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BY THE COMPTROLLER GENERAL

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Report To The Congress

OF THE UNITED STATES

Health Service Program Needs Assessments Found Inadequate

The Department of Health and Human Services operates programs to address many of the Nation's health care problems. Many of these programs require that an assessment of the need for the proposed services be made.

GAO found that the need determination mechanisms for the community health center program, as presently structured and operated, do not provide adequate justification for establishing specific centers. Based on its work as well as studies by others, GAO noted that weaknesses in need determination mechanisms permeate other health service grant programs.

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

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To the President of the Senate and the
Speaker of the House of Representatives

This report discusses deficiencies in the needs assessment processes used to justify funding grantees under the rural and urban health initiatives and several other health programs administered by the Department of Health and Human Services. We made this review to determine the extent to which needs assessments were being performed and used in funding Federal health service grantees.

We are sending copies of this report to the chairmen of interested congressional committees and subcommittees; the Director, Office of Management and Budget; and the Secretary of Health and Human Services.

Milton J. Socolar

Acting Comptroller General
of the United States

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

HEALTH SERVICE PROGRAM NEEDS ASSESSMENTS FOUND INADEQUATE

D I G E S T

The Department of Health and Human Services (HHS) has been given authority and funds to address many of the Nation's health care problems. Through its Health Services Administration and its Alcohol, Drug Abuse, and Mental Health Administration, HHS has initiated and supported grant programs aimed at increasing primary health care capacity in medically underserved areas (MUAs), preventing and treating substance abuse, and providing services to deal with mental illness. Each of these programs requires that an assessment of the need for the proposed services be made.

Several problems--such as changes in the health care delivery system and the need to distinguish between needs and wants--make assessing needs difficult. However, with health costs continuing to rise, it is essential to validly assess the need for Federal health care programs before funds are committed to establishing or maintaining them.

NEED DETERMINATION MECHANISMS DO NOT PROVIDE ADEQUATE JUSTIFICATION FOR ESTABLISHING RURAL AND URBAN HEALTH CENTERS

HHS implemented the rural and urban health initiatives in 1975 and 1977, respectively, as capacity-building strategies to increase the availability of and access to primary health care services for residents of medically underserved rural and urban areas. These programs were administrative initiatives for which HHS had received authority under section 330 of the Public Health Service Act, which had authorized the community health center program in 1975. (See p. 2.)

These health initiatives are administered by HHS' Bureau of Community Health Services. Funds totaling about $115 million were awarded to about 475 grantees under these initiatives between fiscal years 1975 and 1979. (See p. 3.)

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For a prospective grantee to be eligible for Federal funding, it must have a designated MUA in its proposed service area.

The MUA designation criteria HHS used to establish grantee funding eligibility were developed as a rough indicator of the adequacy of medical service in an area and had several weaknesses. Despite these weaknesses, HHS applied the criteria--without change--as the specific measure of medical underservice for the rural and urban community health center program. The Bureau also failed to update the designations to reflect current data. GAO concluded that the MUA criteria as currently developed and applied were not appropriate for use as a specific measure of the adequacy of medical service in an area. (See pp. 9 to 13.)

Grant applicants are required by legislation and regulations to assess the need for services in their proposed service areas. However, HHS has not given grant applicants adequate guidance and criteria to help them assess need. This has resulted in substantial variations in grantees' needs assessments. Half of the grantees GAO visited had not met the minimum needs assessment requirements. For grantees for which the minimum data were available, 11 of 18 were serving areas that may no longer qualify as MUAs. (See pp. 13 to 16.)

Grant applications had other deficiencies. Eleven of the 30 grantees GAO visited had drawn their proposed service boundary lines in a manner that excluded existing available services. In three other cases, grantees identified service areas in their grant applications that were already served by other Federal grantees under the same program. Also, 21 of the 30 grantees had made assertions in their grant applications about the availability and accessibility of health care service for which they had no support. For 14 of the 21, data were available which contradicted those assertions. GAO's work showed that, had grantees adequately addressed these issues, the need for some health centers would have been questionable. (See pp. 17 to 22.)

Even though HHS has recognized the advantages of also assessing the expected demand for services and specifically requires it for some programs, such an assessment is not required for the community health center program. Very few of the grantees GAO visited had assessed the expected demand for services and used the results in their grant applications. Data available for all health center grantees that have been in operation for more than 2 years showed that 58 percent of them did not meet HHS productivity standards. (See pp. 23 and 24.)

Also, HHS' grant application reviews were inadequate. HHS did not determine the validity of the data contained in grant applications, but essentially relied on the original MUA designation to support need. However, none of the HHS regions GAO visited recalculated the MUA scores based on the information in the grant application. HHS said it relied on health systems agency reviews to verify the accuracy of the MUA designation and the data included in the grant applications. However, for 13 of the 30 grantees GAO visited, these reviews had not been performed before HHS awarded the grant. Most reviews that were done were inadequate. (See pp. 25 and 26.)

GAO's review of needs assessment preparation and evaluation shows that:

--HHS has provided little guidance on how grant applicants should meet the legislative requirement of performing a needs assessment.

--Many grantees have approached fulfilling the requirement in a manner which seems to maximize the apparent need for a health center without adequate regard for the validity of data used and opposing views that raise fundamental questions about need.

--HHS grant application reviews are inadequate, and HHS seems to rely heavily on the MUA designation of the proposed service area, which was intended only to be a rough indicator of the adequacy of medical service in an area. (See p. 27.)

GAO recognizes that many areas of the Nation have problems with the availability of and access to health services. However, in GAO's opinion, the need determination mechanisms for the community health center program, as presently structured and operated, (1) provide little assurance that MUAs have been appropriately identified and (2) are not an adequate basis for establishing specific urban and rural health centers. (See p. 27.)

RECOMMENDATION TO THE CONGRESS

The Congress should incorporate a requirement in the community health center legislation for prospective grantees to perform a demand analysis in conjunction with a needs assessment. (See p. 27.)

RECOMMENDATIONS TO HHS

GAO is making several recommendations to the Secretary of HHS to insure that the MUA designation process is appropriate and that urban and rural community health centers are adequately justified. (See pp. 27 and 28.)

HHS generally agreed with GAO's recommendations pertaining to the community health center program. One recommendation it disagreed with concerned the requirement that grantees perform demand analyses in conjunction with a needs assessment. HHS said that suitable methods were not available, such analyses were complex and costly, and the Congress intended that community health centers address need rather than demand for health services.

GAO's fieldwork showed that a large percentage of centers were not meeting minimum productivity standards, and one State visited had been successful in estimating demand using a methodology that was neither complex nor costly. GAO believes that HHS should try to develop demand analysis techniques because the administration is proposing to decrease funding for the program and demand estimates would be useful in determining the appropriate size and staffing of centers. (See pp. 28 to 31.)

WEAKNESSES IN NEED DETERMINATION MECHANISMS PERMEATE OTHER HHS-FUNDED GRANT PROGRAMS

Based on its own work as well as studies performed by HHS and the Office of Management and Budget, GAO noted that the existing weaknesses in the need determination mechanisms for the rural and urban health initiatives also permeate other health care grant programs.

The mechanisms for determining needs for HHS' alcohol, drug abuse, and mental health grant programs suffered from a lack of HHS guidance concerning what constitutes need for purposes of Federal funding and what methodologies grantees should use to perform needs assessments. As a consequence, needs assessments developed at the State and local levels were inconsistent, information in them was not verified, and Federal officials did not rely extensively on them when reviewing State plans or grant applications. At the State and local levels, preparing needs assessments was often regarded as a mandatory exercise that had little effect on decisionmaking. At the Federal level, needs assessments were often viewed as a necessary requirement but one in which greater attention seemed to be given to format than substance. (See pp. 32 to 37.)

GAO's prior work showed that the need determination mechanisms used in the authorization and assignment of National Health Service Corps personnel to communities did not involve an assessment of the potential demand for health care services. As a result, physicians at Corps sites were underused in terms of the number of patients they served. (See pp. 37 to 39.)

GAO is not the only organization that has identified these problems. Past Office of Management and Budget and HHS studies have pointed out many of the same weaknesses in health and other social programs. (See pp. 39 and 40.)

Little benefit is now being obtained from the needs assessment process. Accordingly, the process should be changed to make it more useful to grantees and Federal officials and to provide greater assurance that Federal health service

funds are directed where they are most needed. (See p. 41.)

RECOMMENDATIONS TO HHS

GAO is making a number of recommendations aimed at providing greater assurance that Federal health care funds are directed to areas with a demonstrated need and demand for the services. (See pp. 41 and 42.)

HHS agreed with some of GAO's recommendations and disagreed with others relating to health service programs (other than the community health center program) requiring a needs assessment. (See pp. 42 to 44.)

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In its comments, HHS also noted that the administration is proposing to consolidate various health service grants into block grants to the States. If enacted, these programs would eliminate the need for congressional and departmental actions on GAO's recommendations. However, HHS responded to each of GAO's recommendations and outlined proposed actions to be implemented in the event the Congress does not enact the administration's block grant proposals.

Contents

ABBREVIATIONS

BCHS	Bureau of Community Health Services
CMHC	Community Mental Health Center
GAO	General Accounting Office
HHS	Department of Health and Human Services
HSA	health systems agency
IMU	index of medical underservice
MUA	medically underserved area
NHSC	National Health Service Corps

CHAPTER 1

INTRODUCTION

Since the mid-1960s, total national health care costs have risen dramatically, far exceeding the inflation rate. Health expenditures increased from $38.9 billion in 1965 (5.9 percent of the gross national product) to an estimated $226.4 billion in 1980 (9 percent of the gross national product).

During the same period, the Federal Government has assumed an increasing role in funding and supporting the Nation's health care system. Federal health care outlays increased from $5.2 billion in 1965 to $63.4 billion in 1979. The 1979 outlay, which was split among more than 200 programs, represented nearly 13 percent of the total Federal budget.

The Department of Health and Human Services (HHS) has a major role in protecting and advancing the health status of the American people, and the Congress has given HHS legislative authority and funds to address the Nation's many health problems. Through its Health Services Administration and its Alcohol, Drug Abuse, and Mental Health Administration, HHS has introduced and supported grant programs aimed at

--building and maintaining primary health care capacity in rural and urban medically underserved areas (MUAs) and

--preventing and treating substance abuse and providing services to deal with mental illness.

Through these grant programs HHS has also sought to

--improve the organization and efficiency of health care delivery,

--promote effective and equitable health care, and

--improve the quality of federally financed health services.

Grant funds are distributed to State and local health service organizations through project and formula grant programs.

For the project grants, applications proposing specific health services for a community are prepared by the applicant and submitted to HHS through the appropriate health systems agency (HSA) 1/ and State agency. HHS funds, if provided, go directly to the grant applicant, and HHS retains control over their expenditure.

1/See page 6 for a discussion of HSAs' role in needs assessments.

Under formula grants, funds are allocated to the States in accordance with criteria established for each program. The States then distribute these funds, as well as their own, to various State and local health service organizations. Once these funds are allocated to the States, the Federal Government retains little control over their expenditure.

Each of the programs included in our review (rural and urban health initiatives under the community health center program, and alcohol, drug abuse, and mental health programs) require that the need for the services be determined. For project grants, a needs assessment is generally required as part of the grant application package. For formula grants, a needs assessment is generally required as part of the State plan covering how the funds will be used.

Typically, a grant applicant is asked to determine whether and to what extent the prospective services are needed within the service area, while State agencies are asked to develop statewide plans showing the relative needs of different service areas. This information is provided to the Federal agencies for use in allocating health funds.

RURAL AND URBAN HEALTH INITIATIVES

The rural and urban health initiatives were implemented by HHS in 1975 and 1977, respectively, as capacity-building strategies to increase the availability of and access to primary health care services for residents of rural and urban MUAs. These programs were administrative initiatives for which HHS had received authority under section 330 of the Public Health Service Act, which had authorized the community health center program in 1975.

These health initiatives are administered by HHS' Bureau of Community Health Services (BCHS), whose mission is:

> "* * * to develop the Nation's capacity for delivering basic adequate health services to medically underserved areas and population groups, both urban and rural. The Bureau's goal is to assure the availability, accessibility, and effective utilization of personal health care services throughout the United States."

BCHS strives to accomplish this mission by establishing primary health services in locations where they are nonexistent or insufficient. These locations are commonly referred to as MUAs.

HHS characterizes an MUA as having "high infant mortality rates, large numbers of people living in poverty, large numbers

of people 65 years of age or older, and a shortage of health professionals." According to BCHS, about 51 million people--23 million rural and 28 million urban--reside in approximately 7,500 rural and urban MUAs.

Between fiscal years 1975 and 1979, community health care centers increased by 428 projects (210 percent) and funding increased by $62 million (31 percent). This growth was essentially attributable to the rural and urban health initiatives, which were the only types of new centers being funded under section 330. The following table shows the funding history of the community health center program. BCHS' fiscal year 1980 forward plan showed that it planned to increase the number of health care centers funded under section 330 to 2,000 by fiscal year 1983. However, in January 1981, the BCHS Director told us that no new centers would be started in the foreseeable future.

