determine the manner in which Title VI-assisted facilities were to comply with their uncompensated care and community services requirements was limited, however, by the new Act's specification that Title VI facilities were to be regulated to comply with the contractual assurances they had given "at the time [Hill-Burton] assistance was received."[162] Title XVI expanded the role of DHEW, making it the primary enforcer of Title VI compliance and limiting the enforcement role of state agencies.[163] Although Congress specifically added that a private right of action

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157. Title XVI of the National Health Planning and Resources Act of 1974, Pub. L. No. 93-641, 80 Stat. 2258 (codified at 42 U.S.C. §§ 300o-300t (1976)).

158. *See* 42 U.S.C. §§ 291-291o (1976).

159. *See* 43 Fed. Reg. 49,954 (preface to proposed regulations of Oct. 25, 1978) (DHEW explanation of cessation of Title VI funding).

160. 42 U.S.C. § 300o-3(b)(1)(J) (1976).

161. *Id.* § 300o-1.

162. *Id.* § 300o-1(6). By this phrase, it would appear that Congress intended that the 20-year time limitation on the uncompensated care and community service regulations would continue for Title VI facilities. The time limitation, although not a term of many of the original contracts, had been added by DHEW regulations, *see* notes 94 & 95, 136 & 137 and accompanying text *supra*, and, in the case of the time limitation on the uncompensated care obligation, had been upheld by a federal court. *See* Corum v. Beth Israel Medical Center (*Corum II*), 373 F. Supp. 550 (S.D.N.Y. 1974); text accompanying note 150 *supra*.

163. DHEW was given complete authority for Title XVI enforcement. The new Act required DHEW periodically to investigate Title VI- and XVI-assisted facilities to ascertain their compliance with their obligations, and permitted the agency to invoke sanctions, including a request to the Attorney General to bring an action for specific performance against a noncomplying facility. 42 U.S.C. § 300p-2 (1976).

would exist for enforcement of hospitals' assurances, it limited that right by mandating a preliminary administrative complaint process through DHEW.[164]

The adoption of Title XVI has been viewed by some commentators as Congressional affirmation of the growth and direction of the Hill-Burton regulations between 1972 and 1975, a sort of *ex post facto* expression of the legislative purpose of the original Act.[165] Unquestionably, Congress did not use the enactment of Title XVI as an opportunity to disavow or disapprove the evolution of the Hill-Burton uncompensated care and community service requirements. In fact, quite the opposite happened: Not only did the legislature validate the perception of Hill-Burton as a service-provision statute, but it added many of the new provisions in Title XVI because of dissatisfaction with enforcement agencies' behavior.[166]

The explanation for this action, however, is unclear. It may be that Congress simply fell prey to the change in perception of Hill-Burton's function; that is, that the metamorphosis of the requirements by the courts and DHEW caused Congress to join the ranks of the other government branches that had viewed Hill-Burton as a service-provision vehicle. As an elected body, Congress was presumably more responsive than the courts or government agencies to testimony in hearings, which cited examples of hospitals' failure to comply with the regulations and of indigent persons with urgent medical needs being turned away despite Hill-Burton eligibility. In the course of the hearings, witnesses and representatives criticized DHEW and the state agencies for their lack of enforcement of the regulations that had existed since 1972.[167] The emotional spectre of poor persons who had been denied medical care through facility noncompliance and agency callousness may have been a factor in Congress' decision to ratify the course of the Act's development.

A somewhat more sophisticated speculation would grant that at least some members of Congress understood that the original Act had never been intended as a service-provision statute, but were not displeased with its development in that direction. The regulations, in effect, had grown into a privately funded source of medical care for indigents who were not Medicare or Medicaid

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164. An individual could file a complaint with DHEW charging facility noncompliance; if the Secretary dismissed the complaint or the Attorney General did not bring an action within the six-month period, the complainant could then initiate legal action. *Id.* Whether this administrative process was a condition precedent to suit under Title VI was the subject of rulings in later cases. *See* notes 191 & 220 and accompanying text *infra*.

165. *See* Rosenblatt, *supra* note 22, at 285; *cf.* 11 CONN. L. REV. 248, 251 (1979) (Congressional dissatisfaction with enforcement of and compliance with Act prompted enactment of Title XVI).

166. *See* S. REP. NO. 93-1285, 93d Cong., 2d Sess. (1974), *reprinted in* [1974] U.S. CODE CONG. & AD. NEWS 7842, 7845.

167. *Id.* at 7899-7900.

eligible.[168] Thus, continuation of the uncompensated care requirements cost the government nothing and could serve to relieve some pressure for expansion of Medicare or Medicaid benefits, which would have required additional government expenditure. Moreover, the community service obligation, which required Hill-Burton hospitals to accept Medicare and Medicaid patients,[169] had the effect of broadening acceptability of the programs.

Such an economic analysis would have made Title XVI, and its implied ratification of Title VI's development, an attractive package for Congress. It allowed the government to continue to reap the benefits that had evolved, however unexpectedly, from grants under the original Act. Since no further money was to be spent under Title VI, the benefits of the ongoing "return" of privately funded uncompensated care were costless to the 1975 Congress.[170] At the same time, a vote to fund hospitals under Title XVI was a vote "for" improved health care for the poor at only a fraction of the cost of a government program to that end: Title XVI facilities, it will be remembered, had no twenty-year time limitation on their obligations, and the return on that initial government investment could, theoretically, extend forever.

This statutory scheme made Title XVI funding very unattractive to hospitals, which could borrow money from commercial lenders with less attendant regulation and at finite interest rates. The point was mooted, however, by the appropriations for Title XVI, which funded only the portion of the new Act that assisted public hospitals in complying with safety and accreditation standards.[171] Because no private nonprofit hospital has received funding under Title XVI, its impact has been limited to the changes it made that apply to hospitals that received Hill-Burton aid under the now unfunded Title VI program.

In Title XVI, despite its disapproval of DHEW's Hill-Burton enforcement record, Congress vested total regulatory control in the agency, apparently believing that enforcement would improve if it were centralized in an agency accountable directly to Congress. Despite this belief and despite the terms of the new Act requiring the Secretary to draft new regulations for Title VI and XVI facilities,[172] DHEW delayed in issuing new regulations and the 1972 regulations, as amended in response to *Cook II* and *Corum II*, remained in effect.

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168. Based on the receipt of their Title VI grants or loans, hospitals were obligated to fund a continuing volume of uncompensated care for a specified period, 20 years from receipt of a grant or, in the case of a loan, while it remained unpaid. *See* 37 Fed. Reg. 14,719, 14,720 (binding interim regulations of July 22, 1972, codified at 42 C.F.R. § 53.111(a) (1978)). Medicare and Medicaid made no contribution to offset these costs; such services were funded by increased charges to other patients or by other outside means. *See* notes 53 to 56 and accompanying text *supra*.

169. *See* 39 Fed. Reg. 31,766, 31,767 (final regulations of Aug. 30, 1974, codified at 42 C.F.R. § 53.113(d)(2) (1976)).

170. That is, construction and modernization appropriations made through the Act continued to prompt Title VI facilities' delivery of uncompensated care and community service for 20 years after receipt of a grant or until the balance of a Hill-Burton loan was paid.

171. *See AHA District Court Complaint, supra* note 43, at 6.

172. 42 U.S.C. § 300o–1 (1976).

Further Regulatory Development

As Congress considered Title XVI, the attack on the uncompensated care and community service regulations continued in the familiar forum of *Cook v. Ochsner Foundation Hospital,* which had been reactivated by plaintiffs' filing of yet another amended complaint.[173] In *Cook III,* the plaintiffs reiterated the charge that the entire body of regulations was invalid because the Federal Hospital Council's authority was unconstitutional.[174] They also repeated the challenge to the substantive validity of the time limitation and presumptive compliance guidelines of the uncompensated care regulations.[175] In addition, the plaintiffs charged that the time limitation on the community service regulation was invalid under Title VI.[176]

The court agreed with the analysis of the *Corum II* decision[177] and held that the Council's role in the promulgation of regulations was constitutionally valid.[178] It expanded on the *Corum II* ruling, however, by holding that the presumptive compliance guidelines and the time limitation in the uncompensated care regulations were valid generally, because the provisions resulted in a regulatory scheme that was reasonable under Title VI.[179] In so holding, the court

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173. Civ. No. 70–1969 (E.D. La. March 12, 1975). *See Cook II,* 61 F.R.D. 354 (E.D. La. 1972) (Hill-Burton hospitals may not discriminate against Medicaid patients), notes 120 to 132 and accompanying text *supra*; *Cook I,* 319 F. Supp. 603 (E.D. La. 1970) (indigent plaintiffs have private cause of action under the Act), notes 59 to 62 and accompanying text *supra.*

174. Cook v. Ochsner Foundation Hosp. (*Cook III*), Civ. No. 70–1969 (E.D. La. March 12, 1975), at 1. The challenge to the authority of the Federal Hospital Council was made under the same theory of unlawful delegation of legislative power to a private body that had been pursued and rejected in *Corum II,* 373 F. Supp. 550, 551–53 (S.D.N.Y. 1974). *See* notes 140 to 144 and accompanying text *supra.* Title XVI, 42 U.S.C. §§ 300o–300t (1976), had been enacted three months before this decision, *see* text accompanying notes 157 to 172 *supra,* but DHEW had not yet promulgated new regulations under the Act. Thus, although the role of the Federal Hospital Council in the promulgation of new regulations had been removed through Title XVI, its authority continued so long as the old regulations pertaining to Title VI remained in effect.

The *Cook III* complaint also alleged conflict of interest of some members of the Federal Hospital Council who were administrators of Hill-Burton hospitals. The court rejected this claim, *see* Civ. No. 70–1969 (E.D. La. March 12, 1975), at 4–5, and its ruling was upheld on appeal. Cook v. Ochsner Foundation Hosp., 559 F.2d 968, 974–75 (5th Cir. 1977). *See* note 142 *supra.*

175. Civ. No. 70–1969 (E.D. La. March 12, 1975), at 1. These issues had been raised in *Corum II,* 373 F. Supp. 550, 554, 556 (S.D.N.Y. 1974). *See* notes 145 to 150 and accompanying text *supra.*

176. Civ. No. 70–1969, at 1. The time limitation had been attached to the community service regulations, 39 Fed. Reg. 31,766 (final regulations of Aug. 30, 1974, codified in 42 C.F.R. § 53.113 (1976)), which had been promulgated in response to *Cook II. See* 61 F.R.D. 354 (E.D. La. 1972), notes 120 to 132 and accompanying text *supra.*

177. 373 F. Supp. 550 (S.D.N.Y. 1974); *see* text accompanying notes 139 to 144 *supra.*

178. Civ. No. 70–1969 (E.D. La. March 12, 1975), at 2–4.

179. *Id.* at 6–9. *Corum II* had limited its approval of the terms of the uncompensated care regulation to the application of the regulations to the defendant hospital in that case. *See* notes 148 to 150 and accompanying text *supra.*

recognized that the terms of the uncompensated care regulations permitted recipient hospitals to avoid a "financial burden bearing no reasonable relationship to the amount of federal aid."[180]

Turning to the time limitation on the community service regulation, however, the court stated that it did not impose a financial burden on hospitals and struck down the provision, finding that the durational limit created an "imbalance between popular need and [hospital] need which is inconsistent with legislative aim, and, therefore, impermissible."[181]

Cook III was correct in determining that the community service time limitation was in derogation of the statutory purpose, but misunderstood that the original Hill-Burton Act had sought only to provide *facilities* to meet "popular need." That is, although Title VI had funded hospitals on the condition that they would remain available to all people in the surrounding area, the 1946 Congress could not have anticipated that the community service requirement would be construed in conjunction with the later-enacted Medicare and Medicaid programs. By failing to consider the financial interrelationships between Hill-Burton and these programs, the court came to the mistaken conclusion that the community service requirements did not impose a financial burden on hospitals. In fact, when a Hill-Burton facility accepted Medicare or Medicaid patients, as it was now required to do under the community service obligation, it lost revenue to fund its uncompensated care obligation,[182] and lost the difference between its usual charge and the government's payment rate.[183] In addition, under the Hill-Burton program's reasonable cost crediting standard, the hospital was required to render more service in order to meet its uncompensated care obligation.[184]

That the *Cook III* court did not understand these issues is further illustrated by its characterization of the relationship between the community service requirement and the uncompensated care crediting mechanism. The court noted: "the [community service] regulation itself requires that [facilities] arrange for reimbursement of full community service costs . . . at reasonable cost . . . . *Any cost not reimbursed conceivably could be applied by the facility toward its*

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180. Civ. No. 70–1969 (E.D. La. March 12, 1975), at 8. This ruling was upheld on plaintiffs' appeal. 555 F.2d 968 (5th Cir. 1977).

