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Report to the Ranking Member, Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, House of Representatives

August 2008

HEALTH RESOURCES AND SERVICES ADMINISTRATION

Many Underserved Areas Lack a Health Center Site, and the Health Center Program Needs More Oversight

GAO-08-723

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Highlights

Highlights of GAO-08-723, a report to the Ranking Member, Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, House of Representatives

Why GAO Did This Study

Health centers funded through grants under the Health Center Program—managed by the Health Resources and Services Administration (HRSA), an agency in the U.S. Department of Health and Human Services (HHS)—provide comprehensive primary care services for the medically underserved. HRSA provides funding for training and technical assistance (TA) cooperative agreement recipients to assist grant applicants. GAO was asked to examine (1) to what extent medically underserved areas (MUA) lacked health center sites in 2006 and 2007 and (2) HRSA's oversight of training and TA cooperative agreement recipients' assistance to grant applicants and its provision of written feedback provided to unsuccessful applicants. To do this, GAO obtained and analyzed HRSA data, grant applications, and the written feedback provided to unsuccessful grant applicants and interviewed HRSA officials.

What GAO Recommends

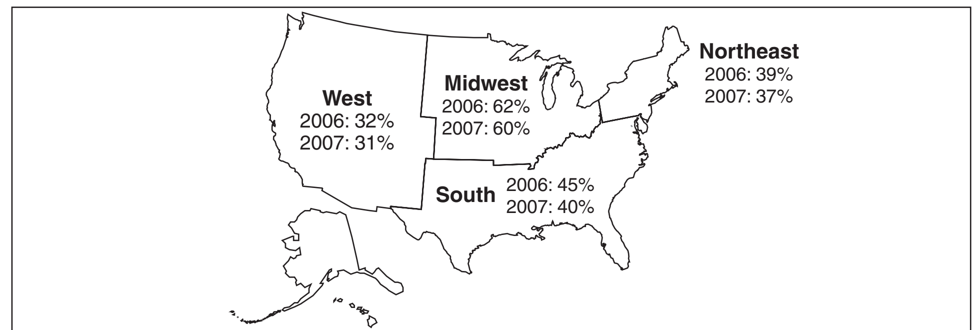
GAO is making recommendations to improve HRSA's oversight of cooperative agreement recipients and the clarity of written feedback provided to unsuccessful grant applicants. HHS concurred and plans to implement these recommendations. However, HHS raised concerns with the report scope and another recommendation to collect site-specific data. GAO believes that the report scope is appropriate and that additional data would benefit HRSA decision making.

To view the full product, including the scope and methodology, click on GAO-08-723. For more information, contact Cynthia A. Bascetta at (202) 512-7114 or bascettac@gao.gov.

What GAO Found

Grant awards for new health center sites in 2007 reduced the overall percentage of MUAs lacking a health center site from 47 percent in 2006 to 43 percent in 2007. In addition, GAO found wide geographic variation in the percentage of MUAs that lacked a health center site in both years. Most of the 2007 nationwide decline in the number of MUAs that lacked a site occurred in the South census region, in large part, because half of all awards made in 2007 for new health center sites were granted to the South census region. GAO also found that HRSA lacks readily available data on the services provided at individual health center sites.

Percentages of MUAs That Lacked a Health Center Site, by Census Region, 2006 and 2007



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HRSA oversees training and TA cooperative agreement recipients, but its oversight is limited in key respects and it does not always provide clear feedback to unsuccessful grant applicants. HRSA oversees recipients using a number of methods, including regular communications, review of cooperative agreement applications, and comprehensive on-site reviews. However, the agency's oversight is limited because it lacks standardized performance measures to assess the performance of the cooperative agreement recipients and it is unlikely to meet its policy goal of conducting comprehensive on-site reviews of these recipients every 3 to 5 years. The lack of standardized performance measures limits HRSA's ability to effectively evaluate cooperative agreement recipients' activities that support the Health Center Program's goals with comparable measures. In addition, without timely comprehensive on-site reviews, HRSA does not have up-to-date comprehensive information on the performance of these recipients in supporting the Health Center Program. HRSA officials stated that they are in the process of developing standardized performance measures. Moreover, more than a third of the written feedback HRSA sent to unsuccessful Health Center Program grant applicants in fiscal years 2005 and 2007 contained unclear statements. The lack of clarity in this written feedback may undermine its usefulness rather than enhance the ability of applicants to successfully compete for grants in the future.