	Community health center (note a)		Rural health initiatives		Urban health initiatives		Total (section 330)	
Fiscal year	Number of projects	Funding	Number of projects	Funding	Number of projects	Funding	Number of projects	Funding
		(millions)		(millions)		(millions)		(millions)
1975	157	$189.4	47	$ 7.2	-	$ -	204	$196.6
1976	164	179.6	138	17.0	-	-	302	196.6
1977	158	184.0	262	23.5	35	7.6	455	215.1
1978	158	201.8	356	39.2	77	14.0	591	255.0
1979	158	202.0	397	43.0	77	14.0	632	258.9
1980 (note b)	158	204.0	526	63.0	178	52.0	862	319.0

a/Community health centers include all urban and rural centers funded under section 330; however, the term as used here describes the larger, primarily urban centers established before implementation of the rural and urban health initiatives.

b/Estimated.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH PROGRAMS

These programs are administered by HHS' Alcohol, Drug Abuse, and Mental Health Administration.

Alcohol formula and project grants

The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (Public Law 91-616), enacted in December of that year, established the National Institute on Alcohol Abuse and Alcoholism. The law authorized (1) State formula grants for planning, establishing, maintaining, coordinating, and evaluating projects for the development of more effective alcohol abuse and alcoholism prevention, treatment, and rehabilitation programs, (2) grants to States for covering the costs of implementing the act, and (3) project grants to public and nonprofit private agencies providing research, prevention, treatment, and rehabilitation services.

Drug abuse formula and project grants

The Drug Abuse Office and Treatment Act of 1972 (Public Law 92-255) established the National Institute on Drug Abuse and authorized formula and project grants for planning, establishing, operating, and coordinating drug abuse prevention, treatment, and rehabilitation programs at the State and local levels. The act's major objectives were to reduce the incidence of drug abuse in the United States and develop a comprehensive, coordinated, long-term Federal strategy to combat drug abuse.

Community Mental Health Center program

The Community Mental Health Center (CMHC) program was initiated in 1963 for two broad purposes: (1) to complement State and Federal efforts to deinstitutionalize mental hospital populations, prevent undue hospitalization, and provide mental health care closer to the patients' home environment and (2) to extend mental health services throughout the Nation, giving greater and more equal access. The program was designed to assist in the construction of CMHCs.

Public Law 94-63 (enacted in July 1975) authorized the funding and initial operation of CMHCs. Public Laws 95-83 and 95-622 enlarged the concept. In October 1980, the Congress enacted the Mental Health Systems Act, which continued funding for CMHCs and provided for several new initiatives in the mental health area.

WHAT ARE NEEDS ASSESSMENTS?

Generally, a needs assessment is a process for gathering and analyzing information to give decisionmakers a rational basis for planning, setting priorities, allocating resources, and evaluating programs.

Various processes have been interpreted to be needs assessments, such as survey research, which can involve

- --gathering opinions on health problems and needs from community leaders or other knowledgeable individuals either individually, in public hearings or committee meetings, or through population surveys;
- --collecting health statistics, such as utilization data;
- --evaluating epidemiologic studies; and
- --analyzing social indicators, such as unemployment, crime, schooling, or income.

Other processes and techniques include (1) consumer demand analysis, which attempts to translate articulated needs into estimates of how extensively consumers would use a particular service, and (2) problem identification and diagnosis, which attempts to quantify and understand the dimensions of particular problems.

While such techniques have been used in one form or another for many years, their use has generally resulted in broad descriptions of needs rather than comprehensive assessments of what needs exist in a given community, what services currently operate to meet those needs, and to what extent remaining unmet needs exist. This situation occurs because it is difficult to find or develop objective standards for determining whether or not a need exists.

Much of the difficulty of doing needs assessment involves making a distinction between needs and wants. The line between the two has always been hazy because people have trouble distinguishing between their health care needs and their wants. For example, a patient who goes to the emergency room with a minor health problem may want help or advice, but the extent to which he or she needs medical care is uncertain. A substantial gap exists between need as perceived by the patient and as perceived by the physician.

As a practical matter, medical care provided is frequently influenced by the patients' desires as well as their needs. A patient may expect the physician to prescribe medication for an ailment even though it may not be required. Similarly, a community may demand a health clinic even though it may not be needed. A more difficult situation may exist when a clinic or service that was once needed is no longer needed.

It must also be recognized that health care needs often change. In 1946, the Hill-Burton Act was passed because a large increase in hospital beds was needed, particularly in rural areas. Now, partly because of decreased hospital use and increasing emphasis on ambulatory care, too many hospital beds may have been constructed and a reduction in these beds may be desirable. Similarly, more recently, an increase in medical school capacity was being encouraged to meet a perceived need for more physicians. Now, however, the Nation may have an oversupply of physicians, and efforts are underway to reduce the capacity or number of medical schools.

WHY DO NEEDS ASSESSMENTS?

With expenditures for health services continuing to rise and with the current Federal interest in exploring means to contain these costs, it is essential to determine whether programs are needed before committing funds to establishing or maintaining them.

However, the mere fact that a problem exists is not always sufficient justification for allocating resources to deal with it. Some assurance is needed that those resources can reasonably be expected to alleviate the problem. Without this assurance, the resources may have little effect.

Without answers to questions concerning what health services are needed, need can be anything from a wish to a necessity of life. Without answers to questions on the extent to which a facility or service will be used, facilities may be established that are not well used even if they are needed. With answers to these questions, a better basis exists for establishing boundaries on what constitutes need and for setting priorities for Federal funding and providing facilities and services that will be used and will contribute toward alleviating health care problems.

Therefore, while performing needs assessments may be difficult, the alternative--authorizing and spending money without appropriate information on the need and potential demand for health care services--is inefficient and wasteful.

THE ROLE OF HEALTH SYSTEMS AGENCIES IN ASSURING THAT HEALTH SERVICES ARE NEEDED

The National Health Planning and Resources Development Act of 1974 (Public Law 93-641) combined and redirected the efforts of a number of federally supported State and local programs related to health planning and resources development. The program provides that decisions about health care needs and priorities are to be made by areawide community organizations, known as health systems agencies.

A primary function of HSAs is to develop health systems plans describing what actions are needed to improve the health care system and the health status of people in a given area. Another function of HSAs is to review the proposed use of Federal funds to be awarded to grant applicants in their service areas under certain Federal health programs. HSAs' reviews strive to assure that the proposed services are in accordance with the needs specified in the agencies' health systems plan.

OBJECTIVES, SCOPE, AND METHODOLOGY

Our overall objective was to determine the degree to which need determinations were being made and used as a basis for funding decisions in Federal health care grant programs. We made a detailed review and analysis of need determinations performed for the community health center program and, to a lesser degree, examined the use of and attitudes toward need determinations in the alcohol, drug abuse, and mental health grant programs.

We also examined how HSAs were carrying out their responsibilities for assuring that grants for health services provided to their service areas were needed and in conformance with established health plans.

Community health center program

In reviewing this program, our objectives were to assess the validity of the criteria used to designate MUAs and to determine if adequate assessments of need and demand for primary health care centers were performed before HHS provided Federal funds for their development and operation.

We performed our community health center work at HHS headquarters and regional offices in regions III, IV, VI, and VIII. Regions III, IV, and VI were selected based on the percentage of the total program funds allocated to them. Region VIII was included at the suggestion of HHS program officials, who said we should also look at grantees in sparsely populated rural areas.

We also visited 30 grantees (see app. II) and the cognizant HSAs having review authority over them. The grantees were selected to provide a mix of rural and urban health initiatives with varying funding levels and start dates. Four of the grantees were not yet operational at the time of our fieldwork.

In addition to interviewing program personnel and reviewing pertinent documentation at all levels, we interviewed local health care officials and administered a structured interview to 20 randomly selected patients of each operational grantee visited (26 of 30) to obtain their views on the need for the centers.

Finally, we visited the Office of Rural Health Services of the North Carolina Department of Human Resources to determine how an agency other than HHS went about assessing the need and demand for primary health care services.

Alcohol, drug abuse, and mental health programs

We reviewed the alcohol, drug abuse, and mental health grant programs to determine to what extent needs assessments were being carried out over a broader range of Federal health care grant programs and whether their results were being used in the funding process to ensure that Federal health care resources were being channeled to the most needy. We did not make a detailed analysis of information used in developing the needs assessments for these programs (as we did for the community health center program). However, we determined whether need determinations were made and obtained the attitudes and views of individuals at all levels responsible for performing and using needs assessments concerning the value of and use made of assessment results in the decisionmaking processes affecting health service grants.

For each of the programs, we performed review work at several levels. At HHS headquarters, we concentrated on reviewing laws and regulations, guidance to regions, grant application reviews, and the uses of and emphasis given to needs data in grant applications. At HHS regions IV, V, VII, and IX, we reviewed similar documentation as it applied to regional program management and discussed the assistance received from HHS headquarters.

At State-level organizations in Iowa, Missouri, Ohio, Indiana, and California, we reviewed statewide plans and supporting need-type data. We examined data used to represent need and the processes used to develop need data.

At the local and regional levels, we visited 21 health service grantees and 8 HSAs to document how they carried out their needs assessment responsibilities and to obtain their views on the value of and usefulness of need determinations in allocating Federal health care resources.

States and grantees were selected to obtain broad coverage throughout the Nation.

CHAPTER 2

NEED DETERMINATION MECHANISMS DO NOT PROVIDE ADEQUATE JUSTIFICATION FOR ESTABLISHING RURAL AND URBAN HEALTH CENTERS

Because of weaknesses in the rural and urban health initiative programs, health centers have been established without the need and demand for them being adequately justified. The weaknesses include problems in developing and applying HHS' MUA criteria, inadequate needs assessments by grant applicants, and inadequate reviews of grant applications by HHS.

Organizations and individuals involved in the initial development of the MUA criteria identified several weaknesses in the process. In addition, we found weaknesses in the application of the MUA criteria to the community health center program. We believe that these weaknesses raise serious questions about the validity of the MUA process as an adequate measure of medical underservice.

Also, HHS has not given grant applicants adequate guidance to help them assess the health care needs of the geographic areas they proposed to serve. This has caused substantial variations in the scope and quality of grantees' needs assessments. Many of the assessments have been prepared in a manner intended to maximize the apparent need for a project without adequate regard for the validity of data used and opposing views.

Finally, HHS reviews of grant applications were often perfunctory, and reviewing officials did not adequately verify information in the application either themselves or through the HSAs. In the final analysis, they relied heavily on the MUA designation as a specific measure of need.

WEAKNESSES IN THE DEVELOPMENT AND APPLICATION OF THE MEDICALLY UNDERSERVED AREA DESIGNATION

A project grants applicant must have a designated MUA within the proposed service area to be eligible for Federal funds under the rural and urban health initiatives. If this requirement is met, an applicant can submit a grant application through the HSA covering its service area to the HHS regional office. The application then proceeds through the regional office grant review process along with competing applications.

The criteria used by BCHS to designate MUAs were originally developed by the University of Wisconsin Health Services Research Group 1/ for determining funding priorities for health maintenance organizations. As such, they were developed essentially as rough indicators of the adequacy of medical service in an area, rather than specific measures of need at the community level. Using the MUA criteria, BCHS adopted a scoring system (see app. III) to arrive at an index of medical underservice (IMU), which in turn was used to determine whether particular areas should be designated as medically underserved.

Organizations and individuals involved in originally developing the MUA criteria have highlighted several weaknesses in the process, including a failure to define what constituted medical underservice and limitations of the consensus approach used to identify MUAs.

These weaknesses become particularly important in light of the results of a study by two researchers of HHS' National Center for Health Statistics. That study found no difference between "medically underserved" and "adequately served" area residents in the number of physician visits per year or in the proportion with at least one visit in the past year. Also, only small differences were noted between "medically underserved" and "adequately served" area residents in the percentage with regular sources of care and the percentage reporting they did not get needed care. The implication of these findings, according to the researchers, is that the concept of medical underservice needs to be examined and defined more specifically.

We found weaknesses in BCHS' application of the MUA criteria to the community health center program, including the (1) use of an arbitrary cutoff score to distinguish between medically underserved and adequately served areas, (2) failure to consider rational 2/ health service areas, (3) inappropriate application of data, and (4) failure to update the MUA list.

1/See app. III for a complete discussion of the MUA criteria development process.

2/Rational service areas would essentially give recognition to where people live and work, normal patterns of commerce, and medical care capability in nearby areas.

Arbitrary cutoff used

HHS' use of a median 1/ IMU score to designate MUAs was arbitrary and essentially guaranteed that half of all U.S. counties would be designated as MUAs regardless of their relative IMU scores. Consequently, some areas being designated as MUAs may have adequate primary medical care services.

In 1975, when BCHS decided to use the median IMU score (62) as the cutoff for MUAs under the community health center program, alternative scores (ranging from 30 to 65 with a mean of 50) were suggested by the same experts who had been involved in developing the MUA. According to a BCHS official, no change was made to the cutoff score because BCHS believed that having two different cutoff points--one for health maintenance organizations and one for community health centers--would be confusing even though program intent was different. However, in discussing the cutoff score, an HHS official who participated in the original decision process to use the the median score told us that a more stringent cutoff score should have been used to designate medically underserved areas for community health center program funding. As shown in the following table, if the cutoff had been set at 50, about 80 percent of the designated MUAs would have been eliminated.

IMU scores greater than	Number of MUAs that would be eliminated	Percent of total MUAs (note a)
40	7,161	95
50	6,071	81
56.6	3,752	50
60	1,818	24

a/Total MUAs equals 7,502.