181. Civ. No. 70–1969, at 6.

182. As explained previously, Medicare and Medicaid reimbursement do not contribute to the funding of uncompensated care. *See* notes 54 & 55 and accompanying text *supra*; note 323 *infra*. When treating patients under these programs, as a Hill-Burton facility was required to do per force of the community service obligation, the burden of financing uncompensated care was placed on the hospital, which, in turn, either drew upon its general endowment or passed increased costs along in the form of higher rates.

183. *See* notes 52 to 56 and accompanying text *supra*.

184. The same "reasonable cost" reimbursement rate paid by Medicare and Medicaid applied when a hospital sought Hill-Burton credit for treatment of a patient under its obligation; Hill-Burton credit was allowed only to the extent that the government would have reimbursed for the service had the patient been eligible, not on the basis of the hospital's usual charge for the service. *See* notes 52 to 56 and accompanying text *supra*.

requisite 'reasonable volume' of uncompensated care."[185] This statement revealed a fundamental misunderstanding of the Hill-Burton regulations, which specifically prohibited the crediting of the difference between reasonable cost reimbursement and hospital charges.[186] Despite the fact that the *Cook III* court's decision to strike down the community service time limitation was based, at least in part, on this misconception, DHEW did not appeal the ruling.[187]

In September 1975 another challenge to the regulations was faced in *Gordon v. Forsyth County Hospital Authority*,[188] a class action in which the court agreed with the holding of *Corum II* regarding the prior determination of patient eligibility.[189] In denying plaintiffs' motion for summary judgment on their individual claims of entitlement to uncompensated care under the Act, however, the court found that the new administrative procedures portion of Title XVI applied to complaints based on Title VI facilities' compliance and held that the plaintiffs were required to exhaust remedies in a complaint proceeding to the Secretary of DHEW prior to seeking judicial relief.[190]

The court also dealt with several other claims that had not been submitted in previous cases. First, the plaintiffs attacked the priority system used by Forsyth Memorial Hospital to dispense Hill-Burton care. The hospital used a triage system, which gave priority to the most severe medical problems over the course of the year until the Hill-Burton obligation was met.[191] The plaintiffs claimed that, under the Act, care should be dispensed on a "first-come, first-serve" basis regardless of the severity of the medical problem.[192] On this issue, the court came to the correct conclusion that it had no jurisdiction to revise the hospital's system because its evaluation was the responsibility of the supervising state and federal administrative agencies.[193]

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185. Civ. No. 70–1969 (E.D. La. March 12, 1975), at 9 (emphasis added).

186. *See* note 92 and accompanying text *supra*; *see also* Newsom v. Vanderbilt Univ., 453 F. Supp. 401, 419 (M.D. Tenn. 1978); note 234 and accompanying text *infra*.

187. *See* note 156 *supra* (possible explanations for DHEW's failure to appeal district court decisions affecting Hill-Burton regulations).

188. 409 F. Supp. 708 (M.D.N.C. 1975). The court had before it cross motions for summary judgment and plaintiffs' motion for class certification, which was granted, *id.* at 717–18.

189. *Id.* at 723–24 (quoting Corum v. Beth Israel Medical Center (*Corum II*), 373 F. Supp. 550, 557–58 (S.D.N.Y. 1974)).

190. *Id.* at 721–22 (citing 42 U.S.C. § 300p–2(c) (1976)). *See* note 164 and accompanying text *supra*.

191. 409 F. Supp. at 722.

192. *Id.*

193. *Id.* at 722–23. The court invoked the doctrine of primary jurisdiction, which is properly applied in instances in which a court is presented with a problem that may most appropriately be given over to agency expertise for initial determination. It governs the court's decision whether the court or the administrative agency should make the initial decision or finding of fact. *See id.* at 722 n.12 (quoting 3 K. DAVIS, ADMINISTRATIVE LAW TREATISE § 19.09, at 53 (rev. ed. 1958)). Plaintiffs asserted that agency unresponsiveness to their objections made application of the primary jurisdiction doctrine inappropriate. The court held, however, that the opportunity to raise objections to the hospital's plan for distribution of services was presented by the state agency's annual review of the hospital's services, and that plaintiffs should first pursue this course of action. *Id.* at 723.

The plaintiffs also challenged, on equal protection grounds, Forsyth's system of transferring non-acute care patients from its facility to another affiliated hospital, which was not a Hill-Burton grantee. Upon transfer to the non-grantee hospital, patients were no longer eligible for uncompensated care.[194] The plaintiffs claimed that under this system, which operated at the discretion of Forsyth physicians, the classification of patients to be transferred, and thus deprived of Hill-Burton benefits, was arbitrary and bore no rational relationship to a legitimate government interest.[195] The court agreed, finding that Hill-Burton funding imbued Forsyth's acts with state action,[196] and ordering the hospital to formulate a written transfer policy.[197]

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194. The system, which was designed to meet demands for acute-care bed space at Forsyth, resulted in the transfer of less seriously ill or recovering patients from Forsyth to another hospital that was less acute-care oriented. *Id.* at 726.

195. *Id.*

196. *Id.* (citing Simkins v. Moses H. Cone Memorial Hosp., 323 F.2d 959 (4th Cir. 1963), *cert. denied,* 376 U.S. 938 (1964)). In stating that there was "no question" that Hill-Burton funding triggered a state action characterization of defendant's acts, the court was somewhat conclusory. Although *Simkins* and several other early Hill-Burton cases had held that the receipt of Hill-Burton funds was sufficient to imbue defendant hospitals' acts with state action, the Supreme Court's holdings in subsequent cases altered that perception. *See* Jackson v. Metropolitan Edison Co., 419 U.S. 345, 350–51 (1974) (mere state regulation does not constitute state action; inquiry is whether there is sufficiently close nexus between state and challenged action of regulated entity); Moose Lodge No. 107 v. Irvis, 407 U.S. 163, 175–79 (1972) (same; state licensure insufficient). The Court's previous holding in Burton v. Wilmington Parking Auth., 365 U.S. 715 (1961), however, has created some confusion as to the appropriate test for state action. The Court found that the symbiotic relationship between the state and a private party engaged in discrimination made the state a joint participant in the discriminatory acts. *Id.* at 721–26. This has been termed the "overall relationship" theory of state action. *See* Greene v. The Johns Hopkins Univ., 469 F. Supp. 187, 195 (D. Md. 1979). Following *Jackson*, a number of courts adopted a three-pronged test to determine if Hill-Burton hospitals' acts or omissions constituted state action, *viz*: (1) significant government involvement in the hospital's operation (*e.g.*, government management or major funding); (2) nexus between the government's involvement and the complained-of action or omission (*e.g.*, refusal to admit or treat); (3) finding that the government's acts resulted in or provoked the complained of action or omission (*e.g.*, admissions or discharge policy). *See, e.g.*, Jackson v. Norton-Children's Hosp., Inc., 487 F.2d 502, 503 (6th Cir. 1974). *See also* Greene v. The Johns Hopkins Univ., 469 F. Supp. 187, 197 (D. Md. 1979) (student cannot support claim under 42 U.S.C. § 1983 with Hill-Burton funding of university hospital; no state action found under either overall relationship theory of *Wilmington Parking Authority* or close nexus theory of *Moose Lodge*).

Because Forsyth Memorial Hospital was a public hospital controlled by a county authority, the characterization of state action by the court was correct under either test enunciated by the Supreme Court, but not, as stated by the court, simply by virtue of the hospital's receipt of Hill-Burton funds. *See generally* 11 CONN. L. REV. 248, 260–64 (1979).

197. 409 F. Supp. at 727. Forsyth was also ordered to submit the plan to the state Hill-Burton agency and to DHEW for their approval, and to submit the plan and the agencies' comments to the court. Although Title XVI had vested total regulatory authority in DHEW, *see* note 161 and accompanying text *supra*, since DHEW had yet to issue any regulations under the new Act, the supervisory role of the state Hill-Burton agencies continued with regard to Title VI facilities.

Using *Goldberg v. Kelly* by way of analogy, the court also found that the current regulations' requirement of newspaper announcements was inadequate to provide effective notice of the availability of uncompensated services to potential Hill-Burton patients.[198] Although conceding that the Act did not require that all members of the public have "*actual* notice of the benefits available," the court referred to the text of the posted notice that was contained in the proposed uncompensated care regulations that DHEW had proposed;[199] the court added some clarifying language to the text of the proposed notice and ordered Forsyth to post such notices immediately, before DHEW's regulations became effective.[200]

By this implicit due process order, albeit unstated and limited to the defendant hospital,[201] the *Gordon* court forestalled any attempt by DHEW to weaken the posted notice requirement in its forthcoming final regulations.[202] Furthermore, the order, in combination with the specific state action and equal protection holdings on the transfer of patients issue, added a constitutional dimension to the delivery of care through the Hill-Burton program. This was another step in the Act's development, as the holdings rested on a notion of potential beneficiaries' entitlement to certain procedural safeguards. In addition, the *Gordon* complaint illustrated the exactness with which plaintiffs were seeking interpretation of the Act: From the original general language of the statute mandating a "reasonable volume" of uncompensated services, plaintiffs were seeking invalidation of the method that a hospital used to distribute such care and proposing that the Act had implied another system.

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198. 409 F. Supp. at 725 (citing 397 U.S. 254 (1970)).

199. *Id.* (emphasis in original) (referring to 40 Fed. Reg. 10,686 (proposed regulations of March 7, 1975)). *See* notes 152 to 154 *supra*. The issuance had been prompted by Corum v. Beth Israel Medical Center (*Corum II*), 373 F. Supp. 550 (S.D.N.Y. 1974).

200. 409 F. Supp. at 725. The plaintiffs pursued this issue and the district court's holding that exhaustion of administrative remedies was required prior to judicial intervention. Gordon v. Forsyth County Hosp. Auth., 554 F.2d 748 (4th Cir. 1976) (affirmance of district court).

201. 409 F. Supp. at 725. The court said that such notice was "necessary as a practical matter, to the implementation of the purpose and goal of the Hill-Burton Act in making available a reasonable volume of medical services to persons unable to pay therefor."

202. Although DHEW was not a defendant in the *Gordon* case, this order was obviously intended to influence the agency's regulatory process. Because DHEW had not yet drafted new regulations under Title XVI for Title VI facilities, the Federal Hospital Council continued to have authority over Title VI regulations. Rose, *supra* note 2, indicates that there was reason for concern that the Federal Hospital Council would act to diminish the requirements of the March proposed posted notice regulation before its finalization. In a May 1975 meeting, the Council had voted to require posted notice only of facilities that had failed to achieve their presumptive compliance percentage minimum. *Id.* at 193 n.143. Without the court's pointed ruling concerning Forsyth, it appears that this change would have gone into effect in the final regulations.