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Abbreviations

HHS	U.S. Department of Health and Human Services
HRSA	Health Resources and Services Administration
MUA	medically underserved area
MUP	medically underserved population
PCA	primary care association
TA	technical assistance
UDS	uniform data system

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United States Government Accountability Office
Washington, DC 20548

August 8, 2008

The Honorable John M. Shimkus
Ranking Member
Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
House of Representatives

Dear Mr. Shimkus:

Health centers in the federal Health Center Program provide comprehensive primary health care services—preventive, diagnostic, treatment, and emergency services as well as referrals to specialty care—to federally designated medically underserved populations (MUP) or those individuals residing in federally designated medically underserved areas (MUA).[1] To fulfill the Health Center Program's mission of increasing access to primary health care services for the medically underserved, the Health Resources and Services Administration (HRSA)—the agency within the U.S. Department of Health and Human Services (HHS) that administers the Health Center Program—provides grants to health centers. These grants, along with other federal benefits available to health center grantees through the Health Center Program, are an important part of successful health center operations and viability.[2] In 2006, Health Center Program grants made up about 20 percent of all health center grantees' revenues. A health center grantee may provide services at one or more delivery sites—known as health center sites. Not all health center sites are required to provide the full range of comprehensive primary care services; some health center sites may provide only limited services, such as dental and mental health services. In 2006, approximately 1,000 health center grantees operated more than 6,000 health center sites while serving more than 15 million people.

[1]The Health Resources and Services Administration designates MUAs based on a geographic area, such as a county, while MUPs are based on a specific population that demonstrates economic, cultural, or linguistic barriers to primary care services. The people served by health centers include Medicaid beneficiaries, the uninsured, and others who may have difficulty obtaining access to health care.

[2]Other federal benefits include enhanced Medicaid and Medicare payment rates and reduced drug pricing.

Beginning in fiscal year 2002, HRSA significantly expanded the Health Center Program under a 5-year effort—the President's Health Centers Initiative—to increase access to comprehensive primary care services for underserved populations, including those in MUAs. Under the initiative, HRSA set a goal of awarding 630 grants to open new health center sites—such grants are known as new access point grants—and 570 grants to expand services at existing health center sites by the end of fiscal year 2006. New access point grants fund one or more new health center sites operated by either new or existing health center grantees. In July 2005, we reported challenges HRSA encountered during this expansion of the Health Center Program.[3] In particular, we found that HRSA's process for awarding new access point grants might not sufficiently target communities with the greatest need for services, though we concluded that changes HRSA had made to its grant award process could help the agency appropriately consider community need when distributing federal resources. We also reported that HRSA lacked reliable information on the number and location of the sites where health centers provide care, and we recommended that HRSA collect this information. In response to our recommendation, HRSA took steps to improve its data collection efforts in 2006 to more reliably account for the number and location of health center sites funded under the Health Center Program.

By the end of fiscal year 2007, HRSA had achieved its grant goals under the original President's Health Centers Initiative and launched a second nationwide effort, the High Poverty County Presidential Initiative. In fiscal year 2007, HRSA held two new access point competitions, one focused on opening new health center sites in up to 200 HRSA-selected counties that lacked a health center site—part of the High Poverty County Presidential Initiative—and one that was an open competition.[4]

To assist potential health center grantees in applying for new access point grants, HRSA provides funds to national, regional, and state organizations to promote Health Center Program grant opportunities and help applicants secure funding. This funding mechanism is known as a training and

[3] GAO, *Health Centers: Competition for Grants and Efforts to Measure Performance Have Increased*, GAO-05-645 (Washington, D.C.: July 13, 2005).

[4] This new access point competition is described as open because applicants were not required to be located in certain geographic areas in order to apply but were required to demonstrate in the proposal that the health center and its associated sites would serve, in whole or in part, an MUA or MUP.

technical assistance (TA) cooperative agreement. For fiscal year 2007, HRSA awarded nearly $53 million in cooperative agreements to national organizations—specifically, those that assist broadly with health center operations as well as expand access to health care for underserved populations—and regional and state primary care associations (PCA), organizations that also support health centers and other safety net providers in increasing access to primary care services. HRSA also assists potential grantees by providing written feedback to applicants that apply for, but are not awarded, HRSA grants through the Health Center Program. This written feedback—known as summary statements—characterizes the strengths and weaknesses of the applications. The summary statements are intended to help unsuccessful applicants improve the quality—and therefore success—of future grant applications. The summary statements are prepared by objective review committees selected by HRSA to evaluate health center grant applications. Before HRSA releases the statements to unsuccessful applicants, the agency removes any internal recommendations made by the committee and reviews them for accuracy.