Rational service areas not considered

As discussed in appendix III, in identifying MUAs, HHS first scored counties. Then, for all counties not at or below the median county score (62), HHS rescored their political subdivisions (census tracts, census county divisions, and minor civil divisions) to determine if they fell below the median county score. During this process, medical services available in areas contiguous to the political divisions or subdivisions designated as MUAs were

1/The median of a group of numbers is the middle number or value when each item in the group is arranged according to size (e.g., lowest to highest). The median essentially has the same number of items above it as below it.

not considered. Since the purpose of the community health center program is to provide access to primary medical care in areas experiencing shortages of such services, it would seem appropriate to determine rational service areas instead of using political boundaries that may exclude services within reasonable distances.

Inconsistent application of data

In designating countywide MUAs, BCHS used census tract data for demographic characteristics of age and poverty, and county level data for physician-to-population ratios and infant mortality rates. However, for subcounty areas (minor civil divisions, census county divisions, and census tracts), the county-level data were applied to the subcounty areas. In using the data in this manner, BCHS assumed that the distribution of the population, physicians, and infant births and deaths was uniform throughout the county. For example, in designating certain census tracts in the Miami Beach area as MUAs, BCHS used countywide infant mortality rates even though 70 percent of the population in those census tracts was over 65 years old. It was doubtful that the same infant mortality rates were being experienced in this designated area as in other parts of Dade County where only 15 percent of the population was over 65.

MUA designations not updated to reflect current data

MUA designations were not updated to reflect the most current data available, and data sources being used were from 7 to 11 years old. The following table shows the date of data being used versus that which was available.

Type of data	Date of data being used	Date of data available (note a)
Physician	1973	1978
Infant mortality	1969-73	1973-77
Poverty level	1970	1978
Age (65 and over)	1970	1978

a/These are the dates of the latest available data at the time of our fieldwork; however, more current data than those being used by BCHS have been available since the current MUA list was published in 1976.

BCHS stated that, after the MUA criteria were developed, the MUA list would be continuously revised using national updates. However, no national updates have been made to the MUA list since it was first published in 1976. In the fall of 1980 BCHS did make a trial run using 1976 physician data, 1971-75 infant mortality data, 1970 census data for subcounty areas, and 1976 county population estimates. According to BCHS, the trial run showed that

the median IMU score had changed from 62 to 64 and that some areas previously designated MUAs no longer qualified. BCHS officials said they planned to wait until late 1980 to get more current data to make an update rather than use the trial run.

Our analysis of the trial run data showed that, of 482 counties that were designated as MUAs and contained a BCHS-funded community health center, 59 had IMU scores over 62. Therefore, these counties would no longer qualify as MUAs, and the health centers in these counties would be ineligible for BCHS funding unless the cutoff score were changed.

NEEDS ASSESSMENTS BY GRANT APPLICANTS OFTEN ARE INADEQUATE

HHS has not given grant applicants adequate criteria and guidance to help them assess the health care needs of the geographic area they propose to serve. Consequently, the needs assessments performed, and their results, have varied both in scope and quality. Further, the community health center legislation does not require that applicants assess the expected demand for services. Consequently, little information concerning the potential viability of a center is available when an application is reviewed. In addition, HHS' review process for determining the completeness and validity of grant applications is inadequate.

As discussed in chapter 1 (see pp. 5 and 6), we recognize that performing a needs assessment can be difficult. However, we visited a State rural health services program that appeared to have built into its program a reasonable and practical way of assessing the need and demand for health services.

Inadequate criteria

Community health center legislation and regulations require that applications for Federal grant funds include an assessment of the need for the proposed project. Regulations specify that the needs assessment include:

> "The results of an assessment of the need that the population served or proposed to be served has for the services to be provided by the project, * * * utilizing, but not limited to * * *"
>
> * * * *
>
> "(1) Available health resources in relation to size of the area and its population, including appropriate ratios of primary care physicians in general or family practice, internal medicine, pediatrics, or obstetrics and gynecology to population.

"(2) Health indices for the population of the area, such as infant mortality rate.

"(3) Economic factors affecting the population's access to health services, such as percentage of the population with incomes below the poverty level.

"(4) Demographic factors affecting the population's need and demand for health services, such as percentage of the population age 65 and over."

Although HHS has developed some general guidance on needs assessments for the community health center program, it has not developed any specific criteria concerning how a needs assessment should be performed or what it should include. Furthermore, the general guidance provided to prospective grantees varies among HHS regions. For example, region VIII routinely provides a package of materials to grant applicants which includes various HHS publications and regionally developed instructions on how to apply for a grant. Some of these materials address the requirement for a needs assessment; however, there are no instructions on how to do a needs assessment other than those contained in the regulations discussed above. By contrast, region IV does not routinely provide materials to grant applicants; instead, the region allows the HHS regional project officer to determine what information to provide to grantees.

Inadequate needs assessments by grantees

The lack of uniform criteria and guidance from HHS on how to perform needs assessments has resulted in variations in grantees' needs assessments. HHS has funded grantees that did not address the minimum needs assessment criteria, did not consider rational service areas and all available health services, asserted problems that either did not exist or were not documented, and ignored available information or opposition views that would detract from the stated need for the project.

Requirements not met

The community health center regulations require that prospective grantees include in their applications the results of a needs assessment which--at a minimum--addresses the four factors paralleling the criteria used in the MUA designation process. (See above.) Of the 30 grantees we visited, only 15 addressed all four of the MUA criteria, and only 4 included information beyond these minimum requirements. The following table shows the needs assessment factors that were not addressed by the other 15 grantees.

Grantee location	Factors Not Addressed: Physician/ population ratio	Infant mortality rate	Poverty level	65 and over
Millsboro, Del.			X	
Pocomoke City, Md.		X	X	X
Millerstown, Pa.			X	
Picture Rocks, Pa.		X	X	
Virginia Beach, Va.	X	X		
Cedar Grove, W.Va.		X	X	X
Miami Beach, Fla.	X			
Sumterville, Fla.			X	X
Edgefield, S.C.			X	
Groesbeck, Tex.		X		
San Antonio, Tex.			X	X
Houston, Tex. (4th ward)	X	X	X	
Houston, Tex. (E Street)				X
Brownsville, Tex.		X		X
Kiowa, Colo.	X	X	X	

For 18 of the 30 grantees visited, we were able to recompute the MUA score. 1/ Of the 18, 11 included designated MUAs in their service areas which no longer qualified as MUAs based on the recomputed scores. Of these 11, 8 may have been ineligible for funding because their service areas did not contain an eligible MUA. The other three grantees had both eligible and ineligible MUAs in their proposed service areas. Although the MUAs claimed by the grantees may have been validly designated, these areas did not qualify as MUAs based upon the more current data included in the grantees' applications or obtained from local HSAs. Regional officials told us that MUA scores were not recomputed based on data submitted in application packages to determine if a designation was still valid. They relied on local HSAs to verify the designations.

The table on the following page shows the original and recomputed MUA scores for the 11 grantees.

Considering both the grantees that did not meet the minimum requirements in the regulations and those whose recomputed scores were too high to qualify for an MUA designation, 21 of the 30 grantees we visited did not meet minimum funding requirements.

1/The grant applications for 15 grantees contained the necessary information, and we obtained additional data for 3 grantees from local HSAs.

Grantee location	MUA score based on Grant application data	MUA score based on Original designation data
Scranton, Pa.:		
Lackawana County	79.3	35.7
Williamstown, Pa.:		
Dauphin County	85.9	48.2
Schuylkill County	a/64.7	57.2
Virginia Beach, Va.	70.0	58.8
Edgefield, S.C. (note b):		
Abbeville County	67.0	44.1
Edgefield County	64.4	39.6
Greenwood County	86.1	c/48.7
Laurens County	66.3	58.7
Palmetto, Ga.:		
Fulton County	75.5	c/38.5
Lucedale, Miss. (note b):		
George County	65.6	53.0
Loving, N. Mex.:		
Eddy County	66.2	54.2
Portales, N. Mex.:		
Roosevelt County	65.7	59.3
Houston, Tex. (4th Ward):		
Harris County (tract #126)	63.6	55.7
Colorado Springs, Colo.:		
El Paso County	67.7	47.5
Center, N. Dak. (note b):		
Mercer County	71.3	49.5

a/Data were available for only three of the four criteria.

b/These grant applicants still had eligible MUAs in their proposed service area.

c/Only certain political subdivisions in the county were designated as MUAs.

Rational service areas not considered

Eleven of the 30 grantees visited drew service area boundary lines in a manner that excluded existing available services. Had those services been included, the need for the grantees' health centers would have been questionable.

For example, one grantee divided a census tract by drawing its boundary line about one block from a medical complex containing 12 primary care physicians. The grant applicant mentioned the medical complex in its grant application, stating that all primary care physicians in the building exceeded 30 patient visits per day--some by as much as 150 percent. In addition, the grantee stated that all other physicians in adjacent areas were also overutilized and that the lack of available primary care providers was the overriding medical care problem. However, the grantee did not provide support for these statements. Conversely, the president of the local Hispanic medical society said there was an oversupply of physicians in and around the area served by the grantee. Moreover, information available from the local HSA showed that there were over 200 primary care physicians within a 3-mile radius of the health center and over 600 in the surrounding urban area. In addition, the service areas of three other Federal primary health care grantees were within 3 miles of the grantee's health center.

Another grantee used three MUA designated census tracts located in the downtown area in which it was located to justify the need for establishing a primary health care center. A "low income corridor" of the city composed of eight census tracts was cited as the service area; however, only seven of the tracts were identified in the application. The shortage of primary care physicians was given as the main health care need of the area.

However, even though the physician-to-population ratio for the identified census tracts in the grantee's service area was poor, there was an abundance of physicians in census tracts contiguous to the service area boundaries drawn by the grantee and less than 1 mile from the grantee's health center. According to data compiled by the local HSA, the primary care physician-to-population ratio for the city in which the grantee was located was 1 to 1,429. For the entire county it was 1 to 1,812. Moreover, in the downtown area where the grantee is located, the ratio was better than 1 to 1,000. 1/

1/HHS guidance suggests that areas with primary care physician-to-population ratios of 1 to 2,000 or less are adequately served.

Areas already served by HHS centers identified by new grantees

Three other grantees included in our sample identified service areas in their grant applications that were already being served by other Federal grantees under the same HHS program.

One grantee included 23 census tracts in its service area, all of which had been designated as MUAs. However, as shown in the illustration on page 19, three of these tracts were already included in the service area of another grantee. A second grantee included six counties in its service area. However, as shown in the illustration on page 20, one of these counties was already being served by a previously established grantee.

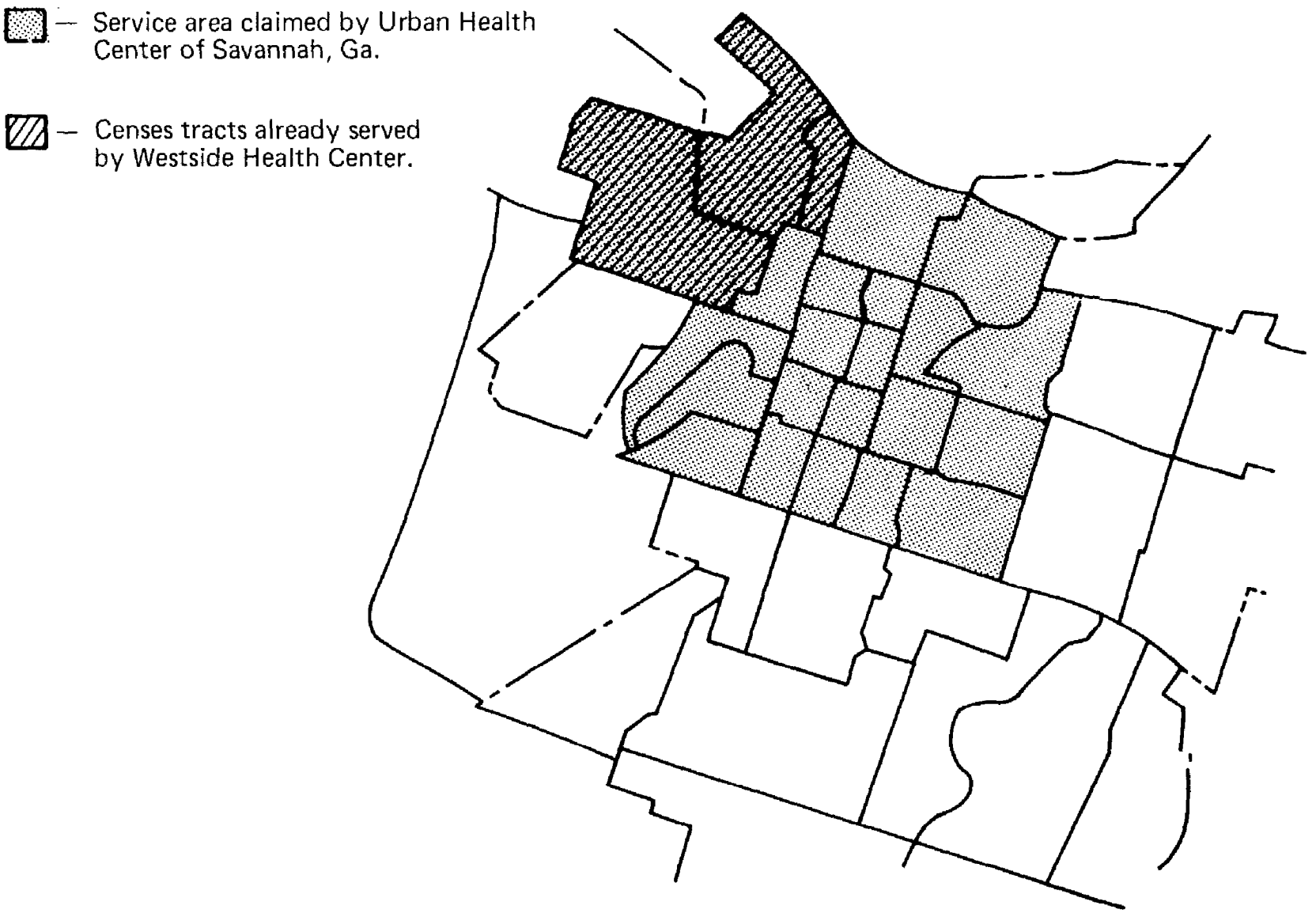
The third grantee included one census tract in its service area which had been designated as an MUA, and parts of four other census tracts that were not MUAs. However, the tract designated as an MUA was already included in the service area of a previously established grantee funded under the same program. Without this MUA-designated census tract, the grantee would have been ineligible to receive funds.