In July 1976 the court in *Lugo v. Simon* (*Lugo I*) agreed with *Cook III* that the statute implied no time limitation on the community service obligation.[203] It also concurred in the *Corum II* and *Cook III* holdings that the uncompensated care obligation could properly be limited in both quantity (the presumptive compliance level) and duration (the time limitation).[204]

Thus, by the multiple decisions of four federal courts, DHEW was prompted to amend the uncompensated care and community service regulations. Final uncompensated care regulations were issued in October 1975 and stated to be effective on the date of issuance.[205] These regulations made effective the new prior determination of patient eligibility standard[206] as ordered by the 1974 *Corum II* decision[207] and suggested by the 1975 ruling in *Gordon v. Forsyth County Hospital Authority*[208] and the posted notice requirements[209] as also discussed in the *Gordon* case.[210]

The deletion of the time limitation on facilities' community service obligations was not accomplished by final regulation until March 1977,[211] some two years after *Cook III* had found the provision invalid,[212] and nine months after the *Lugo I* decision to that same effect.[213]

Enforcement Development through Litigation

At this point, having elicited judicial interpretation of virtually every section of the Hill-Burton regulations, plaintiffs' groups focused their attacks on the lack of agency enforcement and hospital compliance. Records of state and federal enforcement of the 1972 regulations and their amendments showed inattention to compliance, despite the repeated litigation. In large part, it

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203. 426 F. Supp. 28, 36 (N.D. Ohio 1976). The plaintiffs sued several area hospitals, alleging their failure to provide treatment of indigents as required by the regulations, and sought to compel the Ohio Department of Health and DHEW to enforce the hospitals' obligations. This case was heard on DHEW's motion to dismiss or grant summary judgment and plaintiffs' cross motion for partial summary judgment. *Id.* at 30–31.

204. *Id.* at 34–36.

205. 40 Fed. Reg. 46,202 (final regulations of Oct. 6, 1975, codified at 42 C.F.R. § 53.111(f), (i) (1978)).

206. *Id.* at 46,203 (codified at 42 C.F.R. § 53.111(f) (1978)). An exception to the prior determination requirement was made for medical emergencies. In the event that emergency service was rendered prior to a determination, however, it was required that the bill sent for the service contain a notice of Hill-Burton care availability similar in text to the posted notice. *Id.*

207. *See* text accompanying note 151 *supra*.

208. *See* text accompanying note 195 *supra*.

209. 40 Fed. Reg. 46,202, 46,203 (final regulations of Oct. 6, 1975, codified at 42 C.F.R. § 53.111(i) (1978)).

210. *See* text accompanying notes 198 to 200 and accompanying text *supra*.

211. 42 Fed. Reg. 16,780 (final regulations of March 30, 1977, codified at 42 C.F.R. § 53.113(a) (1978)).

212. *See* text accompanying note 181 *supra*.

213. *See* text accompanying note 203 *supra*.

appeared that DHEW's amenable rewriting of its regulations at the behest of the federal courts was the sum of its efforts toward Hill-Burton change.[214]

Two recent Hill-Burton actions not only challenged specific regulatory provisions, but also targeted hospital noncompliance and government failure to enforce its Hill-Burton requirements.[215] These cases resulted in further expansion of the Hill-Burton program's service provision requirements.

As previously discussed, the decision in *Lugo v. Simon* (*Lugo I*) declared invalid the time limitation on the community service regulation.[216] An amended complaint charged officials of the Ohio Department of Health and DHEW with failing to enforce Ohio hospitals' compliance with Title VI Hill-Burton regulations and sought an injunction to compel DHEW to issue new regulations for Title VI facilities as directed by Title XVI.[217]

In *Lugo II*, the confusion surrounding the effect of Title XVI on Title VI prompted the state and federal agency defendants to file accusatory cross-claims against each other. The state health department, claiming that under Title XVI it no longer had authority to enforce the uncompensated care or community service obligation, blamed the lack of enforcement on the Secretary's failure to promulgate regulations under the new statute. DHEW countered by contending that the state's claims constituted an admission of its past and planned failure to adhere to the Title VI regulations and accused the Ohio agency of having submitted a state plan for hospital compliance that was " 'ambiguous, vague, and confusing in certain areas, and [which] has not been modified to incorporate explicitly . . . [required] regulatory amendments subsequent to its adoption.' "[218]

Although the agencies had in their claims against each other implicitly admitted enforcement failure,[219] the court held that the plaintiffs were required

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214. For many examples of federal and state agency failure to monitor or enforce the Hill-Burton requirements from 1972 through 1975, see Rose, *supra* note 2, at 181–94. This author's 1978 review of Maryland state agency Hill-Burton records suggests that the patterns described by Rose continued at least through that year. The explanation given most frequently by state agencies for failure to monitor or enforce the regulations was lack of funds for manpower to do so. *See id.* at 191.

215. Newsom v. Vanderbilt Univ., 453 F. Supp. 401 (M.D. Tenn. 1978); Lugo v. Simon (*Lugo II*), 453 F. Supp. 677 (N.D. Ohio 1978) (continuation, on amended complaint, of *Lugo I*, 426 F. Supp. 28 (N.D. Ohio 1976)).

216. 426 F. Supp. 28 (N.D. Ohio 1976).

217. Lugo v. Simon (*Lugo II*), 453 F. Supp. 677, 684–86 (N.D. Ohio 1978). Nearly three years after the passage of the "new" Hill-Burton Act, DHEW had yet to promulgate the new regulations it required. *See* text accompanying note 172 *supra*.

218. 453 F. Supp. at 682. Although it was the federal agency's statutory responsibility to evaluate and approve states' plans, *see* 42 U.S.C. §§ 291c, 291d (1976); *see also* 42 U.S.C. §§ 300o–1 to –3, 300p–2 (1976), this was apparently DHEW's first expression of dissatisfaction with the Ohio plan since its 1974 approval.

219. Partial summary judgment on the statutory interpretation issue was granted to DHEW, however, in that the Ohio Department of Health was ordered to modify its state plan in accordance with the applicable Title VI regulations, and to implement and enforce both the plan and the federal regulations. 453 F. Supp. at 691–92. In reaching this

to exhaust the administrative remedies provided in Title XVI.[220] On plaintiffs' motion to compel DHEW to draft regulations, the court, although extremely critical of the agency's inactivity since the 1975 enactment, nonetheless stopped short of issuing an injunction, apparently because of DHEW's assertion that new regulations were "under development."[221]

Four months after *Lugo II*, the opinion in *Newsom v. Vanderbilt University*[222] was announced. This last case to rule on interpretation and enforcement issues under the Title VI regulations has become a landmark among Hill-Burton decisions because of its definitive holdings. The class action suit, instituted against Vanderbilt University Hospital, the Tennessee Department of Public Health, and DHEW, first attacked the validity of the time limitation on the uncompensated care obligation as it applied to the defendant hospital. The plaintiffs also alleged that the hospital had failed to fulfill its uncompensated service obligation, and, alternatively, that even if such services had been provided, the hospital's procedures for their distribution failed to afford procedural due process under the fifth and fourteenth amendments.[223] Newsom also charged that the federal and state agencies had failed to fulfill their duties to enforce the Hill-Burton Act and regulations, and asserted that all the defendants had acted under color of state law to deprive her of her rights under the Act and the Constitution.[224]

The threshold question facing the court was the effect that the administrative determination would have on its adjudication. This was a question of first impression under Title XVI. Newsom's administrative complaint had been dismissed by DHEW with a finding that Vanderbilt was in "substantial compliance" with its Hill-Burton uncompensated care obligation.[225] As the

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decision, the court correctly reasoned that nothing in the new Title XVI had invalidated the regulatory responsibilities of the state under the Title VI regulations, and noted that the fact that Title VI funding had ceased did not alter the states' responsibilities to enforce the regulations against facilities that had received such funds in the past. *Id.* at 683.

220. The court required exhaustion although the plaintiffs had filed suit prior to enactment of Title XVI, finding that no "'manifest injustice'" would result from this action. The court also found that although Title XVI did not specify that exhaustion was required prior to filing a claim against a state agency, it would require such exhaustion in concert with exhaustion of the claims against the hospital and federal defendants. *Id.* at 683–85 (citing 42 U.S.C. § 300p–2(c) (1976)).

221. *Id.* at 686. The court refused to grant DHEW's motion for summary judgment against the plaintiffs on the issue of injunctive relief, however, and scheduled a new trial for its resolution. This issue was resolved by a consent decree in which DHEW agreed to issue regulations under Title XVI within a specific time period. *See* Lugo v. Simon, Civ. No. 74–345 (N.D. Ohio Sept. 1, 1978) (stipulation between plaintiffs and DHEW). The defendant hospitals were not parties to this consent decree.

222. 453 F. Supp. 401 (M.D. Tenn. 1978).

223. *Id.* at 410.

224. *Id.* at 405.

225. *Id.* at 406–09. The court said: "The term 'substantial evidence' is not to be found in [the Act], nor is the phrase 'arbitrary and capricious,' nor are any other terms that connote limited review." *Id.* at 407.

administrative procedures section of Title XVI did not specify the effect of an agency decision, the court was forced to employ analogy and the canons of statutory construction to determine the proper standard. After detailed comparison of the Hill-Burton's administrative procedures section with similar provisions of other statutes, the court concluded that the statute required a trial de novo rather than mere judicial review of the Secretary's determination.[226] That is, the court's decision would be based on the entire record before the court, rather than solely on the evidence before DHEW in its decision in favor of Vanderbilt. This was an extremely important ruling because the plaintiffs' claims were dependent on their ability to present evidence that contradicted DHEW's conclusions.[227]

The *Newsom* court addressed the validity of the time limitation on the uncompensated care obligation, particularly as applied to older facilities, like Vanderbilt, that had received grants in the early stages of the Hill-Burton program.[228] The plaintiffs argued that the time limitation was intended to require a facility's provision of service for a twenty-year period. Because Vanderbilt had provided uncompensated service, if at all, only in years subsequent to the 1972 regulations, it should not receive "credit" for the years between the completion of its Hill-Burton building and that time.[229] Agreeing with previous rulings that had upheld the validity of the uncompensated care time limitation under the Act,[230] the court considered how the twenty-year period should properly be calculated. In essence, the court found, it would be impossible to determine a hospital's compliance for the period prior to the 1972 uncompensated care regulations, as no standards for compliance with the requirement existed during that time. Arguably, proof of Vanderbilt's noncompliance could invalidate the twenty-year time limit as it applied to the facility; however, the plaintiffs had an impossible burden on this issue.[231]

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226. In deciding that de novo review was required, the court examined the administrative procedure language of Title XVI, 42 U.S.C. § 300p–2(c) (1976), and compared it with similar provisions of the Civil Rights Act of 1964, 42 U.S.C. § 2000e–5(b), (f)(1) (1976), and other sections of Title XVI, 42 U.S.C. § 300s (1976). 453 F. Supp. at 407–08. It noted that use of the de novo standard did not mean the agency's action was insignificant; it was considered on its merits as a part of the evidentiary record. *Id.* at 406.

227. If the court had found itself limited to the review standards of "arbitrary and capricious," "clearly erroneous," or "substantial evidence," it would have been confined to an examination of the administrative record of the DHEW decision. As noted in the court's decision, some of the evidence before the court "contradict[ed] the factual basis assigned by the Secretary for his finding of Vanderbilt's compliance." *Id.* at 409.

228. *Id.* at 410–13. *See* note 229 *infra.*

229. 453 F. Supp. at 410. It was stipulated that Vanderbilt had received seven Hill-Burton grants, totalling approximately $3 million, between 1957 and 1971. *Id.* at 404.