Given the expansion of the Health Center Program under the President's Health Centers Initiative and the High Poverty County Initiative as well as HRSA's past challenges in targeting its new access point grant awards to serve needy areas, you asked us to examine the extent to which MUAs contain health center sites as well as HRSA's management of the Health Center Program, specifically, efforts to assist applicants for new access point grants. In this report, we examine (1) for 2006, the extent to which MUAs lacked health center sites and the services provided by each site in an MUA; (2) how new access point grants awarded in 2007 changed the extent to which MUAs lacked health center sites; and (3) HRSA's oversight of cooperative agreement recipients' assistance to new access point applicants and feedback the agency provides to unsuccessful applicants.

To examine the extent to which MUAs lacked health center sites nationwide and the services provided by each site in 2006, we interviewed HRSA officials and obtained health center site data from HRSA's uniform data system (UDS). The UDS provided the zip code location of health center sites as of December 31, 2006.[5] We also obtained from HRSA data on the geographic location of MUAs designated for 2006. We linked the location of the MUAs to their associated zip codes using a geographic

[5]Although grant competitions are scheduled according to the fiscal year, the UDS reflects health center data as of December 31 of a calendar year.

crosswalk file based on U.S. Census Bureau data.[6] We then compared the location of health center sites with the location of MUAs by census region and state.[7] We limited our analysis to health center sites operated by grantees that received community health center funding—the type of funding that requires sites to provide services to all residents of the service area regardless of their ability to pay.[8] In addition, because HRSA takes into account the location of federally qualified health center look-alike sites—facilities that operate like health center sites but do not receive HRSA funding[9]—when deciding where to award new access point grants, we obtained from HRSA the location of health center look-alike sites in 2006 and compared them with the location of MUAs.

To examine how new access point grants awarded in 2007 changed the extent to which MUAs lacked health center sites nationwide, we obtained

[6]Although only a portion of the geographic area of a zip code may be included within the geographic boundary of an MUA, we included the whole area of all zip codes associated with an MUA because we could not identify geographic areas smaller than a zip code. As a result, in our analysis, the geographic boundary of an MUA may be larger than that defined by HRSA and a health center site may appear to be located in an MUA when it is located outside the MUA. Therefore, we may overestimate the number of MUAs that contain a health center site.

[7]In this report, we consider the District of Columbia a state.

[8]42 U.S.C. § 254b(a)(1). In contrast, HRSA grantees that operate health center sites targeting migrant farmworkers, public housing residents, and the homeless are not required to serve all residents of their service areas. 42 U.S.C. § 254b(a)(2). Because the UDS does not allow separate identification of individual health center sites for grantees that receive a combination of community health center funding and health center funding to target migrant farmworkers, public housing residents, or the homeless (27 percent of all grantees in 2006), we could not distinguish sites supported exclusively by community health center funding from sites supported exclusively by health center funding for migrant farmworkers, public housing residents, or the homeless. Therefore, we included all sites associated with health center grantees that received, at a minimum, community health center funding (90 percent of all grantees in 2006). As a result, some health center sites included in our analysis are not sites exclusively supported by community health center funding.

[9]Some organizations choose not to apply for funding under the Health Center Program; however, they seek to be recognized by HRSA as federally qualified health center look-alikes, in large part, so that they may become eligible to receive other federal benefits, such as enhanced Medicare and Medicaid payment rates and reduced drug pricing. Federally qualified health center look-alike sites are referred to in this report as health center look-alike sites.

from HRSA the applications submitted[10] for the new access point competitions held in fiscal year 2007 and the list of funded applicants for these competitions.[11] We reviewed the applications to determine the zip code location of proposed new health center sites, that is, sites for which the applicants requested funding, and the list of funded applicants to determine the location of the new health center sites for which grants were awarded in 2007.[12] We also obtained from HRSA data on the location of MUAs in 2007. We then compared the location of proposed and funded new health center sites in 2007 with the location of MUAs in 2007.[13] As with the 2006 analysis, we limited our review to health center sites operated by grantees that requested community health center funding—the type of funding that requires sites to provide services to all residents of the service area regardless of their ability to pay. As we did for the 2006 analysis, we obtained from HRSA the location of health center look-alike sites in 2007 and compared them to the location of MUAs in 2007.