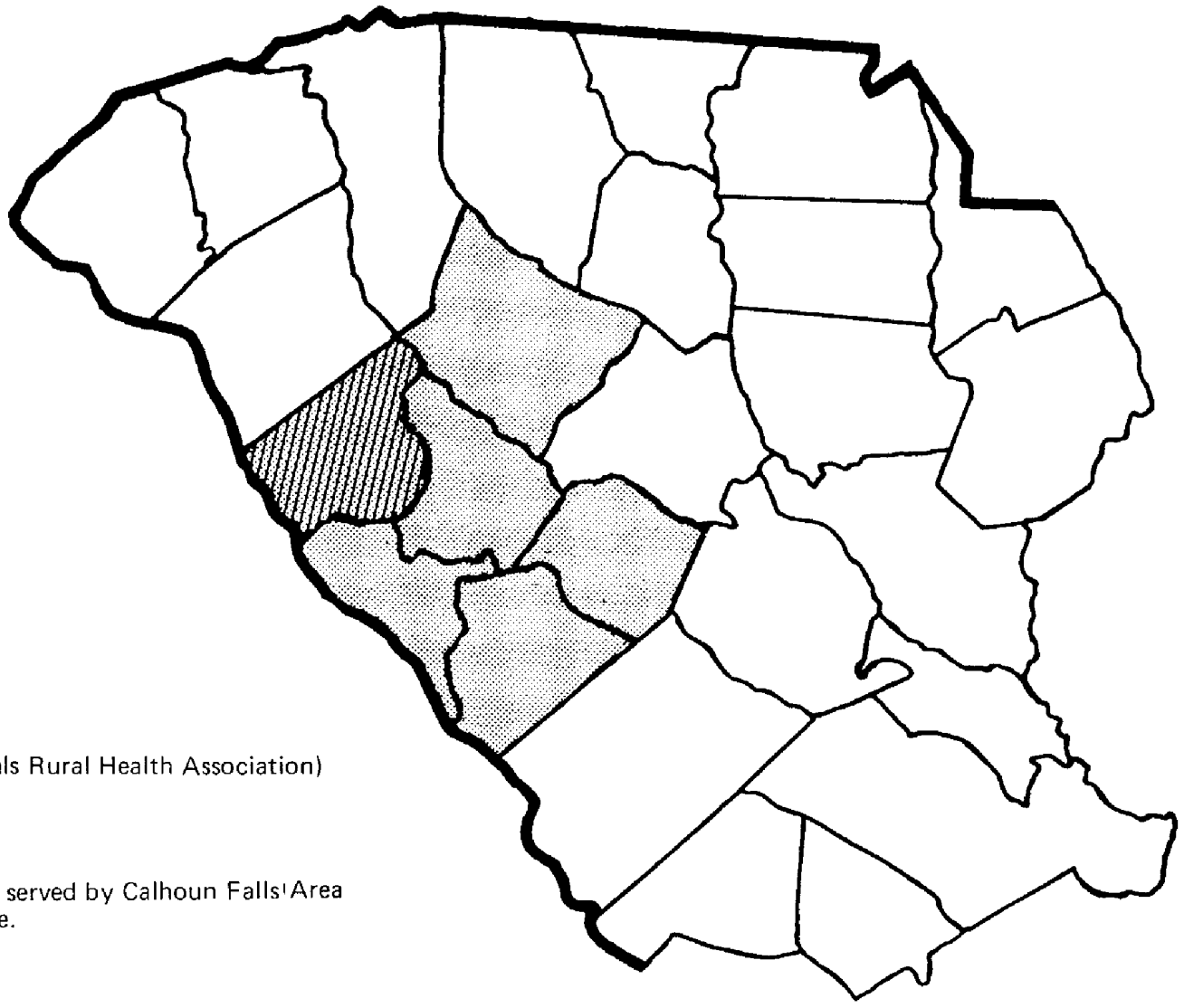
Grantees assert access and availability problems without supporting data

Of the 30 grantees in our review, 21 made assertions about the availability of and access to health care services for which they provided no support. Statements generally dealt with medical services in the grantees' service areas or in contiguous areas. For 14 of the 21 grantees, existing data contradicted the assertions.

For example, one grantee with a large, relatively poor elderly population asserted that the area doctors generally did not accept Medicare assignments, 1/ which severely limited access to care by most of the elderly. However, the HHS representative responsible for monitoring the operations of the Medicare program in the grantee's service area estimated that, of the more than 800 doctors in the area, over 90 percent accepted Medicare assignment. In addition, the county health department had compiled a list of 110 doctors in the area who accepted Medicare assignment. An officer of the county medical association said that his organization distributed a similar list.

1/Medicare assignment is essentially the process whereby a doctor agrees to accept funds received from Medicare as payment in full for services provided.


— Service area claimed by Urban Health Center of Savannah, Ga.
— Censes tracts already served by Westside Health Center.



— Grantee's (Megals Rural Health Association) service area.

— County already served by Calhoun Falls Area Health Initiative.

Another grantee reported that 59 percent of its service area's population needed to travel 30 minutes or more to get to a doctor. However, a summary of consumer survey responses provided to us by the grantee showed that less than 13 percent of the respondents traveled more than 30 minutes to a doctor.

A third grantee elaborated on the "well documented" health care problems and the lack of outpatient clinics in its service area. However, a needs assessment conducted before the grantee's application by an independent contractor concluded that the area did not need outpatient medical centers. Also, a local HSA representative believed that there were probably locations with greater medical needs in that general area.

A lack of health providers in the target area and consumers' inability to pay were given as the two major health problems by another grantee. The lack of providers was based on available doctors being located in a city which was less than 15 miles away--well within the 30 minutes' driving time criterion established by HHS. Consumer inability to pay was presented as another problem even though per capita income of the area compared favorably with the State average and the unemployment rate was much lower than the State average. Furthermore, for a target area population of about 2,000, the grantee estimated fewer than 300 medical indigents.

Another grantee asserted that median family income was slightly over half the State average, and used outdated income data to present a low-income scenario for the proposed service area. However, our interview of a random sample of 20 patients coming to this clinic indicated that their annual average income exceeded $20,000.

A final example related to an applicant that reported that, because of a lack of doctors in the immediate vicinity and the distance to primary health care, the area needed additional medical services. However, the local HSA's staff analysis reported that:

--Medicaid acceptance was no problem.

--Services might be unnecessarily duplicated.

--Patients' health might not be adversely affected if this project were not approved.

--It was questionable whether this area would be considered medically underserved.

Although the HHS review committee expressed similar reservations about this location, the grant was funded.

Grant applications do not adequately reflect opposition views

The establishment of a health center was opposed by various groups for 11 of the 30 grantees we visited, and none of the opposition views were adequately considered or addressed.

For example, in the face of stiff opposition from other health providers, local consumers groups, and the city health planning commission, a local HSA wrote a grant application for one grantee, recruited a board of directors, and obtained a grant award from HHS to establish an urban health center. As a result, a primary care center, operated by the county health department and located only one block away, closed. Opposition to this project raised several questions that were never adequately addressed by the grantee, the HSA, or HHS. Concerns raised included:

--A needs assessment was in progress when the grant application was submitted. Some individuals believed HHS should at least await the outcome of that assessment before investing in health services.

--Some individuals questioned how an area with one of the best physician-to-population ratios in the country could be medically underserved. A city health planning commission official recommended that the HSA survey physicians to determine if there were enough to adequately serve the proposed target population. This issue was not addressed in the grant application.

--Other citizens could not understand why HHS would consider spending more money for a clinic when the identical services were being provided only one block away.

One member of the HHS grant review committee, unaware of the needs assessment being performed, said he would not have recommended approval had he known the above facts.

Critics of another project were doubtful of the need for the project because the grantee did not inform the area residents or medical providers of the grant application. In addition, a city-sponsored needs assessment concluded that no outpatient medical centers were needed in the area. When this grantee applied for National Health Service Corps (NHSC) personnel, HHS concluded that the area was not appropriate for the delivery of primary medical care, and doctors in contiguous areas were not overutilized or inaccessible to the population. However, this was not discussed in the grant application.

Grant applicants are not required to assess the expected demand for services

The community health center legislation does not require grant applicants to assess the expected demand for health services at proposed centers, even though HHS recognizes the importance of accurately assessing demand and has developed some guidance on performing demand analyses. Procedures for establishing health centers under other programs stress the importance of forecasting demand for services. One of the requirements of the health maintenance organization--from which the MUA designation process was borrowed--is a demand for services survey, referred to as a market feasibility study.

In its literature for community health center grant applicants, HHS emphasizes the importance of basing a project on a realistic assessment of the demand for health care services. Also HHS' manual, "Financial Planning in Ambulatory Health Programs," states, "It is not sufficient to assume that there will be a 'demand' for the particular package of services by the particular target population * * *."

Of the 30 grantees in our review, only 9 performed any type of demand analysis, and only 2 had performed community surveys and used the results to estimate workload.

Grant applicant workload estimates are unsupported

For the 30 grantees we visited, workload estimates in the grant application were generally unsupported. In several cases, grantees had decided on the health center's size and staffing first and then backed into utilization estimates using HHS' productivity standards (i.e., 4,200 encounters 1/ per year per physician). As shown in the following table, 19 of the 30 grantees used guesses or workload estimates established in this manner.

	Number of grantees
Guesses (no basis or method for making guess offered)	13
Plugged (number of medical providers budgeted x HHS minimum productivity levels)	6
Previous operations of the center	7
National statistics on average patient visits x target population	2
Unknown (new project management not aware of basis used)	2

1/An encounter essentially represents each contact between the physician and patient.

The grantees we visited tended to overestimate what the actual demand turned out to be--apparently to make centers appear more needed than they really were to help insure HHS funding. Of the 30 centers in our review, at least 16 overestimated users and/or encounters.

Also, as of July 1, 1979, 58 percent of all community health center projects over 2 years old were not meeting HHS' productivity standard. This standard is low when compared to over 5,000 average encounters per year for physicians in private practice.

HHS regional officials recognized the importance of community involvement and input during the project planning phase, and one official stated that HHS needed to apply marketing techniques to both educate and gain the support of potential consumers. However, HHS has not yet moved beyond the step of recognizing this problem because, for most projects visited, consumers either

--were not surveyed to find out what they needed or would use,

--did not have difficulty getting primary health care before the grantee began operating, or

--were openly opposed to a primary care clinic in their community.

Need and demand assessment approach used by the North Carolina Office of Rural Health Services

One State rural health services program we visited appeared to have built into its program a reasonable and practical way of assessing demand and need for health services.

To improve the health of its citizens, the North Carolina General Assembly in 1973 established the Office of Rural Health Services. Operating with an annual budget of about $1.5 million, the Office has 17 operating clinics and 11 others that reached a high level of efficiency and broke away from State support. Within its budget, the Office has also operated a physician placement activity, which has been responsible for recruiting about 300 physicians to rural communities in the State since 1973.

Under this program, the community must first be able to demonstrate that there are no easily accessible medical facilities. The market for health services must then be analyzed to determine if adequate demand exists. Analyzing the health services market includes

--estimating the population inside a target area of 5 to 7-1/2 miles in radius;

--estimating the total number of medical visits expected from the target population; and

--estimating market penetration by considering such factors as proximity of alternate sources of primary care, barriers to access, and traffic flow patterns.

Once the community has been determined to be in an area that could support a health center, the community must raise a minimum amount, usually around $20,000, from at least 750 households to help pay for construction of the facility.

INADEQUATE HHS REVIEWS OF GRANT APPLICATIONS

HHS officials in all four regions in our review stated that the regional review process was not designed to determine the validity of data contained in applications. These officials said they relied on the MUA designation to support the need for a center. However, none of the regions recalculated the MUA scores based on the information submitted in grant applications. As discussed on page 15, 11 of the 30 grantees in our review identified MUAs in their service area which, based on the data in the applications, no longer qualified as MUAs.