230. *Id.* at 410 (citing Cook v. Ochsner Foundation Hosp., 559 F.2d 968 (5th Cir. 1977) (affirmance of uncompensated care time limitation holding of *Cook III,* Civ. No. 70–1969 (E.D. La. March 12, 1975)); Lugo v. Simon (*Lugo I*), 426 F. Supp. 28 (N.D. Ohio 1976); Corum v. Beth Israel Medical Center (*Corum II*), 373 F. Supp. 550 (S.D.N.Y. 1974)).

231. 453 F. Supp. at 410–13. This legally correct conclusion illustrated the inextricable box that the twenty-year time limit had created for plaintiffs.

In evaluating Vanderbilt's uncompensated care compliance since the inauguration of standards, however, the court found that the hospital had been delinquent in important respects. First, contrary to the regulations promulgated in response to the 1974 order in *Corum II*,[232] Vanderbilt had never properly implemented the requirement of prior determination of patient eligibility. Consequently, it had been improperly crediting certain types of services toward its Hill-Burton obligation.[233] Vanderbilt had also been calculating its Hill-Burton credit on the basis of its charges for services, not the reasonable cost principles specified in the regulations.[234] In an order unprecedented in the Hill-Burton cases, the court enjoined such improper crediting[235] and ordered the hospital to make up the deficit incurred by its actions by providing increased uncompensated care in the future.[236] It also enjoined the state and federal agency defendants from finding Vanderbilt to be in compliance with the uncompensated care obligation on the basis of reports that did not reflect actual compliance with the Act and the current regulations.[237] In addition, Vanderbilt was ordered to improve its reporting to the state agency and DHEW,[238] and to refrain from collection efforts against any patients treated after 1972 who would have qualified for Hill-Burton care.[239]

These holdings graphically illustrated the different standards of review and enforcement employed by DHEW and the federal courts. While DHEW had found Vanderbilt to be in "substantial compliance" with its Hill-Burton uncompensated care obligation, the court, acting on much the same evidence that had been presented in the administrative complaint, came to the opposite conclusion.[240] The court's compliance determination, and its specific order to Vanderbilt to "pay back" its uncompensated care "deficit," illustrated Hill-Burton's development: Not only was the holding based on detailed regulatory provisions that had not been contemplated by Congress or recipient facilities,

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232. *See* Corum v. Beth Israel Medical Center (*Corum II*), 373 F. Supp. 550 (S.D.N.Y. 1974), which prompted the issuance of new uncompensated care regulations, 40 Fed. Reg. 46,202 (final regulations of Oct. 6, 1975, codified at 42 C.F.R. § 53.111(f) (1978)).

233. 453 F. Supp. at 415. Vanderbilt claimed that it had never received the September 1974 memorandum from DHEW, and had not implemented any change in its accounting procedures until April 1975. Further, the court found that after the issuance of the final billing and notice regulations in October 1975, Vanderbilt had not included the required notice in bills for emergency treatment rendered prior to the determination of eligibility. *Id.* at 416.

234. *Id.* at 418–19. The parties agreed that the "reasonable cost" reimbursement would, on average, have been 75% of the hospital's charge. In addition, when treating Medicaid or Medicare patients, Vanderbilt had been crediting the difference in charges over reasonable cost toward the Hill-Burton obligation. This was an additional violation of the regulations. *See* notes 91 & 92 and accompanying text *supra*.

235. 453 F. Supp. at 430.

236. *Id.* at 419.

237. *Id.* at 430.

238. *Id.* at 419.

239. *Id.* at 430.

240. *See* note 227 *supra*.

but the court enforced those provisions in a manner that could not have been foreseen.

The *Newsom* case also built on the foundation of procedural due process that had been implied by *Gordon v. Forsyth County Hospital Authority*.[241] In this branch of the case, the court relied upon Vanderbilt's receipt of Hill-Burton funds, its regulation by other state and federal agencies, and its role (as specified by state statute) as an agent of the State of Tennessee to find that the facility's patient care activities constituted state and federal action.[242] Like the *Gordon* court, the *Newsom* court relied on *Goldberg v. Kelly*,[243] but whereas the former decision was limited to the implication that due process required the posting of notices to advise patients of the availability of uncompensated care,[244] the *Newsom* court determined that potential beneficiaries of Hill-Burton had a property interest that was protected by due process requirements, and held that the Supreme Court's definition of due process in *Goldberg v. Kelly* meant that indigent persons were entitled to *actual* notice of their potential eligibility for uncompensated care.[245] Not only was posted notice insufficient, but due process required "notice . . . of the written eligibility criteria upon which the hospital will base its determination to furnish or withhold treatment," "timely and adequate written notice detailing the reasons for the proposed denial of benefits, review by a decision-maker who has not participated in making the initial finding of ineligibility, and a written statement of the reasons for the decision and the evidence relied thereon."[246] Furthermore, individuals must "be given an effective opportunity to present affirmative evidence and to refute adverse evidence, though not necessarily at an oral hearing."[247]

As noted by one commentator, the *Newsom* court's reliance on *Goldberg v. Kelly* was somewhat misplaced.[248] In that case, the Supreme Court determined

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241. 409 F. Supp. 708, 725 (M.D.N.C. 1975); *see* notes 198 to 202 and accompanying text *supra*.

242. 453 F. Supp. at 419–22. In order to impose the due process requirements of the fourteenth and fifth amendments on Vanderbilt's distribution of Hill-Burton services, these activities were required to be shown to constitute state and federal action. *See* 11 CONN. L. REV. 248, 260–64 (1979) (questions basis, although not ultimate result, of court's state action finding). *Cf.* note 196 *supra* (applicable tests for state action determination).

243. 397 U.S. 254 (1970).

244. *See* Gordon v. Forsyth County Hosp. Auth., 409 F. Supp. 708, 725 (M.D.N.C. 1975); notes 198 to 202 and accompanying text *supra*.

245. 453 F. Supp. at 423–24.

246. *Id.*

247. *Id.*

248. 11 CONN. L. REV. 248, 264–68 (1979). As noted in this analysis of the *Newsom* case, "[c]ourts have disagreed on whether Goldberg-type procedural safeguards are required before *application* for government benefits may be denied." *Id.* at 265–66 (emphasis added) (citing Board of Regents v. Roth, 408 U.S. 564 (1972) (implication that present enjoyment of benefits, not mere eligibility for benefits, is necessary to invoke due process protections); Baker Chaput v. Cammett, 406 F. Supp. 1134 (D.N.H. 1976) (due process protections attach upon application for welfare benefits); Scarpa v. United States Bd. of Parole, 477 F.2d 278 (5th Cir. 1973) (due process attaches when government seeks to deprive individual of goods, rights or privileges which he already possesses)).

that welfare beneficiaries could not be subject to the state's termination of their payments without the notice and hearing protections of procedural due process.[249] In *Goldberg v. Kelly* the protected property interest of the plaintiffs was their ongoing receipt of benefits from the state.[250] The interest of the *Newsom* plaintiffs, on the other hand, was potential and uncertain because of the structure of the Hill-Burton regulations. First, no individual could ever be assured of receiving Hill-Burton care so long as the regulations permitted a hospital the discretion of allocating its care throughout the facility and among patients according to any reasonable system approved by the administrative agencies.[251] Second, if a hospital had elected a presumptive compliance percentage minimum, rather than the open door option, its uncompensated care obligation was limited by its annual percentage minimum; after that figure was achieved, the hospital had no further obligation to dispense uncompensated care to anyone until the next fiscal year.[252] Given these facts, the determination that the *Newsom* plaintiffs had a property interest in Hill-Burton benefits expanded considerably upon *Goldberg v. Kelly*.[253]

Newsom v. Vanderbilt University was the apex of Hill-Burton's development in the courts. Five months after the decision, DHEW issued proposed regulations under Title XVI that dealt with the uncompensated care and community service requirements for both Title VI and Title XVI facilities.[254] After extensive public comment, final regulations were issued in May 1979, to be effective in September 1979.[255] The American Hospital Association filed suit in June to seek invalidation of the regulations, and later sought to enjoin their issuance in final

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249. Goldberg v. Kelly, 397 U.S. 254 (1970).

250. *Id.* at 262.

251. *See* Gordon v. Forsyth County Hosp. Auth., 409 F. Supp. 708, 722–23 (M.D.N.C. 1975), notes 191 to 193 and accompanying text *supra*; Corum v. Beth Israel Medical Center (*Corum I*), 359 F. Supp. 909, 917 (S.D.N.Y. 1973), notes 113 to 118 and accompanying text *supra*.

252. *See* 37 Fed. Reg. 14,719, 14,722 (binding interim regulations of July 22, 1972, codified at 42 C.F.R. § 53.111(h) (1978)).

253. The *Newsom* plaintiff's "property interest" in Hill-Burton benefits resembles the "expected" or "future" benefits of *Roth* or *Baker Chaput*, *see* note 248 *supra*, much more than the present property interests of the plaintiffs in *Goldberg*. In fact, because of the factors apart from eligibility that govern the distribution of Hill-Burton care, the nature of the "property interest" is even more attenuated than those articulated in the former cases.

254. 43 Fed. Reg. 49,954 (proposed regulations of Oct. 25, 1978).

255. 44 Fed. Reg. 29,372 (final regulations of May 18, 1979, codified at 42 C.F.R. § 124.501–.607 (1979)). *See* Appendix I: Summary of Public Comments and Department's Actions on the Uncompensated Services and Community Service Regulations, *id.* at 29,382–399.

form.[256] The AHA motions were denied,[257] and the new regulations became effective on September 1, 1979.[258]

Comprehensive Regulatory Change

The 1979 Hill-Burton regulations are the result of comprehensive redrafting of prior provisions, but they also reflect many of the judicial, legislative, and administrative interpretations of the 1972-1978 period. The new issuance is so detailed as to defy easy summary, but highlights of the major changes show the magnitude of their impact on Title VI hospitals. The uncompensated care regulations affect some 3,600 hospitals with balances remaining on their time obligations, and the community service regulations apply to all facilities that ever received Title VI funds.[259]

A. *The 1979 Uncompensated Care Regulations*

Under the 1979 regulations, major conceptual changes have occurred in the definition of the amount of uncompensated care due from recipient hospitals. First, the new regulations eliminate entirely the "open door" compliance option which had been in effect since the 1972 regulations and which had been the chosen compliance option of most Hill-Burton hospitals.[260] A Title VI facility must now elect one of the presumptive compliance minimums, either three

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256. *See AHA District Court Complaint, supra* note 43. *See also* Motion for Temporary Restraining Order and Preliminary Injunction, American Hosp. Ass'n v. Harris, No. 79-C2669 (N.D. Ill., filed Aug. 24, 1979), referred to in American Hosp. Ass'n v. Harris, 477 F. Supp. 665, 666 (N.D. Ill. 1979).

257. *See* American Hosp. Ass'n v. Harris, 477 F. Supp. 665, 666, 669 (N.D. Ill. 1979).

258. 44 Fed. Reg. 29,372 (preface to final regulations of May 18, 1979). Facilities beginning a new fiscal year before that date could implement the requirements at an earlier date. For all facilities beginning their fiscal years after September 1, 1979, the regulations took effect at that time.

259. *See id.* at 29,372, 29,399 n.3 (Appendix I to final regulations of May 18, 1979). The time limitation on Title VI facilities, as established by previous regulations, remains in effect. More than 5,000 Title VI facilities still fall under the time limitation of the uncompensated care requirement, but approximately 1,400 are nursing homes, out-patient clinics, or other types of health facilities.

As in the prior regulations, there is no time limitation on Title VI facilities' community service obligation in the 1979 regulations. The community service regulation has not been so limited since the 1977 regulatory revision prompted by *Cook III*'s holding that the limitation was in derogation of statutory intent. *See* note 181 and accompanying text *supra*.