To examine HRSA's oversight of cooperative agreement recipients' assistance to new access point applicants, we first interviewed HRSA officials and representatives from organizations that had training and TA cooperative agreements with HRSA for fiscal year 2007 to provide assistance to applicants for health center grants. Specifically, we interviewed representatives of the eight national organizations that target assistance to new access point applicants[14] and a judgmental sample of 10

[10]HRSA screens grant applications for eligibility, completeness, and responsiveness to application and program requirements; those applications not meeting these requirements are not considered for the competition. Of 387 applications submitted for fiscal year 2007 new access point competitions, 363 were found to be eligible for consideration; our review was limited to these 363 applications.

[11]All new access point grants awarded in 2007 were made through two new access point competitions held during fiscal year 2007, one of which was an open competition and one of which limited applicants to 200 HRSA-selected counties as part of the High Poverty County Presidential Initiative.

[12]We could not obtain those data from the UDS because it had not yet been updated for 2007 at the time of our review.

[13]Because the UDS had not been updated for 2007 at the time of our review, we could not determine whether any health center sites that were in operation in 2006 were no longer operating in 2007; therefore, we assumed that all health center sites operating in 2006 were still operating in 2007.

[14]Although HRSA had training and TA cooperative agreements with 17 national organizations for fiscal year 2007, only 8 of these national organizations targeted assistance to grant applicants.

geographically diverse state PCAs. We reviewed copies of the organizations' notices of grant awards, work plans (documents detailing health center training and technical assistance activities), and semiannual and annual progress reports submitted to HRSA.[15] We examined documents obtained from HRSA relating to its review of these cooperative agreement recipients' fiscal year 2007 annual noncompeting continuation applications[16] and periodic comprehensive on-site reviews conducted by HRSA. To evaluate HRSA's feedback to unsuccessful applicants, we obtained from HRSA the summary statements that were issued to unsuccessful applicants in connection with each of the three new access point grant competitions held in fiscal years 2005 and 2007.[17] We selected a random sample of 30 percent of the summary statements based on application score. This resulted in a sample of 69 summary statements out of the universe of 230 sent to unsuccessful applicants. The results of our analysis are generalizable to this universe. For each summary statement, we reviewed the information provided on the application's strengths and weaknesses for each of the eight criteria used to evaluate new access point grant applications.

We discussed our data sources with knowledgeable agency officials and performed data reliability checks, such as examining the data for missing values and obvious errors, to test the internal consistency and reliability of the data. After taking these steps, we determined that the data were sufficiently reliable for our purposes. We conducted our work from April 2007 through July 2008 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[15]HRSA notifies cooperative agreement recipients of their funding through a notice of grant award. Notices of grant awards are issued according to a budget period.

[16]Noncompeting continuation applications that include work plans, budgets, and progress reports are submitted annually by cooperative agreement recipients for the duration of their cooperative agreements, usually 2 to 3 years.

[17]HRSA awarded new access point grants in fiscal year 2006 based on applications that had been submitted and reviewed under the fiscal year 2005 new access point competition. In order to examine unsuccessful new access point applicants associated with fiscal year 2006, we reviewed summary statements issued beginning in fiscal year 2005.

Results in Brief

In 2006, 47 percent of MUAs nationwide lacked a health center site; however, the percentage of MUAs lacking a health center site varied widely across census regions and states. For example, more than 60 percent of MUAs in the Midwest census region lacked a health center site while approximately 30 percent of MUAs in the West census region lacked a health center site. In addition, in some states, such as Nebraska and Iowa, more than 80 percent of MUAs lacked a health center site, while in other states, including Mississippi and California, less than 25 percent of the MUAs lacked a health center site. We could not determine the types of services provided by individual health center sites in MUAs because HRSA does not collect and maintain data on the types of services provided at each site. Because HRSA lacks readily available data on the types of services provided at individual sites, the extent to which individuals in MUAs have access to the full range of comprehensive primary care services provided by health center sites is unknown.

New access point awards made by HRSA in 2007 reduced the number of MUAs that lacked a health center site nationwide by about 7 percent. As a result, 43 percent of MUAs lacked a health center site in 2007. Wide geographic variation in the percentage of MUAs lacking a health center site remained. The West and Midwest census regions continued to show the lowest and highest percentages of MUAs that lacked health center sites, respectively. In addition, three of the census regions showed a 1 or 2 percentage point change since 2006, while the South census region showed a 5 percentage point change. The minimal impact of the 2007 awards on geographic variation overall was due, in large part, to the fact that the majority of the decline in MUAs that lacked a health center site in 2007 was concentrated in the South census region, which received the largest proportion of the awards made in 2007.