HSA REVIEWS LACK CONSISTENCY AND VALIDITY

Regional officials said they also relied on HSAs to verify the accuracy of MUA designations and data included in grantee applications. However, for the 30 grantees we visited, HSA reviews were often either not performed or inadequate.

For 13 of the 30 grantees, HSA reviews had not been performed before HHS awarded funds to the grantees. Most HSAs did not perform reviews because, when they received the applications, they were not fully designated as HSAs and, therefore, waived their review rights. Several other HSAs stated that, as a matter of policy, they do not review grant applications. Another HSA promoted a policy contrary to the intent of the health planning legislation and HHS' stated policy. The HSA's policy was to keep hospitals and county health departments out of primary care, whereas legislation and HHS policy encourages augmentation of existing health services if possible. This HSA had prepared the grantee's application and, consequently, did not review it.

Of the other 17 grantees, whose applications were reviewed by HSAs before HHS' initial funding decision, 15 were inadequate. Four of the HSAs recommended that grant applications be approved when available data showed that the applicants' proposed service areas did not include an area qualifying as an MUA. Furthermore,

10 of the HSAs made inaccurate or unsupported assertions in recommending grantees for funding. Finally, one of the HSAs instructed that data be collected in a biased manner in order to demonstrate a greater need for a proposed grantee.

CONCLUSIONS

The MUA designation process had several weaknesses in its development. HHS applied the MUA criteria--without change--as the specific measure of the adequacy of medical service in an area for the community health center program. In our opinion, this application process was inappropriate.

We believe that BCHS should update the MUA list and should address the other weaknesses in the MUA process discussed in this report. Once this has been done, the MUA criteria should be used only as a rough indicator of the adequacy of medical service in areas to be further considered for funding based on a detailed analysis of need and demand at the grantee level.

HHS has not given grant applicants adequate guidance and criteria to help them assess need. Consequently, half of the grantees we visited had not met the minimum grant application requirements. For grantees for which the minimum data were available, 11 of 18 were serving areas that did not qualify as MUAs.

Grant applications had several other deficiencies. Eleven of the 30 grantees had proposed service boundary lines that excluded existing available facilities and services or included service areas already served by other Federal grantees under the same program. Also, 21 of the 30 grantees had made assertions concerning the availability and accessibility of health care services for which they provided no support. For 14 of the 21, data were available which contradicted the grantees' assertions. Further, grantees often did not adequately address in their grant applications opposing views to their proposed centers.

Even though HHS has recognized the advantages of assessing the expected demand for services and specifically requires it for other programs, such an assessment is not required for the community health center program. Few of the grantees we visited had assessed the expected demand for services and used the results in their grant applications.

HHS' grant application reviews were also inadequate. No attempt was made to determine the validity of the data contained in grant applications, and HHS officials essentially relied on the original MUA designation to support need.

HHS said it relied on HSA reviews to verify the accuracy of the MUA designation and the data included in the grant applications. However, for 13 of the 30 grantees we visited, HSA reviews

had not been performed before HHS awarded the grant. Most reviews that were done were inadequate.

Our review of needs assessment preparation and evaluation shows that:

--HHS has provided little guidance on how grant applicants should meet the legislative requirement of performing a needs assessment.

--Many grantees have approached the needs assessment requirement in a manner which seems to maximize the apparent need for a health center without adequate regard for the validity of the data used and opposing views that raise questions about need.

--HHS grant application reviews are inadequate and seem to rely heavily on the original MUA designation of the proposed services area.

We recognize that many areas of the Nation have problems with the availability of and access to health services. In our opinion, however, the need determination mechanisms for the community health center program, as presently structured and operated, provide little assurance that MUAs have been appropriately identified and are not an adequate basis for establishing specific urban and rural health centers.

RECOMMENDATION TO THE CONGRESS

To assure that funding decisions for community health centers will be made with the knowledge of what services are needed and what the realistic expected demand for services will be, we recommend that the Congress incorporate a requirement in the community health center legislation that grant applicants be required to perform a demand analysis in conjunction with a needs assessment.

RECOMMENDATIONS TO THE SECRETARY OF HHS

We recommend that the Secretary:

--Use the MUA designation process only as a rough indicator of the adequacy of medical service for determining areas of the Nation warranting more detailed assessment of need for purposes of Federal funding.

--Update the MUA list and, to the extent practical, consider the other weaknesses discussed in this report relating to the MUA criteria, recognizing they should be used only as a rough indicator of the adequacy of medical service in an area.

--Establish a specific timetable for updating future MUA lists that would consider current data as they become available.

To ensure that urban and rural community health centers are adequately justified, we recommend that the Secretary:

--Develop a definition of "medical underservice" specifically for the rural and urban community health center program.

--Develop and provide to prospective grantees guidance on how to perform and what should be included in needs and demand assessments for the program. As a minimum, the guidance should require that

(1) rational service areas be established,

(2) all health care services in the proposed target area and in contiguous areas be addressed in terms of availability and accessibility,

(3) asserted health care problems be documented, and

(4) opposition views be addressed in grant applications.

--Reevaluate the eligibility of existing grantees in light of the above recommendations and phase out those that cannot meet the revised requirements.

--Revise the grant application review and approval procedures to ensure that future applications comply with all legislative and program requirements.

HHS COMMENTS AND OUR EVALUATION

HHS stated that the administration is proposing to consolidate various health service grants into block grants. If enacted, these programs would eliminate the need for congressional and departmental actions on our recommendations. However, HHS responded to each of our recommendations and outlined proposed actions to be implemented in the event the Congress does not enact the administration's block grant proposals.

Although HHS concurred with our recommendation to use the MUA designation process only as a rough indicator of need, we do not agree with its observation that the MUA list is now used only as a general indicator of medical underservice. Officials responsible for reviewing and approving grant applications in each of the four regions in our review said they relied on the MUA designation to support the need for a center. (See pp. 25.) This, in our opinion, essentially represented using the MUA as a specific measure of need instead of a rough indicator of the adequacy of medical service in an area.

HHS agreed with our recommendation to update the MUA list and recognize other weaknesses relating to the MUA criteria. However, the Department's proposed actions are not as timely as they could be.

We do not believe that HHS should wait until the 1980 census data are available to update the MUA list. Data more current than those now being used have been available to HHS for several years. We believe that the MUA list should be updated now using the most recent data and updated again as more current data become available for each of the data elements used in the designation process.

Also discussed in our response to the previous comment, the Department's statement that the application of the MUA is confined to a "first cut" at identifying shortage areas is contradictory to statements by officials in each of the four regions in our review that they relied on the MUA designation to support the need for a center. (See p. 25.)

The Department stated that it also relied on State and local planning processes to assure compatibility of the needs assessment processes practiced by particular grantees. Our work suggests that such reliance may not be appropriate because HSA reviews for the 30 grantees included in our review were often either not performed or performed inadequately. (See p. 25.)

Although HHS concurred with our recommendation that it establish a specific timetable for updating future MUA lists as data became available, we are concerned that its planned action may not be responsive to the main thrust of our recommendation since it only refers to a single updating effort in 1982. As discussed in our response to the previous comment, we do not believe it is necessary to wait for the 1980 census data to update the MUA list since data more current than those now being used have been available to HHS for several years. We believe HHS should update the list now and establish a timetable for future updates.

HHS did not concur with our recommendation to develop a definition of "medical underservice" specifically for the community health center program. It believed that section 330 of the Public Health Service Act adequately defined need, and that the MUA process and project specific needs assessments, if used together, were an adequate index for funding decisions.

The language in section 330(b)(3) of the Public Health Service Act cited by HHS states that:

> "The term 'medical underserved population' means the population of an urban or rural area designated by the Secretary as an area with a shortage

of personal health services or a population group designated by the Secretary as having a shortage of such services."

This language has little meaning without examining the process used by the Secretary to designate MUAs. Our examination of the process showed that the MUA (1) was developed for the health maintenance organization program, which had different intent than the community health center program, (2) assumed that at least half of all counties in the United States were medically underserved, and (3) generally was not supplemented with information from individual project needs assessments.

If HHS were to use the MUA process (with more current data) as a rough indicator of need and to supplement that information with project specific needs assessments containing the minimum information we recommend (see p. 28), we believe it would provide a more reasonable basis for assessing the adequacy of medical service in an area and for funding decisions on specific projects.

HHS agreed with our recommendation that it develop and provide guidance to prospective grantees on performing needs assessments. It is developing instructions that it expects to issue in June 1981. HHS disagreed with the part of our recommendation dealing with demand analyses. HHS said that no suitable or valid method for analyzing demand for primary care in poor areas has been found, such analyses are complex and costly, and the Congress intended that community health centers address the need rather than the demand for health services.

HHS is acting quickly to provide prospective grantees with guidance on performing needs assessments. Discussions with agency officials in late April 1981 indicated that the instructions would require grantees to develop at least the minimum information we recommended.

HHS' reasons for not requiring grantees to perform demand analyses are not persuasive. The community health center program was intended to serve not just poor areas, but areas experiencing primary care availability and/or access problems. During our fieldwork we found that a large percentage of community health centers were not meeting HHS' minimum productivity standards and one State program (serving rural areas) had been successful in estimating demand using a methodology that is neither complex nor costly. (See pp. 24 and 25.)

Although no generally accepted method for doing demand analyses may be available, we believe that HHS should try to develop a demand assessment methodology since the productivity level at many centers is below the minimum requirement, the funding for the community health center program is scheduled to decrease under the administration's fiscal year 1982 budget proposals, and at least

one State we visited had a fairly reasonable approach for assessing demand. It appears to us that developing such information as (1) the population inside a target area, (2) the total number of medical visits expected from the target population, and (3) the market penetration by considering such factors as proximity of alternate sources of primary care, barriers to access, and traffic flow patterns could produce demand estimates that would be useful to HHS in determining the appropriate size and staffing of community health centers.

We recognize that the statutory language for the community health center program addresses the need for services rather than demand. Therefore, in addition to recommending that HHS require that demand analyses be performed in conjunction with needs assessment, we are also recommending that the Congress incorporate a requirement for demand analyses into the community health center legislation.

HHS concurred with our recommendation that it reevaluate the eligibility of existing grantees, and we believe that HHS' proposed actions are generally responsive to the recommendation.

HHS concurred with our recommendation that it revise grant application review and approval procedures to ensure that future applications comply with all legislative and program requirements. However, we are concerned with some aspects of the Department's comments.

First, we agree that the expansion of the community health center program was carried out with the authorization of the Congress. However, we disagree that it was carried out in accordance with congressional direction since 21 of the 30 projects we reviewed were approved and funded by HHS even though they had not met minimum funding requirements. (See p. 15.)

Second, the question of whether the funding of a community health center in a given area stimulated the influx of additional health care providers does not affect the issues discussed in this report. Our work considered the situations that existed and the information available to HHS when it made the initial decision to fund the 30 community health centers.

Finally, regarding the relationship between grant review procedures and changes in the funding situation from expansion to curtailment, we believe that the grant review process should be carried out in accordance with established procedures regardless of the program's growth status.

CHAPTER 3

WEAKNESSES IN NEED DETERMINATION MECHANISMS PERMEATE OTHER HHS-FUNDED GRANT PROGRAMS

Our review as well as studies by other organizations indicate that the weaknesses in need determination mechanisms discussed in chapter 2 of this report permeate other HHS grant programs.

Our review of the alcohol, drug abuse, and mental health grant programs showed they also suffered from a lack of HHS guidance concerning what constitutes need for purposes of Federal funding and what methodologies grantees should use to perform needs assessments. As a consequence, needs assessments varied at the State and local levels, and Federal officials did not place extensive reliance on them when reviewing State plans or grant applications. Simply stated, at the State and local levels, preparing needs assessments for these programs was often regarded as a mandatory exercise that had little effect on decisionmaking compared to other considerations, such as political and economic factors. At the Federal level, it was often viewed as a necessary requirement, but one in which greater attention seemed to be given to format than substance.

Similarly, our prior work showed that the need determination mechanisms used in the authorization and assignment of National Health Service Corps personnel to communities did not include an assessment of the potential demand for health care services. We found that physicians at NHSC sites were underused in terms of the number of patients served.

Studies by HHS and the Office of Management and Budget have also pointed out many of the same weaknesses. The paradoxical situation--in which needs assessment requirements are commonplace but little emphasis is placed on performing them or using their results--demonstrates that little benefit is now being obtained from this process. The process should be changed to make it more useful to grantees and Federal officials and to provide greater assurance that Federal funds are directed to where they are most needed.

PROBLEMS OF INADEQUATE NEEDS ASSESSMENTS BY GRANTEES ARE WIDESPREAD

Our examination of the needs assessment process for the alcohol, drug abuse, and mental health grant programs showed that HHS had not accomplished the basic first steps of defining what constitutes health care needs for purposes of Federal funding and specifying methodologies to assess those needs. As a result, relative need was not adequately considered in decisionmaking at

any level for these programs. At the State and local levels, the lack of definitions and methodologies has led to inconsistent needs assessment processes and results that have much less influence on decisions than do political and economic considerations. Also, Federal officials do not rely extensively on needs assessment results when reviewing plans and grant applications or when allocating resources.

HHS has not defined need or specified methodologies for performing needs assessments

As shown by the following table, HHS has not defined need for purposes of Federal funding or specified methodologies for performing needs assessments for the health service grant programs we examined.