The 1979 regulations also apply to Title XVI-funded facilities but, as specified in the statute, 42 U.S.C. § 300o-3(b)(J) (1976), facilities funded by Title XVI have no time limitation on their uncompensated care or community service obligations. The terms of the 1979 regulations that refer only to Title XVI facilities are of no consequence to private, non-profit hospitals, however; according to the American Hospital Association, no such hospital has received Title XVI funding. *See* text accompanying note 171 *supra*.

260. *See* 42 C.F.R. § 124.503(a) (1979); 44 Fed. Reg. 29,372, 29,384-86 (Appendix I to final regulations of May 18, 1979). *See also* notes 86, 87 & 108 and accompanying text *supra*.

percent of annual operating costs or ten percent of the amount of the Hill-Burton grant, and supply care to that level.[261] In another fundamental change, a hospital's obligation is now couched in terms of a total volume of services due over the length of time of its uncompensated care obligation. That is, although a hospital's obligation is fulfilled according to an annual presumptive compliance minimum, annual deficits and excesses are carried forward from year to year.[262] If at the end of its obligation period a facility "owes" uncompensated care because of previous shortfalls, it must continue to provide uncompensated care until its total volume is satisfied. By the same token, by exceeding successive annual compliance quotas, a facility may "buy out" of its obligation, and need no longer supply any uncompensated care. Finally, in direct contravention of the language of Title VI, the new regulations eliminate the financial infeasibility waiver whereby a hospital could seek an exemption or reduction of its uncompensated care obligation because of financial hardship.[263]

With the elimination of the open door and waiver options, *all* grantees must now select one of the presumptive compliance minimums.[264] If community need is insufficient to meet either percentage minimum, or if a hospital is financially incapable of delivering enough uncompensated care to meet its selected minimum, the deficits, compounded by an interest factor, carry over to future fiscal years, and act to extend the compliance period. In addition, hospitals claiming insufficient community need must institute affirmative action plans to seek out eligible patients.[265] Both changes impose an unexpected burden on

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261. *See* 42 C.F.R. § 124.503(b)–(d) (1979). DHEW has explained that this change was instituted so that the time limitation could not be used to "'forgive'" noncompliance during the obligation period. 44 Fed. Reg. 29,372, 29,382 (Appendix I to final regulations of May 18, 1979).

262. 42 C.F.R. § 124.503(b)–(d) (1979). Deficits and excesses are carried forward with the addition of an inflation factor by which the deficit or excess to be applied to the total volume figure is adjusted by the percentage change in the national Consumer Price Index for medical care. *Id.* § 124.503(d). The new concept of "buying out" of the uncompensated care obligation through an increased volume of annual care leads to the question whether a hospital could "buy out" by refinancing its Hill-Burton grant or loan through a private lender and repaying the government. In many instances, this course of action would be cheaper for a hospital than compliance with the new regulations. DHEW has indicated that it will not allow hospitals this option. Meeting of DHEW Representatives and Staff of Maryland Health Services Cost Review Commission (Nov. 6, 1979) (notes on file at *Maryland Law Review*). Even if hospitals were permitted to "buy out" of the uncompensated care obligation, it would seem that the community service obligation would continue to apply given that those requirements extend to any hospital that has ever received Title VI funding. *See* note 259 and accompanying text *supra*.

263. *See* 42 C.F.R. § 124.503. *See also* 44 Fed. Reg. 29,372, 29,387 (Appendix I to final regulations of May 18, 1979). Under the waiver provision of Title VI, 42 U.S.C. § 291c(e)(2) (1976), hospitals that are not capable financially of providing uncompensated care may be exempted from compliance.

264. 42 C.F.R. § 124.503(a) (1979).

265. *Id.* § 124.504. DHEW suggests that such plans might include newspaper, radio, and television announcements of the availability of uncompensated care, notice to community groups, expansion of the hospital's service area, voluntary referral arrangements with other hospitals, and expansion of the types of services and income levels of

hospitals, and the waiver elimination also violates the terms of the statute under which these hospitals received funds.

The methods adopted by the 1979 regulations to compute the ten percent of grants presumptive compliance option have also expanded Hill-Burton obligations beyond their original terms. First, the definition of the term "grants" has been expanded to include federal assistance provided through programs that were supplemental to Hill-Burton.[266] Second, the ten percent of grants figure is no longer calculated solely from the dollar amount of assistance received in past years, but is adjusted upward annually by the percentage change in the national Consumer Price Index for medical care.[267] Unlike debts or mortgages, then, the amount owed by Hill-Burton hospitals under the ten percent option will be adjusted upward each year. By precluding hospitals from basing their uncompensated care obligation on pre-inflationary dollars, this change places the ten percent option on similar footing with the three percent of annual operating costs option, which is calculated in current dollars under both the 1972 and 1979 regulations.[268] This new inflation factor will, by DHEW's estimate, result in major increases in the amount of uncompensated care over that due from Hill-Burton hospitals under the previous regulations. The agency estimates that the inflation factor alone will result in an additional $39 million in Hill-Burton care in 1980 and $217 million in 1984.[269] In addition, the national Consumer Price Index medical care inflation rate is an inequitable inflation measurement. First, the medical care index includes many components, such as proprietary drugs, which have nothing to do with the inflation of hospital costs.[270] Second,

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patients served under its Hill-Burton plan. The Secretary has authority to change the plan and to require its continuance until the annual compliance level is reached in a fiscal year. Obviously, the facility must bear these affirmative action expenses.

266. *Id.* § 124.502. The Appalachian Development Act of 1965, 40 U.S.C. app. § 1–423 (1976), is one of four programs considered to be supplemental to Hill-Burton because hospitals receiving monies under these programs gave assurances similar to the uncompensated care and community services provisions. *See* 44 Fed. Reg. 29,372, 29,383 (Appendix I to final regulations of May 18, 1979).

267. 42 C.F.R. § 124.503(a)(ii).

268. Although the 3% of operating costs option may have been cheaper originally for some hospitals than the 10% of grants option, the inflation in medical care costs over time made the 10% option cheaper in almost all cases. That is, hospital operating costs have obviously been tied to inflation, while the 10% of grants option, until the 1979 change, was based on the size of the loan.

269. *See* 44 Fed. Reg. 29,372, 29,403 (Appendix II to final regulations of May 18, 1979). This estimate covers all Hill-Burton facilities, including nursing homes and out-patient facilities. DHEW provides no separate figures for in-patient hospitals, the group that received the great majority of Hill-Burton money. *See* HILL-BURTON PROGRAM PROGRESS REPORT, *supra* note 38, at 2–4. The American Hospital Association notes that by 1984, the inflation factor alone will amount to almost one-half of the present total compliance level of all Hill-Burton assisted facilities and cites the case of one hospital that will be required in 1984 to provide uncompensated care in an amount almost equal to the amount of its original grant. *See* Brief for Appellant, American Hosp. Ass'n v. Harris, No. 79–2162 (7th Cir., filed Oct. 11, 1979), at 15–16 [hereinafter cited as *AHA Circuit Court Brief*].

270. Other examples include vitamins, cough syrup, dentists' fees, eyeglass dispensing. *See* U.S. BUREAU OF LABOR STATISTICS, DEP'T OF LABOR, BULL. NO. 2000, HANDBOOK OF LABOR STATISTICS 1978, at 421–24 (1979).

the application of a national average inflation rate penalizes hospitals that have succeeded in controlling costs to achieve an inflation rate lower than the national average and rewards facilities that have made no attempts to control skyrocketing hospital costs.[271] Even assuming the legitimacy of the addition of some inflation factors, more precise measurements exist for equitable calculation of hospital inflation.[272]

The notice section of the new uncompensated care regulations now requires three types of notice: public, in-facility, and individual.[273] Public notice through newspaper announcement is now to be coordinated with a hospital's local Health Systems Agency, a federally-created planning body.[274] In-facility notices, which are supplied by DHEW, are required in specific locations of the hospital.[275] The individual notice requirement makes the most sweeping notice change, in that Hill-Burton facilities must now provide individual written notice to *every person* who seeks services and must make reasonable efforts to insure that each person understands the meaning of the notice.[276] Individual notice must be given prior to treatment except in some types of emergencies[277] and must continue to be supplied until the facility's uncompensated care minimum is fulfilled for the

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271. Hospital care expenditures have increased 260% in the past 10 years, an average of 14% per year or two and one-half times the rate of growth of the Gross National Product. *See* Gibson, *supra* note 57, at 4; Gibson & Fisher, *National Health Expenditures, Fiscal Year 1977*, SOC. SEC. BULL. 3, July 1978, at 14, 15. Penalizing cost-conscious hospitals conflicts directly with other executive branch proposals, which have sought to limit hospital cost inflation. *See* President's Message to Congress Proposing Enactment of Hospital Cost Containment Act of 1977, 13 WEEKLY COMP. OF PRES. DOC. 603–05 (April 25, 1977).

272. *See* Biles, Schramm, & Atkinson, *Hospital Cost Inflation Under State Rate Setting Programs: The Record*, NEW ENGLAND J. MED. (forthcoming), which presents a state-by-state analysis of hospital cost inflation.

273. 42 C.F.R. § 124.505 (1979).

274. *Id.* § 124.505(a), (b). Section 1515 of the National Health Planning and Resources Development Act of 1974, Pub. L. No. 93–641, 88 Stat. 2239 (1974), gave DHEW the authority to designate a Health Systems Agency for health services areas as defined in the Act. The agencies' primary responsibilities are health planning and development within their respective areas. *See* 42 C.F.R. § 122.101.

275. 42 C.F.R. § 124.505(c). The posted notice must be multilingual in some instances, and the facility must make reasonable efforts to communicate its contents to persons who may reasonably be believed unable to read it.

276. *Id.* § 124.505(d). The notice must state that the facility is required by law to provide a reasonable amount of uncompensated services, must set forth patient eligibility criteria, must announce which hospital services are provided (pursuant to the hospital's allocation plan), and must state that a written determination will be made of a patient's eligibility for uncompensated care within two days of a request for services. The American Hospital Association estimates that distribution of 122 million individual notices will be required in 1980. *See AHA District Court Complaint, supra* note 43, at 18.

277. 42 C.F.R. § 124.505(d)(2). Prior notification is required except where the emergency nature of a case makes it impractical. In this situation, notice is to be supplied to the next of kin or patient as soon as practical, but in no event at a time later than the first presentation of the bill for services.

year.[278] If an applicant is denied uncompensated care, the facility must provide a written statement of the reasons for denial. This requirement survives fulfillment of the annual compliance obligation, that is, it must be given when the reason for denial is that no further obligation exists for the fiscal year.[279]

The individual notice regulation is an outgrowth of the *Newsom v. Vanderbilt University* decision; however, although the *Newsom* court held that potential beneficiaries were entitled to individual notice,[280] the new regulations require individual notice to every hospital patient, regardless of insurance coverage or ability to pay.[281] The administrative, printing, and distribution costs mandated by this requirement are burdensome to hospitals in an absolute sense;[282] moreover, when compared with the actual number of patients who will be eligible for and receive Hill-Burton care, individual notice is an extremely cost-inefficient means of delivering care to the needy.

In conjunction with the individual notice requirement, the 1979 regulations add new standards for patient eligibility determination. A hospital must now make a determination "on request" by the patient; eligibility must not necessarily be made prior to treatment as required under the previous regulations.[283] The criteria for patient eligibility for Hill-Burton care are also

278. *Id.* § 124.505(d)(1). *See also* 44 Fed. Reg. 29,372, 29,390 (Appendix I to final regulations of May 18, 1979).

279. 42 C.F.R. § 124.508(c).

280. 453 F. Supp. 401, 423 (M.D. Tenn. 1978).

281. DHEW's position appears to be that all patients are potential beneficiaries, regardless of apparent ability to pay or third-party insurance coverage, because subsequent financial reversals may entitle them to apply for Hill-Burton benefits even after receiving treatment. *See* text accompanying note 283 *infra*. The new regulations do not, however, adopt the appeal and review procedures found to be required by the *Newsom* court. 453 F. Supp. at 424. In contrast to its acquiescence in other federal district court rulings, DHEW did not implement this requirement because "the governing statute does not require facilities to establish review procedures." 44 Fed. Reg. 29,372, 29,393 (Appendix I to final regulations of May 18, 1979).