HRSA oversees training and TA cooperative agreement recipients that assist new access point applicants using a number of methods, but its oversight is limited in certain key respects, and its feedback to unsuccessful applicants is not always clear. HRSA oversees recipients using a number of methods, including regular communications, review of cooperative agreement applications, and comprehensive on-site reviews. However, the agency's oversight of cooperative agreement recipients has limitations because the agency does not have standardized performance measures to evaluate recipients' performance of training and technical assistance activities. For example, HRSA does not require that recipients be held to a performance measure that would report the number of successful applicants each assisted. Without standardized measures, HRSA cannot effectively assess recipients' performance and compare the

extent to which recipients' activities support the goals of the Health Center Program. HRSA officials told us that they are developing standardized measures to help the agency assess the performance of its cooperative agreement recipients but provided no details on specific measures they may implement. HRSA's oversight is also limited because it is unlikely to meet its policy goal timeline of conducting comprehensive on-site reviews of the recipients every 3 to 5 years. HRSA has conducted comprehensive on-site reviews for fewer than one-quarter of its training and TA cooperative agreement recipients that target assistance to new access point applicants since the agency implemented these reviews in 2004. These reviews evaluate the overall operations of cooperative agreement recipients and are intended to improve the performance of HRSA programs. HRSA officials stated that they had limited resources each year to review cooperative agreement recipients. Moreover, to help unsuccessful applicants, HRSA sends summary statements detailing the strengths and weaknesses of the applications. However, 38 percent of the summary statements sent to unsuccessful applicants for new access point grant competitions held in fiscal years 2005 and 2007 contained unclear feedback. The lack of clarity in the summary statements may undermine the usefulness of the feedback for these applicants rather than enhance their ability to successfully compete for new access point grants in the future.

To help improve the Health Center Program, we recommend that HRSA take the following actions. First, to improve the agency's ability to measure access to comprehensive primary care services in MUAs, we recommend that HRSA collect and maintain readily available data on the types of services provided at each health center site. Second, to enhance the agency's oversight of training and TA cooperative agreement recipients that assist grant applicants, we recommend that HRSA develop and implement standardized performance measures for those recipients, including a measure of the number of grant applicants an organization assisted. Third, given HRSA's concerns about resources to conduct comprehensive on-site reviews of cooperative agreement recipients each year, we recommend that HRSA reevaluate its policy of reviewing training and TA cooperative agreement funding recipients every 3 to 5 years and consider targeting its available resources to focus on comprehensive on-site reviews for cooperative agreement recipients that are most likely to benefit from such oversight. Finally, to improve the clarity of the feedback the agency provides to unsuccessful grant applicants, we recommend that HRSA identify and take appropriate action to ensure that the discussion of applicants' strengths and weaknesses in all summary statements is clear.

In commenting on a draft of this report, HHS raised concerns regarding the scope of the report and one of our recommendations and concurred with the other three recommendations. HHS stated that its most significant concern was that we did not include MUPs in our analysis. Our research objective was to determine the location of health center sites that provide services to residents of an MUA and not to assess how well areas or populations were served. Therefore, MUPs were beyond the scope of our work. Moreover, in our MUA analysis, we covered the health center sites of 90 percent of all Health Center Program grantees. With regard to our recommendation that HRSA collect and maintain data on the services provided at each health center site, HHS acknowledged that site-specific information would be helpful for many purposes, but said collecting this information would place a significant burden on grantees and raise the program's administrative expenses. We believe that having site-specific information on services provided would help HRSA better measure access to comprehensive primary health care services in MUAs when considering the placement of new health center sites and facilitate the agency's ability to evaluate service area overlap in MUAs.

Background

The Health Center Program is governed by section 330 of the Public Health Service Act.[18] By law, grantees with community health center funding must operate health center sites that

- serve, in whole or in part, an MUA or MUP;
- provide comprehensive primary care services as well as enabling services, such as translation and transportation, that facilitate access to health care;
- are available to all residents of the health center service area, with fees on a sliding scale based on patients' ability to pay;
- are governed by a community board of which at least 51 percent of the members are patients of the health center; and
- meet performance and accountability requirements regarding administrative, clinical, and financial operations.

[18]Pub. L. No. 104-299, 110 Stat. 3626 (codified, as amended, at 42 U.S.C. § 254b).

HRSA's MUA Designation Criteria

HRSA may designate a geographic area—such as a group of contiguous counties, a single county, or a portion of a county—as an MUA based on the agency's index of medical underservice, composed of a weighted sum of the area's infant mortality rate, percentage of population below the federal poverty level, ratio of population to the number of primary care physicians, and percentage of population aged 65 and over.