Program	Is needs assessment required?	Who does needs assessment?	Is need defined?	Is there a methodology?
Mental health	Yes	State & local	No	a/No
Alcohol formula	Yes	State	No	No
Alcohol project	Yes	Local	No	a/No
Drug formula	Yes	State	No	No
Drug project	Yes	b/State	No	No

a/Method is suggested but not mandated; allows wide range of approaches.

b/Implicit requirement--States review special project applications against the State plan. States are responsible for allocating funding to areas of greatest need.

According to a December 1977 report by HHS' Office of the Assistant Secretary for Planning and Evaluation, one reason for the confusion about using need as a basis for program management is that need is a relative concept. Needs do not show themselves; someone must decide what constitutes a need. As suggested by the following discussion pertaining to the CMHC program, if the term need is to have operational meaning, it must be defined in a specific context, usually through absolute or relative (comparative) criteria or standards.

The National Institute of Mental Health has not defined need for the CMHC program. While the Federal Government requires State

and local program managers to assess needs, there are no criteria or standards defining what a mental health care need is. Should services be provided only to those whose mental impairment may make them harmful to themselves or others or should services be planned for and delivered to those who suffer from stress and mild depression? These specific questions regarding what degrees of impairment warrant Federal support have not been answered. Without such answers, decisions affecting service delivery are difficult when problems and incidence estimates far exceed the system's capacity to deliver service, which is the case in the mental health program.

A 1978 Presidential commission report stated that as much as 15 percent of the population may have needed mental health services in 1975, but only about 3 percent were receiving these specialized services. Without criteria concerning who should be served, HHS reviewers and State and local grantees are individually deciding what constitutes need, as the following illustrations show.

--Each HHS region develops its own priority system for funding CMHC grants. Region IV's primary concern is funding parity among the States. Centers from States that have historically received less CMHC funds per capita and have relatively fewer federally funded catchment areas are considered to have greater needs. On the other hand, Region V priority systems emphasize minority and poverty status. The poorer areas and those with large numbers of minorities are considered to have greater needs.

--An urban CMHC in Ohio, covering a very small area (21 square miles), decided it needed seven neighborhood clinics to improve accessibility. The justification for these clinics was that, without them, clients from parts of the catchment areas would have to obtain transfers on the city's extensive transit system to receive service. Contrasted to this "need" was the problem of many rural centers we visited that cover several thousand square miles but are financially hard pressed to operate even a few outreach offices.

Officials we talked to at State and local health service and health planning agencies had varying opinions about the usefulness of the guidance they had received on needs assessments. Most believed the guidance did not enable them to effectively determine and use need to plan, structure, and fund programs. These officials often talked about their inability to interpret and convert need data into planning and funding decisions. They said they had to insert their own opinions and interpretations into the needs assessment process. HHS gives grantees a great deal of latitude in performing needs assessments, as shown by the following example:

--HHS has suggested using 131 selected census variables as need indicators for the State mental health plans but has not stipulated how to use them to make decisions. As part of their needs assessments, Indiana used 2 variables, California used 10, and Ohio used 10. Only one common indicator--a poverty index--was used by all three States. California and Ohio had five others in common. Officials in all three States said they made little use of the information in their planning and funding decisions.

Needs assessments have limited influence on State and local decisions

Since needs assessments are required by law and regulation, most program managers we talked to made some attempt to determine health care needs. However, the quality of their efforts varied by program and location. Some seemed to be honest efforts to assess needs, while others seemed to be merely efforts to comply with the minimum Federal requirements. However, as suggested by the following examples, planning and funding decisions of State and local health agencies are affected by various factors. In this environment, health care needs are often overshadowed by other considerations, such as historical service patterns, fund availability, staff interests, and politics. Similarly, Federal funding priorities (which are not necessarily in harmony with State or local needs) sometimes determine State and local spending decisions by targeting certain populations and services for special emphasis. These decisions may not be consistent with needs assessment results.

--An Indiana alcohol and drug agency planner said priority program areas were selected because of available Federal funding sources. The agency's rather extensive needs assessment efforts did not significantly affect priorities or budgets.

--State CMHC officials in Indiana, Ohio, and California said they include needs assessments in their plans primarily to comply with regulations because the information is not particularly useful to their operations. One State official commented that, because the Federal requirements do not mesh with the State's planning and funding mechanisms, needs assessments are of limited usefulness. A National Institute of Mental Health official said States' needs assessments are often done merely to meet Federal requirements, and States do a lot of unnecessary and costly things to produce documents that are basically useless. He said some States make three planning efforts--one to satisfy HHS, another to justify their budget to the State legislature, and a third for actual decisionmaking.

--The assistant director of an alcohol counseling center in Missouri said the needs assessments data included in its grant application to the National Institute on Alcoholism and Alcohol Abuse were for compliance. He strictly followed the one piece of guidance received from the Institute suggesting an assessment method. This effort had no impact on decisions concerning what services the center would deliver.

--In California, results of a mental health needs assessment were altered after political groups strongly objected to the findings. Similarly, in other areas, needs assessments were ignored if they conflicted with the subjective opinions of interest groups. An alcohol planner in California frankly stated that the "squeaky wheel gets the grease."

HHS reviews of plans and grant applications do not focus on the adequacy of need determination

Because the justifications included in grant applications and plans were often based on needs assessments that used inconsistent approaches and unverified data, HHS reviewers gave limited consideration to the needs assessments in their review process. Also, reviewers we talked to received little guidance on the criteria to be used in reviewing grants and plans. As a result, reviews of applications for health service grants tended to focus on format and completeness rather than on program justification and need, as shown by the following illustrations.

--An HHS deputy regional health administrator said that, in the absence of clear guidance and understanding of needs assessment and its relation to funding, reviewers are primarily limited to assuring legal compliance.

--A Region IV official said only the presence or absence of a needs assessment was important; the grantee's method, results, and use were not factors. An analysis of 16 CMHC-approved grant files at Region V disclosed that in 7 cases the relevance of the needs assessment was criticized or questioned. In responding to this analysis, a Region V official stated that needs assessments were not a key consideration in an application review.

--Alcohol project grants are available for local treatment programs aimed at specific target populations. Each year target groups are identified for priority funding based on congressional, Office of Management and Budget, and HHS central office perceived needs. These groups include women, minorities, youths, elderly, and others. Grant applications

are reviewed by the HHS central office and given priority ranking scores based largely on stated needs. HHS then funds as many applications as possible within each target group's allocation. As a consequence of this funding system, some projects with greater stated needs are not funded, while others with lesser stated needs are.

--According to both regional and headquarters officials, HHS reviews of the plans developed by the health planning agencies are also process oriented rather than results oriented. Reviews are primarily concerned with assuring that plans are complete, are arranged in the prescribed format, and flow logically from stated needs to the goals, objectives, and actions designed to meet those needs. With respect to HSAs, an HHS central office official said the accuracy and adequacy of the needs assessment data are not verified. Instead, HHS relies on regional offices to evaluate the data. However, at the regional offices we visited, need was seldom even considered, much less evaluated for accuracy and adequacy. A Region V reviewer explained that need is a locally determined matter not subject to HHS evaluation. According to another reviewer, an HHS central office official told him not to judge a certain plan on its needs assessment or on the quality of planning. The reviewer said that, from a quality standpoint the plan was not acceptable, but from a format standpoint, it was. During our exit conference Region V officials agreed that plans were judged on format--not the quality of the plan or its needs assessment.

PRIOR GAO WORK POINTS OUT THAT NHSC NEED DETERMINATION MECHANISM DOES NOT CONSIDER POTENTIAL DEMAND FOR HEALTH CARE

In a 1978 report, 1/ we noted that HHS did not adequately consider demand for health care in assigning NHSC providers to communities located in underserved areas. Primarily because HHS had not done so, many NHSC physicians were underused in terms of the number of patients they served.

In authorizing and assigning physicians to practice in health manpower shortage area communities, HHS gave little consideration to the actual demand for health care in those communities before assigning personnel.

1/"Progress and Problems in Improving the Availability of Primary Care Providers in Underserved Areas" (HRD-77-135, Aug. 23, 1978).

Our report went on to point out that, although located in critical health manpower shortage areas, NHSC physicians on the average saw about 35 percent fewer patients per hour than the average office-based primary care physician and about 49 percent fewer patients per hour than the average general practitioner and family practitioner in nonmetropolitan areas. Data presented in the report for a 3-month period showed that NHSC physicians at 110 sites that had been operating for 1 year or more averaged slightly fewer than 2 patients per hour and none averaged as high as the 2.95 national average for office-based primary care physicians.

In our report we concluded that the fact that demand was not considered in authorizing and assigning physicians to practice in communities, together with the low utilization of NHSC providers, raised serious questions about the extent of unmet demand for health care in some communities.

Our report recommended that HHS:

--Require that communities and other entities requesting NHSC health care providers conduct studies which identify, to the extent possible, the number and types of residents located therein who are likely to seek care from an NHSC-sponsored practice.

--Verify the above information, to the extent possible, before assigning health care providers to the applicant.

In commenting on our draft report, HHS concurred in the intent of our recommendation that communities seeking NHSC assistance conduct studies that would identify those likely to seek care from an NHSC-sponsored practice. However, HHS questioned the recommendation's practicality, stating that it was not clear how to make such a determination. HHS added that, if a method of determining demand were chosen from among those currently available, an enormous data collection effort would be required, and it did not seem feasible to place such a burden on local communities.

HHS also mentioned that HSAs and other health planning agencies, under the National Health Planning and Resources Development Act of 1974, have as one of their responsibilities undertaken studies of unmet demand for services. HHS added that, under the new NHSC authorizing legislation, the designation and site approval processes both depend strongly on these planning agencies' evaluations of need. In the designation process, health planning agencies would be asked to evaluate the size of a potential site's service population and consider accessibility to nearby resources. In the site approval process, comments of the planning agencies are to be solicited and considered.

In responding to those comments, we recognized that requiring communities to conduct studies to estimate potential demand from an NHSC-sponsored practice might place a burden on the local community and possibly require additional data collection. We also recognized the role outlined for the health planning agencies in both the designation and site approval process.

Nevertheless, we believed that, in addition to obtaining comments of the planning agencies in the site approval process, it is both practical and necessary for HHS to require designated shortage area communities to justify the need for NHSC health practitioners by conducting studies designed to estimate expected potential demand for medical care from an NHSC-sponsored practice. We believed this was important since many areas might not have enough people seeking care to justify a full-time medical practice staffed by a single physician and some areas might not even be able to sustain or justify a physician extender.

STUDIES BY OTHER ORGANIZATIONS DISCUSS NEEDS ASSESSMENT PROBLEMS

Our work focused on the adequacy of the needs assessment process for several health service programs. Some HHS reports and an Office of Management and Budget study have pointed to similar problems in these and other health, social, and educational programs. The work done in this area seems to suggest strongly that the problems related to performing and using needs assessments may occur in most programs requiring a need determination. HHS' Office of the Assistant Secretary for Planning and Evaluation has issued a series of reports on problems experienced in doing and using needs assessments. 1/ These reports concluded that:

--Neither need nor needs assessment has a clear unique operational definition.

--HHS has been deficient in giving direction and guidance on how needs assessments should be used to develop services.

--Current needs assessments vary widely in quality and extent and are seldom used by grantees in making programmatic decisions.

--Authorizing legislation and administrative regulations do not define and communicate needs and needs assessment requirements in a usable form.

1/"A Compendium of Laws and Regulations Requiring Needs Assessments," May 1977. "Needs Assessment: An Exploratory Critique," May 1977. "Needs Assessment: A Critical Perspective," December 1977.

In 1977, the President directed the Office of Management and Budget and the executive agencies to study Federal planning requirements imposed on State and local grantees. A report 1/ noted that:

--There is inadequate guidance for assessing needs, identifying problems, and setting priorities.

--Duplicate planning at various administrative levels often leads to wasteful and inconsistent decisions.

--Data collection requirements are nonuniform and deficient, sometimes resulting in voluminous information with little efforts.

Neither HHS nor the Office of Management and Budget reports contained specific recommendations for improving needs assessments; however, they did pose questions that should be answered before a needs assessment is undertaken, and certain options for improving needs assessment data. A basic message of these reports was that the Federal Government should change the need assessments processes that now generate large amounts of data that are not useful to program planners and managers, and direct them more toward identifying and solving specific problems.

CONCLUSIONS

Both our prior and current work related to HHS grant programs and studies issued by other organizations show that the weaknesses in need determination mechanisms discussed in chapter 2 of this report also permeate other health grant programs. Our prior work showed that the need determination mechanisms used in the authorization and assignment of NHSC personnel to communities did not involve an assessment of the potential demand for health care services. As a result, our August 1978 report showed that physicians at NHSC sites were underused in terms of the number of patients they served.

Also, the mechanisms for determining needs for the alcohol, drug, and mental health programs suffer from a lack of HHS guidance concerning what constitutes need for purposes of Federal funding and what methodologies grantees should use to perform needs assessments. As a consequence, needs assessments varied at the State and local levels, information in them was not verified, and Federal officials did not place extensive reliance on them when reviewing State plans or grant applications. Simply stated,

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1/"Preliminary Working Papers: Review of Federal Planning Requirements," Interagency Task Force on Federal Planning Requirements, October 1977.

at the State and local levels, preparing needs assessments was often regarded as a mandatory exercise that had little effect on decisionmaking. At the Federal level, needs assessments were often viewed as a necessary requirement, but one in which greater attention seemed to be given to format than substance.