282. DHEW's cost estimate for all facilities' administration of the combined notice requirements is approximately $58 million per year. *See* 44 Fed. Reg. 29,372, 20,406, Table 4 (Appendix II to final regulations of May 18, 1979). This figure does not include compliance costs other than administrative ones, such as the cost of printing approximately 122 million individual notices and legal expenses related to Hill-Burton claims. DHEW estimates that its own administrative costs in 1980 will be approximately $1.5 million. 44 Fed. Reg. 29,400.

283. 42 C.F.R. § 124.508. *See also* 44 Fed. Reg. 29,372, 29,392–93 (Appendix I to final regulations of May 18, 1979). The prior determination of eligibility requirement was adopted by DHEW in response to *Corum II*. *See* text accompanying note 151 *supra*. The change in this provision appears to reflect DHEW's understanding that prior determination is not always feasible or fair to otherwise eligible patients who did not seek eligibility determinations. Theoretically, this change comports with a more equitable distribution system; practically, however, it acts to expand the class of potential applicants for a finite amount of care. Under the new regulations, an application for Hill-Burton care could be considered by the hospital even after its institution of a collection suit against the patient. *See* 44 Fed. Reg. 29,372, 29,393 (Appendix I to final regulations of May 18, 1979). Arguably, this raises the possibility that hospital noncompliance may be raised as a defense in a collection action. 42 C.F.R. § 124.507. *See* note 328 and accompanying text *infra*.

changed. Under prior regulations, these standards were set by each state Hill-Burton agency;[284] now, hospitals must use a uniform income standard.[285] The use of a national standard does not account for regional variations in income or medical costs;[286] furthermore, the standard is based solely on income; other factors that might influence a patient's ability to pay are not considered.[287] In addition, the regulation creates an upper "cap" on patient eligibility; thus, a patient with an income just above the eligibility limit may no longer qualify for Hill-Burton care even after exhausting his savings.[288]

Pursuant to guidelines included in the regulations, a facility must formulate a plan for distributing care among eligible patients and must also specify which services will be offered and how they will be spread over the year. A hospital still has discretion in selecting the services that it will provide to meet its obligations, and, as under the prior regulations, an indigent in need of a specific medical service remains at the mercy of pre-set determinations as to whether such services will be offered under the hospital's plan. The uncompensated care regulations now require, however, that a hospital's plan take into account its local Health Systems Agency's comments on community need.[289]

Although the reasonable cost calculation and crediting methods of previous regulations are continued in the new regulations, certain expenses and types of services that were creditable under the previous regulations are now excluded. The new provision forces a hospital either to refuse to supply such nonqualifying

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284. *See* note 89 and accompanying text *supra*.

285. *See* 42 C.F.R. § 124.506. The standard is taken from the Community Service Administration's (CSA) poverty income criteria. Two categories of patient eligibility are set: Category A includes persons with incomes below the CSA poverty income guideline; Category B includes persons with incomes above the guideline, but not more than twice that figure. A hospital's plan may provide for services to both groups, but if Category B patients are to be Hill-Burton eligible, the plan must specify whether such persons will receive free or reduced charge services and, if the latter, the method for determining the reduced charge. *See id.* § 124.507(a)(4).

286. In the public comment on the uniform standard, it was pointed out that the Medicare and Medicaid systems recognize regional variations in these factors. Nonetheless, DHEW retained the uniform standard on the ground of its administrative simplicity. *See* 42 Fed. Reg. 29,372, 29,390–91 (Appendix I to final regulations of May 18, 1979).

287. Such factors might include other assets (*e.g.*, property, securities) or other sources of funds (*e.g.*, savings). *See id.*

288. In addition, another component of the eligibility regulation may pose administrative problems for hospitals. Many persons defined as Hill-Burton eligible by the new income standards are also Medicaid eligible, yet the regulations prohibit a hospital from claiming Hill-Burton credit for care given to any person who is eligible for any third party or government insurance program, regardless of the person's actual enrollment in such a program. A hospital may credit services rendered to such a patient only if he refuses to take necessary action to obtain entitlement to benefits. *See* 42 C.F.R. § 124.509(a); 44 Fed. Reg. 29,372, 29,393–94 (Appendix I to final regulations of May 18, 1979). This requirement is consistent with Hill-Burton's policy of being a program of "last resort," *see* 44 Fed. Reg. at 29,393–94; however, it may involve hospitals in administrative conflicts over eligibility and crediting.

289. *See* 42 C.F.R. § 124.507.

charity services or to bear the expense without receiving Hill-Burton credit. In some instances, the provision will disrupt comprehensive programs of care for the needy and force those patients into the hospital's Hill-Burton plan, which may not offer full services.[290]

These intricate new regulations spring, ostensibly, from the Hill-Burton Act's requirement that there be "made available . . . a reasonable volume of hospital services to persons unable to pay therefor."[291] Overall, the new uncompensated care regulations are a strange mix of overly broad categorizations — such as the uniform inflation rate and income eligibility standard — when such is deemed efficient for DHEW administration, and overly specific requirements — such as individual notice to every person seeking hospital treatment — when the agency sees fit to impose such requirements. They go beyond the terms of past regulations to place a heavier financial burden on Hill-Burton hospitals, both in real dollars for actual uncompensated care dispensed,[292] and in administrative costs for compliance.[293] Yet, they do little to further any comprehensive policy for improved health care to the poor.

B. *The 1979 Community Service Regulations*

Like the uncompensated care regulations, the new community service requirements reflect DHEW initiative and also manifest the influence of various federal courts. *Cook II* and *Cook III* held, respectively, that the original Hill-Burton Act compelled grantee hospitals' acceptance of Medicaid patients under the community service clause[294] and did not permit the time limitation on the requirement.[295] These interpretations have been maintained and expanded in the 1979 community service regulations,[296] which require hospitals to institute

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290. *See id.* § 124.509. One such requirement excludes from allowable credit any amount in excess of the payment that a facility has agreed to accept from any other reimbursement program. *Id.* § 124.509(b). This limitation is reduced to meaning by the objection of a particular hospital to the provision when the regulations were in proposed form: The hospital maintained a reimbursement agreement with a locally funded medical program for indigents under which it was paid approximately one-quarter of the average cost of the services provided. Under the old regulations, the hospital was permitted to charge against its Hill-Burton obligation the difference between the lower local reimbursement rate and the higher rate of Medicaid reimbursement; however, under the new regulations, this credit is not permitted. As noted by the hospital, the new regulation called into question the financial advisability of continuing the local program. *See* 44 Fed. Reg. 29,372, 29,393 (Appendix I to final regulations of May 18, 1979).

291. 42 U.S.C. § 291c(e)(2) (1976). For example, DHEW explains its expansion of the grant base to include supplemental programs, *see* note 266 and accompanying text *supra*, by stating that "the Secretary is clearly authorized to define what is a 'reasonable volume' of services." 44 Fed. Reg. 29,372, 29,384 (Appendix I to final regulations of May 18, 1979).

292. *See* note 269 and accompanying text *supra*.

293. *See* note 282 *supra*.

294. Cook v. Ochsner Foundation Hosp. (*Cook II*), 61 F.R.D. 354, 360 (E.D. La. 1972).

295. Cook v. Ochsner Foundation Hosp. (*Cook III*), Civ. No. 70–1969 (E.D. La. March 12, 1975).

296. 42 C.F.R. §§ 124.601, .603 (1979).

new operating policies and administrative procedures. Unlike the uncompensated care regulations, which deal with delivery of services to persons who are not Medicare or Medicaid eligible, the new community service regulations focus on these programs and, in effect, operate as adjunct regulations in DHEW's administration of Medicare and Medicaid.

For example, in order to improve Medicare and Medicaid beneficiaries' access to Hill-Burton hospitals, the community service requirement now prohibits facilities from maintaining admissions policies whereby a patient must be referred by a physician with staff privileges. If such a policy has the "effect of excluding persons who reside in the area because they do not have a private family doctor," the facility must make alternate arrangements for admission.[297] In addition, if Medicaid patients are accepted by an inadequate number of staff-privileged physicians in the hospital or any of its departments, and this practice has the effect of excluding Medicaid patients from the facility or any of its services, the facility is deemed out of compliance and must take steps to ensure full access to all services by Medicaid patients.[298] DHEW suggests that these defects in admissions policies may be remedied by allowing physicians without staff privileges to treat their patients in the facility, obtaining the voluntary agreement of staff-privileged physicians to accept referrals of such patients, requiring staff-privileged physicians to treat such patients as a condition to obtaining or renewing their privileges, establishing new clinics through which such patients may be treated or admitted, or hiring new physicians to treat patients who have no private physicians.[299]

The original purpose of Hill-Burton's community service clause was to prohibit racial discrimination and to prevent the monopoly of government-funded hospitals by special interests.[300] These new requirements completely transform this purpose. Although the goal of complete access to hospital services by Medicaid patients and other persons unable to pay for services is laudable, the use of the Hill-Burton regulations as a device to achieve it is an inappropriate "back door" approach to a serious health care issue. Such an approach ignores the real problems inherent in medical care to the poor and shifts the entire burden of a new health care initiative to hospitals that once received Hill-Burton funds and their privately insured and cash-paying patients.[301]

In addition to transforming Hill-Burton's original purpose, the new regulations complicate some elements of hospitals' operating procedures. Some

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297. *Id.* § 124.603(d)(1).

298. *Id.* § 124.603(d)(2).

299. *Id.* § 124.603(i)–(v).

300. *See* notes 22 to 28 and accompanying text *supra*.

301. Although it may be argued that physician discretion to treat patients based on ability to pay or reimbursement constitutes a fundamental inequity in the health care system, the fact remains that such practices do exist. Restructuring the health care system to eliminate these and other inequities requires a comprehensive approach, not one accomplished by fiat and imposed on selected hospitals.

of the new requirements conflict with the accreditation and licensure requirements for many hospitals and raise questions of hospital liability for the acts of physicians practicing within the facility.[302] Also, an ambiguity is created by provisions that limit the circumstances in which hospitals may collect preadmission deposits. If this practice has the effect of denying or delaying admission because of inability to pay, it is a violation of the community service regulations. The policy, however, is not limited to patients who are Hill-Burton, Medicaid, or Medicare eligible, but includes "employed persons and persons with other collateral [who] do not have savings" or other available cash at the time that services are requested, but who "probably can pay for services."[303] This portion of the regulations leaves uncertainty as to the circumstances in which preadmission deposits may be collected, and has caused concern among hospitals that rely on such funds to maintain cash flow and reduce bad debt.[304] Implementation of this broadly phrased requirement furthers the notion that the Hill-Burton Act may be expanded to regulate any hospital practice that touches upon any facet of hospital care.[305]

Finally, the community service regulations prohibit denial of emergency services to any resident of a facility's service area because of the patient's inability to pay.[306] This requirement, per se, does not impose a major new burden on Hill-Burton hospitals, most of which have treated all emergency cases regardless of ability to pay.[307] Rather, the requirement is another instance of overreaching the limits of the Hill-Burton Act. In this respect, the provision is much like the community services provision requiring that hospitals participate in the Medicaid and Medicare programs. Most hospitals would participate in these programs regardless of the Hill-Burton requirement,[308] and objections to

302. *See AHA Circuit Court Brief, supra* note 269, at 21 & 22.

303. 42 C.F.R. § 124.603(d)(3).

304. *See* 44 Fed. Reg. 29,372, 29,398 (Appendix I to final regulations of May 18, 1979); *AHA Circuit Court Brief, supra* note 269, at 33.

