

SUBCHAPTER H—HEALTH CARE INFRASTRUCTURE IMPROVEMENT PROGRAM

PART 505—ESTABLISHMENT OF THE HEALTH CARE INFRASTRUCTURE IMPROVEMENT PROGRAM

Subpart A—Loan Criteria

Secs.

- 505.1 Basis and scope.
- 505.3 Definitions.
- 505.5 Loan criteria.
- 505.7 Terms of the loan.
- 505.9 State and local permits.
- 505.11 Loan application requirements and procedures.

Subpart B—Forgiveness of Indebtedness

- 505.13 Conditions for loan forgiveness.
- 505.15 Plan criteria for meeting the conditions for loan forgiveness.
- 505.17 Reporting requirements for meeting the conditions for loan forgiveness.
- 505.19 Approval or denial of loan forgiveness.

AUTHORITY: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C 1302 and 1395hh).

SOURCE: 70 FR 57374, Sept. 30, 2005, unless otherwise noted.

Subpart A—Loan Criteria

§ 505.1 Basis and scope.

This part implements section 1016 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) which amends section 1897 of the Act. Section 1897 of the Act as amended by section 6045 of the Tsunami Relief Act of 2005 authorizes the Secretary to establish a loan program by which qualifying hospitals may apply for a loan for the capital costs of the health care infrastructure improvement projects. Section 1897 of the Act appropriates \$142,000,000 for the loan program including program administration. The funds are available beginning July 1, 2004 through September 30, 2008. This part sets forth the criteria that CMS uses to select among qualifying hospitals.

§ 505.3 Definitions.

For purposes of this subpart, the following definitions apply:

Eligible project means the project of a qualifying hospital that is designed to improve the health care infrastructure of the hospital, including construction, renovation, or other capital improvements.

Entity is an entity described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from tax under section 501(a) of the code. An entity must also have at least one existing memorandum of understanding or affiliation agreement with a hospital located in the State in which the entity is located and retains clinical outpatient treatment for cancer on site as well as laboratory research, education, and outreach for cancer in the same facility.

Outreach programs mean formal cancer programs for teaching, diagnostic screening, therapy or treatment, prevention, or interventions to enhance the health and knowledge of their designated population(s).

Qualifying hospital means a hospital as defined at section 1861(e) of the Act (42 U.S.C. 1395x(e)) or an entity (as defined in this section) that is engaged in research in the causes, prevention, and treatment of cancer; and is either designated as a cancer center for the National Cancer Institute; or designated by the State legislature as the official cancer institute of the State before December 8, 2003.

Unique research resources means resources that are used for the purpose of discovering or testing options related to the causes, prevention, and treatment of cancer.

[70 FR 57374, Sept. 30, 2005, as amended at 71 FR 48143, Aug. 18, 2006]

§ 505.5 Loan criteria.

(a) *Qualifying criteria.* To qualify for the loan program, the applicant must meet the following conditions:

(1) Meet the definition of a “qualifying hospital” as set forth in § 505.3 of this part.

(2) Request a loan for the capital costs of an “eligible project” as defined in § 505.3 of this part. The capital costs

for which a qualifying hospital may obtain a loan are limited to the reasonable costs incurred by the hospital, and capitalized on the Medicare cost report, for any facility or item of equipment that it has acquired the possession or use of at the time the loan funding is awarded.

(b) *Selection criteria.* In selecting loan recipients, CMS prioritizes qualifying hospitals that meet the following criteria:

(1) The hospital is located in a State that, based on population density, is defined as a rural State. A rural State is one of ten States with the lowest population density. An applicant entity is required to be located in one of these ten States. The ten States are prioritized beginning with the State with the lowest population density. Population density is determined based on the most recent available U.S. Census Bureau data.

(2) The hospital is located in a State with multiple Indian tribes in the State. After prioritizing based on paragraph (b)(1) of this section, States are further prioritized based on the States with the most Indian tribes. The number of Indian tribes in a State is based on the most recent data available published in “Indian Entities Recognized and Eligible to Receive Services from the United State Bureau of Indian Affairs.” (68 FR 68180) published on December 5, 2003.

(c) CMS will send written notice to qualifying hospitals that have been selected to participate in the loan program under this part.

§ 505.7 Terms of the loan.

All loan recipients must agree to the following loan terms:

(a) *Loan obligation.* An authorized official of a qualifying hospital must execute a promissory note, loan agreement, or a form approved by CMS and accompanied by any other documents CMS may designate. The loan recipient must provide required documentation in a timely manner.

(b) *Schedule of loan.* A loan recipient receives a lump sum distribution for which payment of principal and interest is deferred for 60 months beginning with the day of award notification

from CMS. The loan repayment period is 20 years.

(c) *Bankruptcy protection.* In the event a loan recipient files for bankruptcy protection in a court of competent jurisdiction or otherwise proves to be insolvent, CMS may terminate the deferment period described in paragraph (b) of this section and require immediate payment of the loan. If a loan recipient should file for bankruptcy protection in a court of competent jurisdiction or should otherwise evidence insolvency after the deferment period we will require immediate repayment of the outstanding principal and interest due. Those payments may be deducted from any Medicare payments otherwise due that hospital.

(d) *Loan forgiveness.* CMS does not require a loan recipient to begin making payments of principal or interest at the end of the 60-month deferment period if it determines that the loan recipient meets the criteria for loan forgiveness under section 1897 of the Act, as determined by the Secretary.

(e) *Default.* If a loan recipient fails to make any payment in repayment of a loan under this subpart within 10 days of its due date, the loan recipient may be considered to have defaulted on the loan. Upon default, all principal and accrued interest become due immediately, and CMS may require immediate payment of any outstanding principal and interest due. Those payments may be deducted from any Medicare payments otherwise due that hospital.

(f) *Loan repayment.* The loan recipient must meet the following conditions:

(1) Make payments every month for 20 years until the loan, including interest payments, are paid in full.

(2) Pay interest on the unpaid principal until the full amount of principal has been paid.

(3) Pay interest at a yearly rate based upon the rate as fixed by the Secretary of the Treasury and set forth at 45 CFR 30.13(a).

(4) If a loan recipient fails to make any payment in repayment of a loan under this subpart within 10 days of its due date, that payment may be deducted from any Medicare payments otherwise due to the recipient.