We are not the only organization that has identified these problems. Past HHS and Office of Management and Budget studies have pointed out many of the same weaknesses in health and other social programs.

Little benefit is now being obtained from the needs assessment process. Accordingly, the process should be changed to make it more useful to grantees and Federal officials and to provide greater assurance that Federal health service funds are directed to where they are most needed.

Based on our work in the need determination area, we believe that the need for health programs and services should be addressed from two perspectives. First, from the national perspective, need should be defined and mechanisms should be established which serve as screens to identify--in a rough fashion--geographic areas that meet the essential conditions for Federal support. The MUA concept could be a reasonable approach--if appropriate statistical indicators of need could be established for the alcohol, drug abuse, and mental health programs.

Second, the indications of need that result from the MUA concept or need determination mechanisms established for other health service programs should be tempered with analyses that realistically identify the need and expected demand for services in a given geographic area. Therefore, applicants for health service program grants should be required to justify the specific health services in accordance with criteria established by HHS. Such criteria should--as a minimum--address (1) the need for the services in the context of the health problem they will address, (2) the facilities and providers that already provide similar services in the area, and (3) a realistic analysis of the potential demand for services.

In our opinion, a properly implemented two-step process such as this could give HHS officials better information on the need as well as potential demand for the health services proposed by grant applicants.

RECOMMENDATIONS TO THE SECRETARY OF HHS

To better ensure that Federal health care funds are directed to geographic areas with a demonstrated need and potential demand for the services, we recommend--as we did for the community health

center program--that, for other health service programs requiring need determination, the Secretary:

--Clearly define what constitutes need or eligibility for purposes of Federal funding.

--Develop rough need indicators, similar to the MUA concept, which would serve as screens to identify geographic areas that would be candidates for Federal funding under the various health service programs.

--Develop needs assessment guidance for the use of grant applicants that would address the need for services as well as a realistic analysis of the potential demand for services. As was recommended for the community health center program, such guidance should require that

(1) rational service areas be established,

(2) health care services in the proposed target areas and in contiguous areas be addressed in terms of availability and accessibility,

(3) asserted health care problems be documented, and

(4) opposition views be addressed in grant applications.

--Establish mechanisms for verifying the information contained in all grant applications.

--Give HHS reviewers direction on how need and demand information should be used in the grant review process.

HHS COMMENTS AND OUR EVALUATION

HHS agreed with some of our recommendations and disagreed with others. The Department also stated that current administration proposals to consolidate various health service grants into block grants would, if enacted, eliminate the need for departmental actions on our recommendations. However, HHS responded to each of our recommendations and outlined proposed actions to be implemented in the event the Congress does not enact the block grant proposals.

HHS did not concur with our recommendations that for health services programs (other than the community health center program) requiring a needs assessment it (1) clearly define what constitutes need or eligibility for purposes of Federal funding and (2) develop rough need indicators, similar to the MUA concept, which would serve as screens to identify geographic areas that would be candidates for Federal funding. HHS said that existing mechanisms

already identified areas of need that were reflected in State plans reviewed by the Alcohol, Drug Abuse, and Mental Health Administration and used to identify areas that would be candidates for funding under other service programs.

As discussed in our scope and methodology section (see p. 8), we did not review the needs assessment process for the alcohol, drug abuse, and mental health programs as thoroughly as we did for the community health center program. Essentially, we obtained the attitudes and views of individuals at various levels of government concerning the value and use made of needs assessment results in the decisionmaking processes affecting these health service grants. Based on our work we concluded that, at the State and local levels, preparing needs assessments was often regarded as a mandatory exercise that had little effect on decisionmaking. At the Federal level, needs assessments were often viewed as a necessary requirement, but one in which greater attention seemed to be given to format than substance. (See p. 40.)

Our discussion of studies done by other organizations was included to point out that HHS and the Office of Management and Budget have been aware of the needs assessment problem for some time. The attitudes and views we obtained at the Federal, State, and local levels suggested that, whatever action HHS has taken to improve the needs assessment process has had little impact.

Our reference to the prior report concerning NHSC was made to point out that we had previously recommended that demand analyses be performed to deal with low physician productivity, one of the problems we identified at the community health centers. The material was not included to question the adequacy of the health manpower shortage area designation process, and for purposes of our recommendations, we did not consider it to be a health service program, such as alcohol, drug abuse, or mental health.

Taken together, our discussions of the above three areas suggested that many of the problems we found in the community health center program permeated other health service programs. Therefore, we believed that our recommendations regarding the community health center program could be applicable to other health service delivery programs. Consequently, our recommendations were aimed at all health service delivery programs that contain a requirement for a needs assessment and not only the alcohol, drug abuse, and mental health programs. We continue to believe our recommendations are appropriate.

HHS concurred with our recommendation that it develop needs assessment guidance that would address the need for services as well as a realistic analysis of the potential demand for services. Although HHS concurred, we noted that its comments were silent

concerning the extent to which it agreed that demand analyses should be performed. Because HHS disagreed with our recommendation that demand analyses be performed for the community health center program, we want to reemphasize that we believe that such analyses should be done to the extent possible for other health service programs.

HHS did not concur with our recommendation that it establish mechanisms for verifying the information in all grant applications. With respect to the alcohol, drug abuse, and mental health programs, HHS commented that such efforts would be duplicative of the functions currently performed by Single State Agencies, the Office of Management and Budget Circular A-95 process, and HSAs. We did not review the Single State Agency process or the A-95 process. However, our work at HSAs and at HHS' regional offices indicated that little effort was given to data verification. Similar conditions were found for the community health center program.

We suggest that, if HHS plans to rely on Single State Agencies, the A-95 process, and HSAs in the future, it take steps to assure that these groups are adequately carrying out their responsibilities. We continue to believe that the data in grant applications should be verified by HHS or through a more reliable mechanism than now exists.

HHS concurred with our recommendation that it give grant reviewers direction on how need and demand information should be used in the grant review process. However, it noted that the Alcohol, Drug Abuse, and Mental Health Administration is not planning to issue new instructions to HHS grant reviewers since its programs are presently being proposed for consolidation into a block grant.

APPENDIX I

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

20 APR 1981

Mr. Gregory J. Ahart
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report entitled, "Health Service Program Needs Assessments Should Be Improved." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Bryan B. Mitchell
Acting Inspector General

Enclosure

COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ON THE GENERAL ACCOUNTING OFFICE DRAFT REPORT ENTITLED "HEALTH SERVICE PROGRAM NEEDS ASSESSMENTS SHOULD BE IMPROVED"

General Comments

In February 1981, after the General Accounting Office (GAO) review was completed, the President proposed that the Congress consolidate the Community Health Centers (CHC) program and the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) service programs into basic health care block grants. Prompt enactment of the President's proposal would eliminate the need for congressional and departmental actions on the recommendations contained in this report. However, if the Congress decides not to legislate the consolidation of the two programs into block grants, the Department will proceed with the implementation of the proposed actions as outlined in the comments to the GAO recommendations cited below.

The Department has under development a new methodology for identifying underserved areas. We believe this new methodology will accommodate many of the concerns expressed in this report. This methodology is now being refined and tested. Once these analyses are complete, we will make a final decision on whether to use this methodology to supersede present methods used for both the Medically Underserved Areas (MUAs) and the Health Manpower Shortage Areas (HMSAs) designation processes. The new methodology could be implemented in 1982 when the 1980 Census data are available. In the event the new methodology is not acceptable to the Congress or proves inadequate for program management needs, we will continue to improve the designation processes as indicated in our specific comments on each GAO recommendation.

Also, it is important to note that the National Health Service Corps (NHSC) assignment program was not included in the President's proposal. Therefore, the Department's comments to the recommendations pertaining to NHSC are not subject to the above mentioned caveat.

GAO Recommendation

We recommend that the Secretary use the MUA designation process only as a gross indicator for determining areas of the Nation warranting more detailed assessment of need for purposes of Federal funding.

Department Comment

We concur. The Health Services Administration's Bureau of Community Health Services (BCHS) does use the MUA list only as a general indicator of medical underservice. BCHS has always perceived and defined the MUA designation as a gross or rough indicator of need to be further refined, validated, and updated at the community level.

GAO Recommendation

We recommend that the Secretary update the MUA listing and, to the extent practical, consider the other weaknesses discussed in this report relating to the MUA criteria, recognizing it should only be used as a gross indicator of medical underservice.

Department Comment

We concur. The MUA list will be updated as soon as the 1980 Census data become available.

The Department fully recognizes the limitations of the methodology used for designating MUAs, and confines the application of the MUA to a "first cut" at identifying shortage areas.

After identifying an area as medically underserved, the Department has relied on state and local planning processes to assure compatibility of the needs assessments process practiced by particular grantees. By law, the Health Systems Agencies (HSAs) and the State Health Planning and Development Agencies are required to (1) collect and analyze community needs of health services, (2) periodically update the needs data, and (3) perform reviews of existing health services. Furthermore, a grant applicant for a CHC program is required to comply with OMB Circular A-95 for a state and areawide clearinghouse review. The A-95 project notification and review system coordinates the CHC program with state, areawide, and local planning evaluations. The state and local planning agencies thereby have the opportunity to consider the needs assessments submitted by CHC grant applicants in combination with the views of those opposed to the project funding.

As we now face resource constraints, the Department does not anticipate the development of new CHC projects. This frees our attention to conduct in-depth reviews of all existing CHC projects. In these reviews, we are strengthening the guidance for needs assessments processes at the community level.

GAO Recommendation

We recommend that the Secretary establish a specific timetable for updating future MUA lists that would consider current data as they become available.

Department Comment

We concur. The Department plans to revise the MUA list once the 1980 Census data becomes available in 1982.

GAO Recommendation

To ensure that urban and rural community health centers are adequately justified, we recommend that the Secretary develop a definition of "medical underservice" specifically for the rural and urban community health center program.

Department Comment

We do not concur. The existing MUA designation process is adequate as a gross indicator of need for personal health services. When combined with the project-specific needs assessments process, the MUA designation

process provides a sufficiently accurate index for funding decisions. Moreover, we consider the terminology in Section 330(b)(3) of the Public Health Service Act concerning CHCs adequate.

GAO Recommendation

Develop and provide to prospective grantees guidance on how to perform and what should be included in needs and demand assessments for the program. As a minimum, the guidance should require that; (1) rational service areas be established, (2) all health care services in the proposed target area and in contiguous areas be addressed in terms of availability and accessibility, (3) asserted health care problems should be documented, and (4) opposition views be addressed in grant applications.

Department Comment

We concur with the recommendation to provide guidance to prospective grantees. However, we do not concur with the detailed minimums.

BCHS is currently completing a set of instructions to grantees and to Regional Health Administrators on the community needs assessments of all CHCs. The instructions include guidance and specific procedures applicable to primary care projects with limited research resources. The instructions are guides for use by grantees in performing community needs assessments as part of the review of grant applications for initial or continuation awards. The instructions are also directions to the regional offices on necessary reviews of needs assessments as contained in grant applications. These instructions will supplement the existing MUA designation process with a close analysis of community health needs and health resources including contiguous areas. This set of instructions is expected to be issued in June 1981.

We do not concur with the part of the recommendation that grantees should perform a demand analysis because no suitable or valid method for analyzing demand for primary care in poor areas has been found. Further, analagous studies on demand analysis made by hospital care and health maintenance organizations have shown that ample resource staff and methodologies far more complex and costly than can be afforded by CHCs would be required. Moreover, the Congress clearly intended in the statutory language that CHCs address the need for health services rather than the demand.

GAO Recommendation

We recommend that the Secretary reevaluate the eligibility of existing grantees in light of the above recommendations, and phase out those that cannot meet the revised requirements.

Department Comment

We concur. BCHS is currently reviewing the appropriateness of all grants and is examining the continued eligibility and funding levels for all primary care grantees in light of the stengthen needs assessments guidance.

In addition, BCHS has established internal monitoring processes to screen the MUA status of grantees. Through this screening process, a number of "at risk" grantees has been identified for phaseout.

GAO Recommendation

We recommend that the Secretary revise the grant application review and approval procedures to ensure that future applications comply with all legislative and program requirements.

Department Comment

We concur. The Department recognizes that grant review and approval procedures appropriate during a time of expansion may require modification and restriction during a time of curtailment. Under present circumstances, new grantee requests for funding are irrelevant. Administrative efforts have been redirected to managing existing centers and determining their eligibility for continuation. We recognize that the expansion of CHCs over the past 5 years, carried out with full congressional direction and authorization, may have stimulated an even further influx of other health providers into some projects' catchment areas. The Department's tighter and more exacting reviews and approvals of continuation grant needs assessments are thus being implemented at an opportune time.

GAO Recommendation

To better ensure that Federal health care funds are directed to geographic areas with a demonstrated need and potential demand for the services, we recommend--as we did for the Community Health Center program--that for other health service programs requiring need determination, that the Secretary clearly define what constitutes need or eligibility for purposes of Federal funding.