In previous reports, we identified problems with HRSA's methodology for designating MUAs, including the agency's lack of timeliness in updating its designation criteria.[19] HRSA published a notice of proposed rule making in 1998 to revise the MUA designation system, but it was withdrawn because of a number of issues raised in over 800 public comments.[20] In February 2008, HRSA published a revised proposal and the period for pubic comment closed in June 2008.[21]

HRSA's New Access Point Grant Process

HRSA uses a competitive process to award Health Center Program grants. There are four types of health center grants available through the Health Center Program, but only new access point grants are used to establish new health center sites.[22] Since 2005, HRSA has evaluated applications for new access point grants using eight criteria for which an application can receive a maximum of 100 points (see table 1).

[19]GAO, *Health Professional Shortage Areas: Problems Remain with Primary Care Shortage Area Designation System*, GAO-07-84 (Washington, D.C.: Oct. 24, 2006), and *Health Care Shortage Areas: Designations Not a Useful Tool for Directing Resources to the Underserved*, GAO/HEHS-95-200 (Washington, D.C.: Sept. 8, 1995).

[20]63 Fed. Reg. 46,538 (Sept. 1, 1998).

[21]73 Fed. Reg. 11,232 (Feb. 29, 2008).

[22]The other three types of Health Center Program grants are (1) expanded medical capacity—to fund the expansion of an existing health center or delivery site in order to significantly increase the provision of comprehensive primary care services in areas of high need; (2) service expansion—to provide opportunities for existing health centers to expand and improve access to specialty health care services, such as mental health and substance abuse, oral health, pharmacy, or quality care management services; and (3) service area competition—to open competition for an existing service area when a grantee's project period, or the duration of its grant before it must compete to retain its funding, is about to expire.

Table 1: Description of Criteria and Maximum Points Awarded for New Access Point Grant Opportunities, Fiscal Years 2005 and 2007

Criterion	Description	Maximum points for the 2005 and 2007 open new access point competition	Maximum points for the 2007 high poverty county new access point competition
Need	The applicant's description of need in the proposed service area.	10	35
Response	The applicant's proposal to respond to the health care need.	30	20
Evaluative measures	The applicant's ability to measure its own performance.	10	5
Impact	The applicant's justification of requested funding and how it will increase access to care.	10	6
Resources/ capabilities	The applicant's organizational and financial plan and past accomplishments.	15	11
Support requested	The applicant's budget.	10	8
Governance	The applicant's plans for establishing a governing board.	10	10
Readiness	The applicant's ability to begin providing services.	5	5
	Total	**100**	**100**

Source: GAO analysis of HRSA's new access point health center application guidance from fiscal years 2005 and 2007.

Grant applications are evaluated by an objective review committee—a panel of independent experts, selected by HRSA, who have health center-related experience. The objective review committee scores the applications by awarding up to the maximum number of points allowed for each criterion and prepares summary statements that detail an application's strengths and weaknesses in each evaluative criterion. The summary statements also contain the committee's recommended funding amounts and advisory comments for HRSA's internal use; for example, the committee may recommend that HRSA consider whether the applicant's budgeted amount for physician salaries is appropriate. The committee develops a rank order list—a list of all evaluated applications in descending order by score. HRSA uses the internal comments—recommended funding amounts and advisory comments—from the summary statements and the rank order list when making final funding decisions. In addition, HRSA is required to take into account the urban/rural distribution of grants, the distribution of funds to different types of health centers, and whether a health center site is located in a sparsely populated rural area.[23] HRSA also considers the geographic

[23]42 U.S.C. § 254b(k)(4), (r)(2)(B), (p).

distribution of health center sites—to determine if overlap exists in the areas served by the sites—as well as the financial viability of grantees.[24] After the funding decisions are made, HRSA officials review the summary statements for accuracy, remove the recommended funding amounts and any advisory comments, and send the summary statements to unsuccessful applicants as feedback.

HRSA's Training and TA Cooperative Agreements

For fiscal year 2007, HRSA funded 60 training and TA cooperative agreements with various national, regional, and state organizations to support the Health Center Program, in part, by providing training and technical assistance to health center grant applicants.[25] Cooperative agreements are a type of federal assistance that entails substantial involvement between the government agency—in this case, HRSA—and the funding recipient—that is, the national, regional, and state organizations. HRSA relies on these training and TA cooperative agreement recipients to identify underserved areas and populations across the country in order to assist the agency in increasing access to primary care services for underserved people. In addition, these cooperative agreement recipients serve as HRSA's primary form of outreach to potential applicants for health center grants.