305. This requirement also ignores the ruling in Cloud v. Regenstein, No. C 77-599A (N.D. Ga. April 29, 1977) (denial of plaintiffs' motions for preliminary injunction and class certification), that the Hill-Burton Act was not intended to control such administrative functions. This suit has been reactivated since the 1979 regulations became effective.

306. 42 C.F.R. § 124.603(b). This requirement extends beyond the point at which a facility has fulfilled its annual obligation, although such service may be credited toward the Hill-Burton obligation throughout the year. The facility must continue treatment until the medical judgment is made that transfer or discharge would not be detrimental.

307. Even apart from hospitals' independent action in this regard, many states and localities have laws that compel hospitals to treat all emergency cases. *See* 44 Fed. Reg. 29,372, 29,393 (Appendix I to final regulations of May 18, 1979).

308. *Cf.* note 57 *supra* (Medicare and Medicaid represent 35% of hospital revenues). For many hospitals, Medicare and Medicaid are major funding sources; program participation is necessary for financial survival. For example, The Johns Hopkins Hospital derives 47% of annual revenues from the programs, *see* THE JOHNS HOPKINS HOSPITAL, 1979 ANNUAL REPORT 35 (1979); the Greater Baltimore Medical Center derives 36% of annual revenues from Medicare and Medicaid. Conversation with S. Erdman, Comptroller, Greater Baltimore Medical Center (March 3, 1980).

In the past, however, it has not been the case that every service in a participating hospital would necessarily be available to such patients. Availability of a particular

the requirement go much less to its substance than to the broad scope of power that DHEW has now claimed under the Act. These detailed changes in the community service regulations, which have evolved from the general statutory requirement that Hill-Burton hospitals should "be made available to all persons residing in the territorial area,"[309] have been promulgated in disregard of the Act's specific prohibition of federal interference with the operation or administration of recipient hospitals.[310]

It may be that the 1979 regulations are DHEW's atonement for its lack of responsiveness and enforcement from 1972 to 1978. In this regard, the new regulations have been accompanied by indications of DHEW's intent to provide "more vigorous enforcement" of the requirements.[311] The problem, however, is that DHEW has shifted the burden of reparation to Hill-Burton hospitals in

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service has generally turned upon the willingness of individual physicians on a service to accept government payment for their services. *See* Perry v. Cape Cod Hosp., Mass. Dep't of Pub. Health (March 14, 1979), an administrative ruling that determined that Massachusetts Hill-Burton hospitals could not comply with the previous community service requirements, 42 C.F.R. § 53.113(e) (1978), "merely by participating in the Medicaid program." The Department concluded that access to certain services was unlawfully limited because no physicians on the services accepted Medicaid patients. *Id.* at 5; *see also* HEALTH LAW NEWSLETTER, No. 96 (April 1979), at 1–2. It appears that the language of the new community service requirement was modeled after the conclusion reached in this case. Letter from Holly D. Ladd, Director, Mass. Hill-Burton Program, to author (Nov. 26, 1979) (on file with *Maryland Law Review*).

309. 42 U.S.C. § 291c(e)(2) (1976).

310. *Id.* § 291m. The section provides:

> Except as otherwise specifically provided, nothing in this subchapter shall be construed as conferring on any Federal officer or employee the right to exercise any supervision or control over the administration, personnel, maintenance or operation of any facility with respect to which any funds have been or may be expended under this subchapter.

This section was discussed in Euresti v. Stenner, 458 F.2d 1115 (10th Cir. 1972). *See* note 64 *supra*. The provision is repeated in the 1975 Title XVI enactment. 42 U.S.C. § 300s–2 (1976).

311. *See* 44 Fed. Reg. 29,372, 29,396 (Appendix I to final regulations of May 18, 1979); *see also id.* at 29,383, 29,400, 29,401. This attitude was expressed at a meeting attended by the author between representatives of DHEW Region III divisions (Public Health Service, Office of the General Counsel, Health Resources Administration, Health Care Financing Administration) and the staff of Maryland Health Services Cost Review Commission to discuss the impact of the new regulations on Maryland hospitals (Nov. 6, 1979) (notes on file at *Maryland Law Review*).

The regulations include reporting and record maintenance requirements and investigation and enforcement provisions that comport with the substantive requirements of the regulations. 42 C.F.R. §§ 124.510, .511. These provisions eliminate the authority previously vested in the state Hill-Burton agencies and, in accordance with the terms of Title XVI, acknowledge DHEW as the primary monitoring and enforcement agency. *Compare* 37 Fed. Reg. 14,719, 14,720 (binding interim regulations of July 22, 1972, codified at 42 C.F.R. § 53.111(i) (1978)) *with* 42 C.F.R. §§ 124.510, .511 (1979). *See* text accompanying notes 160 & 162 *supra*. DHEW may, however, at its discretion, enter into agreements with state agencies to obtain their administrative assistance. 42 C.F.R. § 124.512 (1979).

disregard of the regulations' impact on these facilities as compared with the actual improvement in the delivery of health care to the indigent. The agency has also continued its myopic regulation of Hill-Burton without consideration of other health care programs under its aegis.

PART III: THE FALLACY OF HILL-BURTON FROM A POLICY PERSPECTIVE

The American Hospital Association is seeking invalidation of the 1979 regulations,[312] basing its claims on impairment of contract, taking of Hill-Burton hospitals' property without due process,[313] and an overreaching of regulatory authority[314] on the government's redefinition of the contractual terms under which hospitals accepted Hill-Burton funding, the requirement of major expenditures by at least some Hill-Burton hospitals, and the fact that the detailed new requirements exceed and even conflict with statutory authority. It is interesting that these issues are presented for judicial resolution, in that partial responsibility for the regulations' evolution to this stage can be traced to the alteration of the Act's scope resulting from some courts' misinterpretations

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312. American Hosp. Ass'n v. Harris, No. 79-2162 (7th Cir., filed October 11, 1979). The AHA has appealed the denial of its motion for preliminary injunction of the 1979 regulations, 477 F. Supp. 665 (N.D. Ill. 1979), wherein the court applied the weighing of hardships test and found:

> The Regulations at issue, and the relevant enabling statutes . . . were developed to provide the poor with greater access to hospital care . . . . To deny such poor individuals access to the hospital care they require . . . would be to impose upon them a hardship that is far greater than any of the AHA's member organizations will have to endure.

Id. at 668. The district court followed in the footsteps of previous courts in finding that the Act's purpose was to provide hospital care to the poor, and thus erred by balancing that interest against the hospitals' hardships. Instead, the proper comparison would have been to weigh the effects of the old regulatory scheme against the effects of the new regulatory scheme on Hill-Burton hospitals.

313. *AHA Circuit Court Brief, supra* note 269, at 13–30. In its contract impairment and taking claims, the AHA relies on the line of Supreme Court cases that have stated that abrogation of a contract by the United States may be a violation of the fifth amendment's due process clause. *AHA Circuit Court Brief, supra* note 216, at 27–28 (citing *inter alia,* Lynch v. United States, 292 U.S. 571, 579 (1934)). The fifth amendment states: "No persons shall be . . . deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation." U.S. CONST. amend. V. It has been held to protect private contracts from federal government impairment and to restrain the federal government from abrogating contracts to which it is a party in much the same manner that the contracts clause, U.S. CONST. art. I, § 10, prohibits the states from impairing or abrogating contracts. *See generally* Hochman, *The Supreme Court and the Constitutionality of Retroactive Legislation,* 73 HARV. L. REV. 692 (1960). For an excellent treatment of the impairment of contract issue as it relates to the 1979 Hill-Burton regulations, see *Hill-Burton Facilities, supra* note 22.

314. In its agency overreaching claim, the AHA has focused on the principle that administration of a federal statute is intended to effectuate, not amplify or alter, the will of Congress. *See AHA Circuit Court Brief, supra* note 296, at 23–24 (citing, *inter alia,* Ernst & Ernst v. Hochfelder, 425 U.S. 185, 213 (1975)).

of Hill-Burton's purpose. In its consideration of the AHA claim, the circuit court would do well to ignore the misperception of Hill-Burton that has arisen through litigation and to take a fresh look at the Act's purpose and the development of the regulations.

As has been discussed, because the courts have been compelled to consider Hill-Burton in isolation from broader health policy concerns, the program has not grown in any coordinated fashion. In *American Hospital Association v. Harris,* the court, like its predecessors, is limited to consideration of legal issues and cannot address the policy problems inherent in the new regulations. Many of these problems extend well beyond the specific regulatory provisions to concern the effect of the entire Hill-Burton program.

The result of Hill-Burton's unplanned development from a hospital construction and modernization program into a service-provision program is the delivery of a small amount of service to the indigent through a cumbersome administrative system. The program is highly cost-efficient: In 1980 DHEW estimates that somewhat less than $395 million in Hill-Burton care will be delivered through the uncompensated care requirement, and an additional $59.5 million will be spent to administer the program.[315] This represents a ratio of 6.6 : 1, Hill-Burton care delivered to administrative costs. In contrast, Medicare and Medicaid benefits exceeded $41 billion in 1978, the last year for which published figures are available, and administrative expenses totaled $2 billion.[316] Under Medicare and Medicaid, then, the ratio of care delivered to administrative expenses is approximately 20.5 : 1. Not only do the relative dollar values of care delivered show Hill-Burton to be an inadequate step toward more comprehensive financing of health care for the poor, but the high administrative costs associated with the program illustrate its inefficiencies.[317]

Furthermore, under the regulations whether any individual indigent will actually receive Hill-Burton hospital care is highly uncertain. The delivery of

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315. 44 Fed. Reg. 29,372, 29,399 (Appendix II to final regulations of May 18, 1979). The $395 estimate is based on the assumption that all Title VI facilities still falling within the time limitation, including out-patient facilities and nursing homes, will elect the 10% compliance option. Costs to hospitals, which received 83% of all Hill-Burton funds, are not estimated separately. *Id.* at n.3. In fact, as DHEW points out, some facilities may elect the 3% of operating costs option because it will be cheaper; thus, the value of care delivered will be less than $395 million. *Id.*

DHEW estimates that of the $59.5 million administrative costs for 1980, $58 million will be borne by Hill-Burton institutions. This estimate does not include some administrative elements of compliance. *See* note 282 *supra.*

316. *See* Gibson, *supra* note 57, at 29 (Table 6). Given that 1978 expenditures increased approximately 13% over 1977 expenditures, *see id.* at 1, 10, and that health care inflation has continued at about that same rate since 1978, it may be assumed that the 1980 figure would, in fact, be larger.

317. Promulgation of the regulations thus conflicts with other government initiatives to decrease regulatory costs. *See* note 271 *supra*; DeMuth, *Constraining Regulatory Costs — The White House Programs* (pt. 1), 3 REGULATION, Jan./Feb. 1980, at 13–26.

care is dependent upon a number of factors totally unrelated to his need for medical care for which he cannot pay, such as

(1) residence (Does he live near a hospital that once received Hill-Burton funds?);

(2) the year in which the facility received the grant (Has the uncompensated care obligation expired?);

(3) the size of the hospital's operating budget or Hill-Burton grant (What is the extent of the obligation?);

(4) the hospital's financial condition (Does the hospital have a diminished obligation because of deferral to a future year?);

(5) the time of the year (Has the hospital already met its annual quota?);

(6) the medical service needed (Does the hospital's plan offer such a service?);

(7) the income level in the area (Have other needy persons already consumed the available uncompensated care?);

(8) the patient's income level (Does he meet the income standards? How does the hospital's plan divide care among the various classes of eligible patients?).[318]

A further anomaly with respect to patient care is seen in the manner in which the community service regulations arbitrarily differentiate between Hill-Burton patients and Medicare or Medicaid patients. As noted above, Hill-Burton patients have access to only those services offered in the hospital's distribution plan, and must be served only so long as the hospital retains a balance on its annual obligation. In contrast, Medicare and Medicaid patients are eligible for all Hill-Burton hospital services at any time.[319] Medicare and Medicaid beneficiaries may not be able to receive care, however, if they do not have access to a hospital that once received Hill-Burton funds, since only Hill-Burton hospitals are required to institute new procedures to ensure full access to Medicare and Medicaid patients.[320] Forcing selected hospitals to incur the expenses of hiring new staff and maintaining new clinics under the authority of the community service regulations is one issue; another is the rationality of differentiating among Medicare and Medicaid beneficiaries on the basis of Hill-Burton funding of their area hospital.