Department Comment

We do not concur. The Department has already established mechanisms for defining eligibilities for Federal programs. In regards to NHSC personnel placement program which requires a needs determination, the Department's designation of HMSAs is a process which clearly defines the criteria for eligibility to receive NHSC personnel. In this connection, Section 332(b) of the PHS Act (42 CFR Part 5) requires the Secretary to establish criteria for designation of geographic areas, population groups, medical facilities, and other public facilities in the states as HMSAs.

For purposes of defining criteria for designation of areas having shortages of primary medical care manpower, a geographic area is designated if the following three conditions are met:

1. The area is a rational area for the delivery of primary medical care services;

2. One of the following conditions prevails within the area:

   a. The area has a population to primary care physician ratio of at least 3,500:1, or

   b. The area has a population to primary care physician ratio of less than 3,500:1 but greater than 3,000:1 and has either unusually high needs for primary medical care service or insufficient capacity of existing primary care providers.

3. Primary medical care manpower in contiguous areas is overutilized, excessively distant, or inaccessible to the population of the area under consideration.

With respect to ADAMHA service programs which require a needs determination, ADAMHA has already defined what constitutes needs for purposes of Federal funding. In this regard, the formula for funding of grants for CMHCs is based on the provision of mental health services to residents of urban and rural poverty areas, while the total amount of funds a region receives for new CMHCs is based on the number of catchment areas in that region currently without CMHCs.

The GAO report cites its 1978 study, "Progress and Problems in Improving the Availability of Primary Care Providers in Underserved Areas." However, the report does not update the 1978 report, nor does it include in the list of grantees reviewed cited in Appendix I a single CMHC. Therefore, the report misses the continuing improvements ADAMHA and NHSC have made since 1978 in determining needs assessments.

GAO Recommendation

Develop gross need indicators, similar to the MUA concept, which would serve as screens to identify geographic areas that would be candidates for Federal funding under the various health service programs.

Department Comment

We do not concur. The HMSA process, relative to NHSC personnel placement described below, already includes gross need indicators.

1. Eligible areas for NHSC placement are now designated according to the HMSA process. The new procedures place more emphasis on considering contiguous area resources, impose more stringent requirements for defining rational service areas, and give more consideration to factors such as high infant mortality, poverty, and fertility rates.

2. Copies of the area's applications are routinely sent to the relevant state professional society for their review and comment as HMSA designations are considered for NHSC personnel assignment.

3. Priorities for placement are set according to physician/population ratios, health status indicators such as infant mortality, and presence of high-risk populations like migrants. The Department uses the HMSA designation as merely a first cut at identifying health services shortage areas.

4. Productivity of encounters per full-time equivalent physician has increased steadily since 1978. Therefore, for all NHSC sites, it is now within five percent of compliance with the standard of 4,200 encounters per year.

Concerning the CMHC, the Single State Agencies (SSAs) already identify areas of great need in the state plans which are reviewed by ADAMHA and these plans also identify geographic areas that would be candidates for Federal funding under ADAMHA's service programs. We will continue to work with the states as they proceed to further develop and refine gross indicators.

GAO Recommendation

Develop needs assessments guidance for the use of grant applicants that would address the need for services as well as a realistic analysis of the potential demand for services. As was recommended for the community health center program, such guidance should require that (1) rational service areas be established, (2) health care services in the proposed target areas and in contiguous areas be addressed in terms of availability and accessibility, (3) asserted health care problems should be documented, and (4) opposition views be addressed in grant applications.

Department Comment

We concur. Regarding the NHSC personnel placement program, the criteria for the HMSA process already include guidance addressing (1) the definition and establishment of rational service areas, (2) the availability and accessibility of health resources in proposed target and contiguous areas, and (3) the extent and degree of documentation required on existing health care problems. Additionally, to ensure that opposing views are addressed in grant applications, the Department is currently developing a process to require that the sponsoring organization provide written comments from the appropriate professional societies. If local professional societies are not supportive of the placement, the sponsoring organization would have to redefine and justify the relevant issues.

Regarding the CMHCs and related programs, ADAMHA has procedures in effect to address the above recommendations. In this connection, applying for both new and continuation grants, CMHC grantees are provided with an ADAMHA designed package of information, instructions, checklists, forms, and tables for the proper preparation and subsequent review of grant applications. This includes instructions and tables for the Determination

of Poverty Eligibility. These packaged data are more specific than GAO's recommendations on items 1, 2, and 3. For example, in the case of alcoholism programs, the grant package information addresses the needs of specific underserved population groups with inadequate prevention, treatment, or rehabilitative services. In the case of drug abuse programs, emphasis is placed on the severity of drug abuse problems within urban and non-urban areas as determined by the individual state plans.

Regarding item 4 of the recommendation, HSAs already review grant applications. In addition, CMHC grant applications are further exposed to opposition views as they go through the OMB Circular A-95 clearinghouse reviews. The OMB Circular A-95 project notification and review system coordinates and compares CMHC projects with state, areawide, and local planning evaluations.

GAO Recommendation

Establish mechanisms for verifying the information contained in all grant applications.

Department Comment

We do not concur. With regard to NHSC personnel assignments, this is already part of the HMSA process. Applications for HMSA designation are also reviewed by state professional societies and health planning agencies.

With respect to ADAMHA service programs, we believe that the implementation of this recommendation would be expensive and duplicative of the functions currently provided by the SSAs, the A-95 process, and the HSAs.

GAO Recommendation

Give HHS reviewers direction on how need and demand information should be used in the grant review process.

Department Comment

We concur. Relative to the applications requesting assignment of NHSC personnel, the HMSA process is done centrally under very clear criteria. Guidances for NHSC placement give regional offices clear standards in the deployment of Corps personnel. This process has been tightened significantly since 1978, the time of the GAO fieldwork on the NHSC. These criteria include:

1. continued need for health manpower for the area,

2. appropriate and efficient use of Corps members previously assigned,

3. continued efforts to secure health manpower in that area,

4. community support for the assignment of Corps members, and

5. sound project fiscal management, third party recovery funds, and compliance with the BCHS Common Reporting Requirements semiannual report submissions regarding previously assigned NHSC personnel.

With respect to ADAMHA's service programs, the only demand information required of ADAMHA grantees is related to long-range plans for the extension of services in meeting anticipated increases in demand by recipients of the catchment area, including estimates of increased costs to be paid for from Federal funds.

In connection with needs determination information, ADAMHA is not planning on any new instructions to the Department's grant reviewers since its programs are presently being proposed for consolidation into a basic health care block grant.

Technical Comments

On page IV, the report refers to BCHS utilization criteria and on page 41 to the same standard of measurement as an HHS productivity standard, i.e., 4,200 encounters per year per physician. For consistent terminology, this standard of measurement should be referred to as HHS productivity standard (set at 4,200 - 6,000 encounters per year per full-time equivalent physician).

The report does not recognize the role of HSAs in the MUA process. The 1976 Federal Register notice on designation of MUAs clearly spells out the expectation that HSAs will recommend deletions and additions to the list of MUAs initially and at any subsequent time in which changes occur in local communities.

As we noted previously at the time of the 1978 GAO report, it is inappropriate to compare NHSC physicians to all office-based general practitioners or primary care physicians. Rather, adjustments must be made to account for physician specialty, age of physician, age of practice, patient mix, and case mix.

The 1978 GAO report, quoted in this GAO report, suggests that we conduct demand analyses in addition to needs assessments before assignment of NHSC personnel. We have found it more appropriate to refine our needs assessments criteria and process. As can be seen by the increasing productivity of NHSC providers (now 3,978 encounters/year), effective demand, as measured by utilization, has also increased.

GRANTEES INCLUDED IN THE COMMUNITY HEALTH CENTER PORTION OF THE REVIEW

REGION III

Greenwood Medical Association
Millerston, Pennsylvania

Medical Services Foundation
Virginia Beach, Virginia

Mid-Sussex Health Center
Millsboro, Delaware

Peninsula Institute for Community Health
Newport News, Virginia

Pocomoke City Area Care Corporation
Pocomoke City, Maryland

Scranton Primary Health Care Center
Scranton, Pennsylvania

Tri-town Jaycees Medical Association
Williamstown, Pennsylvania

Upper Kanawha Health Association
Cedar Grove, West Virginia

Valley Community Health Care Center
Picture Rocks, Pennsylvania

REGION IV

Benson Area Medical Center, Inc.
Benson, North Carolina

Franklin Memorial Primary Health Center
Mobile, Alabama

George and Green County RHI
Lucedale, Mississippi

Miami Beach Community Health, Inc.
Miami Beach, Florida

Monroe Clinic Development Plan
Madisonville, Tennessee

Palmetto Medical Center
Palmetto, Georgia

APPENDIX II

Project Health, Inc.
Sumterville, Florida

Megals Rural Health Association
Edgefield, South Carolina

Urban Health Center, Inc.
Savannah, Georgia

REGION VI

City of Brownsville UHI
Brownsville, Texas

Eddy County Community Action Center
Carlsbad, New Mexico

La Casa de Buena Salud
Portales, New Mexico

La Clinica Amistad
San Antonio, Texas

Riverside Hospital (4th Ward)
Houston, Texas

San Jacinto County
Coldspring, Texas

South Limestone
Groesbeck, Texas

Southeast Oklahoma Comprehensive Health Center
Hugo, Oklahoma

St. Elizabeth Hospital
Houston, Texas

REGION VIII

Colorado Springs UHI
Colorado Springs, Colorado

Elbert County EMS, Inc.
Kiowa, Colorado

Mercer-Oliver Health Services, Inc.
Hazen, North Dakota

DEVELOPMENT OF MUA DESIGNATION

The criteria used to designate MUAs were originally developed for determining funding priorities for health maintenance organizations. One feature of the Health Maintenance Organization Act of 1973 (Public Law 93-222) was to provide funding priority to organizations that proposed to draw not less than 30 or more than 75 percent of their membership from medically underserved populations. The act required HHS to develop the criteria for designating MUAs within 3 months and to designate the areas within 1 year.

The task of developing the criteria was given to BCHS, which in turn contracted with the University of Wisconsin Health Services Research Group. The university group interviewed many health experts and found substantial disagreement concerning what constituted direct measures of medical underservice. However, the group found that the same health experts tended to agree when asked to rank-order familiar communities according to degree of perceived underservice. On the basis of these findings, the group and BCHS agreed that expert "consensus" assessments represented an acceptable practical standard for designating MUAs for purposes of the Health Maintenance Organization Act.

The university group then developed a mathematical model to predict what health professionals' assessments would be when asked to rank-order familiar communities according to degree of perceived medical underservice. In its final form, this model used four variables with conversion scales for each variable to arrive at a single score, called the index of medical underservice, which ranged from 0 to 100. The four variables used were

--primary care physician-to-population ratio,

--infant mortality rate,

--percentage of population age 65 and over, and

--percentage of population below the poverty level.

BCHS developed a list of MUAs by applying the IMU procedures described above to data on the four variables. County-level data were used for the physician-to-population ratios and infant mortality rates. For the other two variables--percentage of population below the poverty level and percentage age 65 or over--county, minor civil division, or census county division data were used in nonmetropolitan areas, and census tract data were used in metropolitan areas.

When the IMU was computed for all the Nation's counties, the median score was 62. BCHS decided this was an acceptable cutoff point to identify underserved from adequately served areas for

the purposes of priority funding of health maintenance organizations. Consequently, areas with IMU scores of 62 or less were designated as MUAs.

In nonmetropolitan counties with IMU scores above 62, BCHS computed the IMU for each minor civil division and census county division. Also, for census tracts within standard metropolitan statistical areas, BCHS computed the IMU for each census tract. BCHS assumed that county physician-to-population ratios and infant mortality rates applied uniformly to minor civil divisions, census county divisions, and census tracts. The IMU scores for these county subdivisions were recomputed based on this assumption, and all that scored 62 or less were added to the list of designated MUAs.

Applicants for Federal assistance under the Health Maintenance Organization Act were also asked to identify MUAs by using the IMU methodology. The complete list of MUAs was then submitted to local comprehensive health planning agencies (now called HSAs) for review. BCHS then incorporated revisions resulting from the review process into a final MUA list.

WEAKNESSES IN THE DEVELOPMENT AND APPLICATION OF THE MUA CRITERIA

Organizations and individuals involved in the original development of the MUA criteria have highlighted several weaknesses in the process, including (1) a failure to define what constituted medical underservice and (2) limitations of the consensus approach used to identify MUAs.

Health planners and other health care experts have cited, as a weakness of the IMU concept, the lack of definition of medical underservice. BCHS and the university group did not define medical underservice while developing the designation criteria because of the limited time available and the failure of health experts to agree on a definition.

The university group involved in the original criteria development process also identified weaknesses in using the consensus approach. The group stated that the consensus approach, "a critical building block in this methodology, appeared less strong in some metropolitan areas." According to the group, considerable agreement was demonstrated by experts in their assessments of whole counties, cities, and towns. However, agreement among the experts was weak when they assessed selected metropolitan consensus tracts. The group could not explain this apparent weakness. Although this limitation was pointed out, BCHS designated over 4,000 census tracts as MUAs (about 54 percent of the total) using this approach.

A second weakness identified by the university group was that geographic areas used to correlate with the experts' consensus judgments were not chosen randomly. The group stated:

> "* * * the study sites used do not constitute a random sample of all 3,141 counties in the United States, and some statistical evidence suggests that the sites are not representative. Therefore, * * *, the correlations calculated to estimate the extent of consensus and predictive ability may be artificially inflated."

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