For each cooperative agreement recipient, HRSA assigns a project officer who serves as a recipient's main point of contact with the agency. The duration of a cooperative agreement, known as the project period, is generally 2 or 3 years, with each year known as a budget period. As a condition of the cooperative agreements, HRSA project officers and the organizations jointly develop work plans detailing the specific training and technical assistance activities to be conducted during each budget period. Activities targeted to new access point applicants can include assistance with assessing community needs, disseminating information in underserved communities regarding health center program requirements, and developing and writing grant applications. After cooperative agreement recipients secure funding through a competitive process, they reapply for annual funding through what is known as a noncompeting

[24]Center applications must demonstrate financial responsibility by the use of accounting procedures as prescribed by HRSA. 42 U.S.C. § 254b(k)(3)(D).

[25]For fiscal year 2007, HRSA funded training and TA cooperative agreements with 52 regional and state organizations and 8 national organizations that target assistance to grant applicants.

continuation application each budget period until the end of their project period. These continuation applications typically include a work plan and budget for the upcoming budget period and progress report on the organization's current activities.

HRSA policy states that cooperative agreement recipients will undergo a comprehensive on-site review by agency officials once every 3 to 5 years. During these comprehensive on-site reviews, HRSA evaluates the cooperative agreement recipients using selected performance measures—developed in collaboration with the organizations—and requires recipients to develop action plans to improve operations if necessary. The purpose of these reviews is for the agency to evaluate the overall operations of all its funding recipients and improve the performance of its programs.

Almost Half of MUAs Lacked a Health Center Site in 2006, and the Types of Services Provided by Each Site Could Not Be Determined

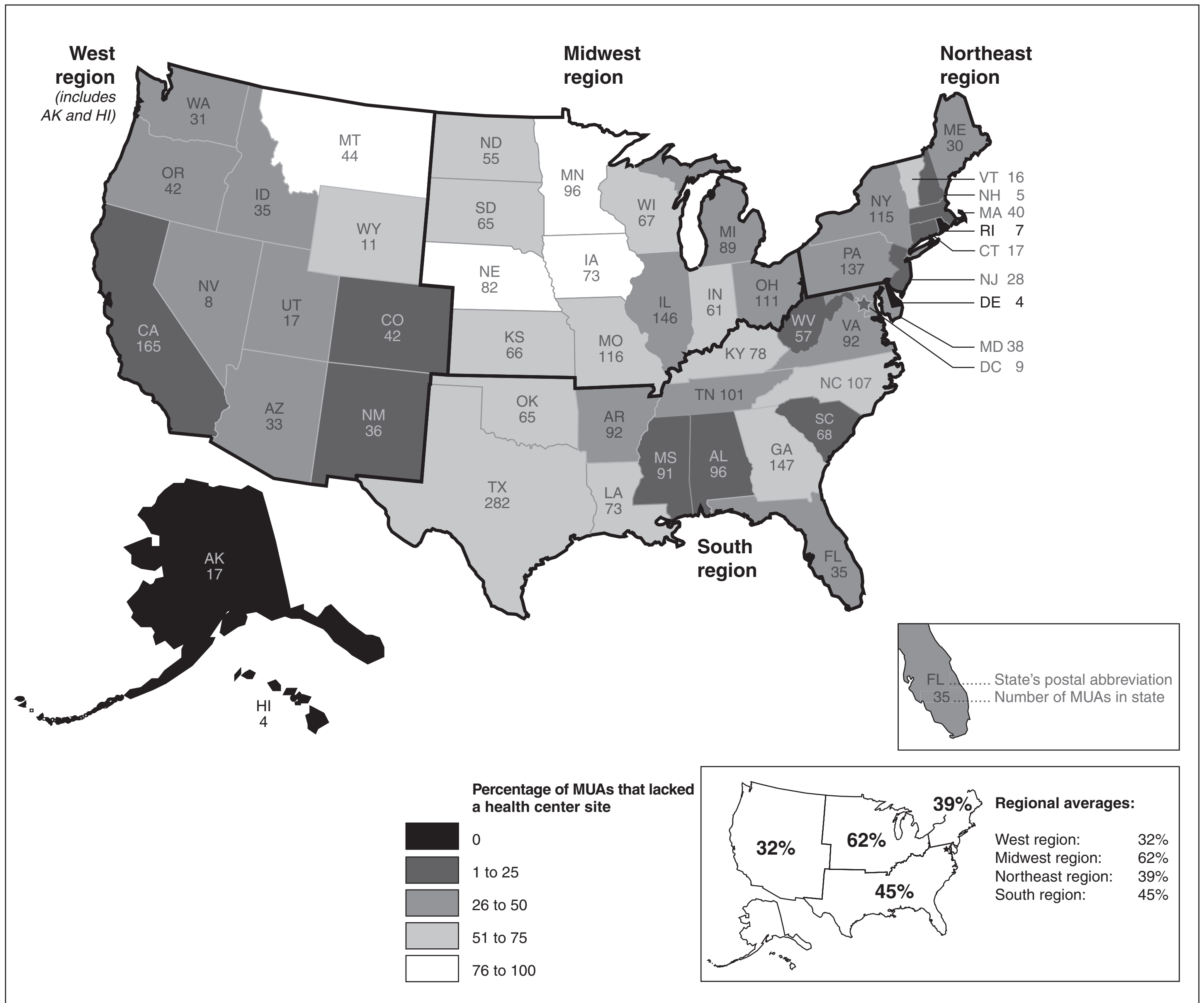
Almost half of MUAs nationwide lacked a health center site in 2006. The percentage of MUAs that lacked a health center site varied widely across census regions and states. We could not determine the types of primary care services provided by health center sites in MUAs because HRSA does not maintain data on the types of services offered at each site. Because of this, the extent to which individuals in MUAs have access to the full range of comprehensive primary care services provided by health center sites is unknown.