In terms of patient care distributed, another irony is found in DHEW's cost analysis of the new uncompensated care regulations, which states that one major effect of the requirements will be to redistribute among hospitals the existing financial burden of charity care.[321] The requirements will trigger a reduction in the charity care volume of some non-Hill-Burton hospitals and an increase for some Hill-Burton hospitals. Thus, a large part of the additional care delivered through Hill-Burton hospitals will not represent an increase in the

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318. *See generally* 42 C.F.R. § 124.501–.509 (1979).

319. *See id.* § 124.603.

320. *See* note 308 and accompanying text *supra*.

321. *See* 44 Fed. Reg. 29,409 (Appendix II to final regulations of May 18, 1979).

total amount of care available to indigents, but will merely offset decreases in availability and demand in non-Hill-Burton facilities.[322] This assessment undercuts one major rationale of the new regulations, that poor people were receiving inadequate hospital care under the old regulations.

Moreover, uncertainty about how redistribution will occur is one factor that makes it difficult to ascertain the real impact of the new regulations on individual Hill-Burton hospitals. DHEW's acceptance of this phenomenon glosses over the fact that Hill-Burton care is not funded by any public taxation system. If redistribution results in an increased uncompensated care obligation for a particular Hill-Burton hospital, then its charge-paying patients will bear the increased hospital charges made to support the additional care.[323] This is

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322. A non-Hill-Burton hospital may reduce its charity care volume and refer patients to a Hill-Burton facility. Poor people may thus continue to receive care, but simply in a different location. Or, a non-Hill-Burton hospital may experience a decrease in demand for charity care as a nearby Hill-Burton hospital provides adequate services to meet community need. In fact, a more logical approach would look not to the location in which the poor receive health care, but to whether it is being received. Instead, the redistribution concept perpetuates the *quid pro quo* theory of Hill-Burton, *see* text accompanying notes 101 to 103 *supra,* and focuses on hospitals' obligations rather than on the need for services. In turn, this focus recalls the issue of contract impairment. *See* note 313 *supra.*

323. DHEW is not unmindful of this consequence. In its cost analysis, the agency states that most of the redistribution will involve a "shift to increased charges" to cash-paying patients, privately insured patients, and philanthropy. 44 Fed. Reg. 29,372, 29,409 (Appendix II to final regulations of May 18, 1979). By philanthropy, it appears that DHEW means contributions to hospital endowments or general funds, as charitable reimbursement for specific patient services may not be credited toward the Hill-Burton obligation. *See* 42 C.F.R. § 124.509 (1979).

The agency's continued insistence that Medicare and Medicaid reimbursement will not share in funding Hill-Burton care is seen in its response to actions that have sought such coverage. The DHEW Provider Reimbursement Review Board (PRRB), the adjudicatory body created by statute to hear cost reimbursement cases involving at least $10,000, *see* 42 U.S.C. § 1395oo (1976), has found that Hill-Burton uncompensated care is not an "allowable cost" under the Medicare statute, 42 U.S.C. § 1395x(v)(1)(A)(i) (1976), which provides that hospital costs incurred with respect to individuals who are not Medicare beneficiaries shall not be borne by the program. *See, e.g.,* Indiana Hosp. Ass'n Group Appeal No. 1. v. Blue Cross Ass'n/Mutual Hosp. Ins., Inc., Health Care Financing Administration, Administrator's Decision, [1980] 3 MEDICARE & MEDICAID GUIDE (CCH) ¶30,333, *aff'g in part* PRRB Dec. No. 79-D95, [1979-2 Transfer Binder] MEDICARE & MEDICAID GUIDE (CCH) ¶ 30,163. *See also* Rapides General Hosp. v. Mathews, 435 F. Supp. 384, 387-89 (W.D. La. 1977), which granted summary judgment to the plaintiff hospital on its appeal of the PRRB's decision, PRRB Dec. No. 76-D3, [1976 Transfer Binder] MEDICARE & MEDICAID GUIDE (CCH) ¶ 27,721, that had denied Medicare reimbursement to share in the cost of Hill-Burton care. The court found that the cost of providing Hill-Burton uncompensated care, which was incurred because the hospital accepted government funds for construction, was analogous to interest payments on a privately-financed capital construction project. Since Medicare pays its share of the latter expense, the court reasoned, it should also pay its share of Hill-Burton uncompensated care. 435 F. Supp. at 387-89. *See* note 56 and accompanying text *supra. Rapides* was appealed by DHEW, but on remand to the district court for further fact-finding, was dismissed because of errors in the plaintiff hospital's cost reports. Conversation with P. Hofstra, Counsel,

particularly unfair to citizens in localities that operate public hospitals to care for the needy. These citizens will pay twice for care for the indigent, once through their taxes to operate the public hospital, and again through higher rates to finance the required volume of uncompensated care at the private hospital. In some instances, the public hospital may remain underutilized while the private hospital is forced to deliver care to its mandatory minimum. Hill-Burton hospitals in poorer areas, where a large portion of the patient population are Medicaid or Medicare beneficiaries, will also be hard pressed to pass the entire burden of uncompensated care along to a small percentage of charge-paying patients. In these and other instances, imposing this subsidization of services on persons whose local hospital happened at one time to have accepted Hill-Burton funds is fundamentally unfair and illogical.

In some states, hospitals seeking to increase rates must gain permission of regulatory authorities that control hospital costs.[324] Under some state regulatory mechanisms, rate increases may not be permitted in order to fund increased charity care.[325] Thus, some hospitals may be forced to meet increased costs by resorting to endowments, or reducing the current quality of services in order to economize.

For other Hill-Burton hospitals, the major effect of the new uncompensated care regulations may be to alter hospital administrative procedures, not to increase the volume of uncompensated care dispensed. It appears that a number of Hill-Burton hospitals currently provide sufficient charity care to meet their obligations under the new regulations;[326] they have not, however, been distributing it in accordance with the specific methods detailed by the 1979 regulations. In such instances, the new regulations provide hospitals with an incentive to classify all eligible Hill-Burton patients in order to obtain program credit, thus prompting increased administrative expenses with no concommitant increase in care.

American Hospital Association, April 25, 1980. Litigation on the reimbursement issue is pending in at least three district courts. Memorial Hosp. v. Harris, No. 80–67-ORL-Civ.-Y (M.D. Fla., filed Feb. 11, 1980); St. James Hosp. v. Harris, Civ. No. 80C–0735 (N.D. Ill., filed Feb. 11, 1980); Miami Valley Hosp. v. Harris, Civ. No. C–2–80–95 (S.D. Ohio, filed Feb. 8, 1980).

324. There are approximately 25 state rate-setting programs now in operation. Authority over hospital costs varies from mandatory compliance to advisory budget review. Biles, Schramm & Atkinson, *supra* note 272. In Maryland, where mandatory rate setting is accomplished by a state commission, hospitals must be granted approval prior to any rate increase. *See* MD. ANN. CODE art. 43, §§ 568H-Z (1980).

325. *See AHA Circuit Court Brief, supra* note 269, at 35–36 (Minnesota rate review system does not allow hospitals to increase rates to charge-paying patients to cover an increased charity care obligation of the volume demanded by the new Hill-Burton regulations).

326. According to a preliminary analysis, this appears to be the case for all Maryland Hill-Burton hospitals. Added costs to these facilities will be incurred for administration of the requirements. *See* HEALTH SERVICES COST REVIEW COMM'N, FINANCIAL ACCESS EXPERIMENT (DRAFT) 5 (1980). To date, three Maryland hospitals have been granted rate increases to meet these added administrative costs. Interview with Dr. Harold A. Cohen, Executive Director, Maryland Health Services Cost Review Commission, March 11, 1980.

In other instances, the major effect of the uncompensated care regulations may be the redistribution of a hospital's fixed amount of charity care among its own needy patients. Patients who would previously have been Hill-Burton eligible may not meet the new income requirements, and care may be redistributed from the "less" needy to those deemed by the eligibility standards to be "more" needy. Alternately, because eligibility is based only on income, and does not consider assets, some patients who could afford at least partial payment may receive free Hill-Burton care.[327]

Finally, the growth of Hill-Burton into a service-provision program may have other less obvious consequences for recipient hospitals. For example, DHEW's interpretation of the new regulations suggests that Hill-Burton compliance may now be considered a proper affirmative defense to a hospital collection suit.[328] The interjection of compliance has the potential to call into question such items as the hospital's calculations of its available volume of care, its plan for allocation of services throughout the facility, notice to patients, or eligibility determination methods, and could complicate such proceedings to the point of forcing hospitals to abandon or compromise otherwise rightful claims for payment. Another potential problem is raised by the use of Hill-Burton as a basis for medical malpractice claims in which a plaintiff alleges that proper medical treatment was not received because of a hospital's violation of some facet of the regulations.[329] Again, linking Hill-Burton to the already complex factual issues of medical malpractice would involve the courts in compliance determinations that could complicate and expand such litigation. To assume that such actions are a natural outgrowth of a hospital construction and modernization statute is to strain credulity.

CONCLUSION

Examination of the results and potential outcomes of the original Hill-Burton Act as interpreted through the 1979 regulations shows the program to have grown into a cumbersome and inefficient device for the delivery of a small

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327. *See* 42 C.F.R. § 124.506 (1979); notes 283 to 288 and accompanying text *supra*.

328. *See* 44 Fed. Reg. 29,372, 29,393 (Appendix I to final regulations of May 18, 1979) (explains that new regulations, unlike previous ones, do not require determination of patient eligibility prior to service). The explanation reads: "Under [the regulations], the timing of the determination depends solely upon when the request for uncompensated services is made. The determination may be made after services (or even after institution of suit), if that is when the request is made." Prior to the 1979 regulations, two state court decisions had found that the Act and regulations did not imply that an individual had a right to raise hospital noncompliance as a defense to a collection action. *See* Yale-New Haven Hosp. v. Matthews, 32 Conn. Supp. 539, 343 A.2d 661 (1974), *cert. denied*, 423 U.S. 1024 (1975); Valley Credit Serv., Inc. v. Mair, 35 Or. App. 637, 582 P.2d 47 (1978). It remains to be seen whether DHEW's interpretation of the new requirement means that this affirmative defense would now be accepted.

329. *See* Roth, *Hill-Burton: A Basis for Medical Malpractice Litigation?*, HOSPITAL LAW MANUAL, No. 82 (Dec. 1979), at 7–8.

and uncertain amount of medical care to an arbitrarily designated group of indigents. To accomplish this end, the program imposes inequitable financial and administrative burdens and potential liabilities on recipient hospitals. Most of these issues are not justiciable; thus, at this point, it is left to Congress to recognize that Hill-Burton has grown apart from any sensible or equitable strategy to improve health care to the poor.

A comprehensive approach is needed in order to attain the goal of adequate health care for all Americans regardless of ability to pay. Hill-Burton is not remotely capable of being a vehicle by which to work toward this end; in fact, the apparent inequities, costliness, and bureaucratic requirements associated with the program only serve to diminish confidence in the government's ability to manage adequate and workable health care programs. Congress should repeal the Hill-Burton Act and take an overall approach to these issues through the expansion and improvement of Medicare and Medicaid or the enactment of a national health insurance program.