Almost Half of MUAs Nationwide Lacked Health Center Sites in 2006, and the Percentage of MUAs Lacking Sites Varied Widely by Census Region and State

Based on our analysis of HRSA data, we found that 47 percent of MUAs nationwide—1,600 of 3,421—lacked a health center site in 2006.[26] We found wide variation among census regions—Northeast, Midwest, South, and West—and across states in the percentage of MUAs that lacked health center sites. (See fig. 1.) The Midwest census region had the most MUAs that lacked a health center site (62 percent) while the West census region had the fewest MUAs that lacked a health center site (32 percent).

[26]When we included the 294 health center look-alike sites operating in 2006, we found that the percentage of MUAs lacking either a health center site or health center look-alike site in 2006 was 46 percent (or 1,564 MUAs).

Figure 1: Percentage of MUAs That Lacked a Health Center Site, by Census Region and State, 2006



Source: Copyright © Corel Corp. All rights reserved (map); GAO analysis of HRSA and U.S. Census Bureau data.

Note: U.S. territories are not included in this map.

More than three-quarters of the MUAs in 4 states—Nebraska (91 percent), Iowa (82 percent), Minnesota (77 percent), and Montana (77 percent)—lacked a health center site; in contrast, fewer than one-quarter of the MUAs in 13 states—including Colorado (21 percent), California (20 percent), Mississippi (20 percent), and West Virginia (19 percent)—lacked a health center site. (See app. I for more detail on the percentage of MUAs in each state and the U.S. territories that lacked a health center site in 2006.)

In 2006, among all MUAs, 32 percent contained more than one health center site; among MUAs with at least one health center site, 60 percent contained multiple health center sites. Almost half of all MUAs in the West census region contained more than one health center site while less than one-quarter of MUAs in the Midwest contained multiple health center sites. The states with three-quarters or more of their MUAs containing more than one health center site were Alaska, Connecticut, the District of Columbia, Hawaii, New Hampshire, and Rhode Island. In contrast, Nebraska, Iowa, and North Dakota were the states where less than 10 percent of MUAs contained multiple sites.

The Types of Services Provided at Individual Sites Could Not Be Determined Because Data Were Not Readily Available

We could not determine the types of primary care services provided at each health center site because HRSA does not collect and maintain readily available data on the types of services provided at individual health center sites. While HRSA requests information from applicants in their grant applications on the services each site provides, in order for HRSA to access and analyze individual health center site information on the services provided, HRSA would have to retrieve this information from the grant applications manually. HRSA separately collects data through the UDS from each grantee on the types of services it provides across all of its health center sites, but it does not collect data on services provided at each site. Although each grantee with community health center funding is required to provide the full range of comprehensive primary care services, it is not required to provide all services at each health center site it operates. HRSA officials told us that some sites provide limited services—such as dental or mental health services. Because HRSA lacks readily available data on the types of services provided at individual sites, it cannot determine the extent to which individuals in MUAs have access to the full range of comprehensive primary care services provided by health center sites. This lack of basic information can limit HRSA's ability to assess the full range of primary care services available in needy areas when considering the placement of new access points and limit the agency's ability to evaluate service area overlap in MUAs.

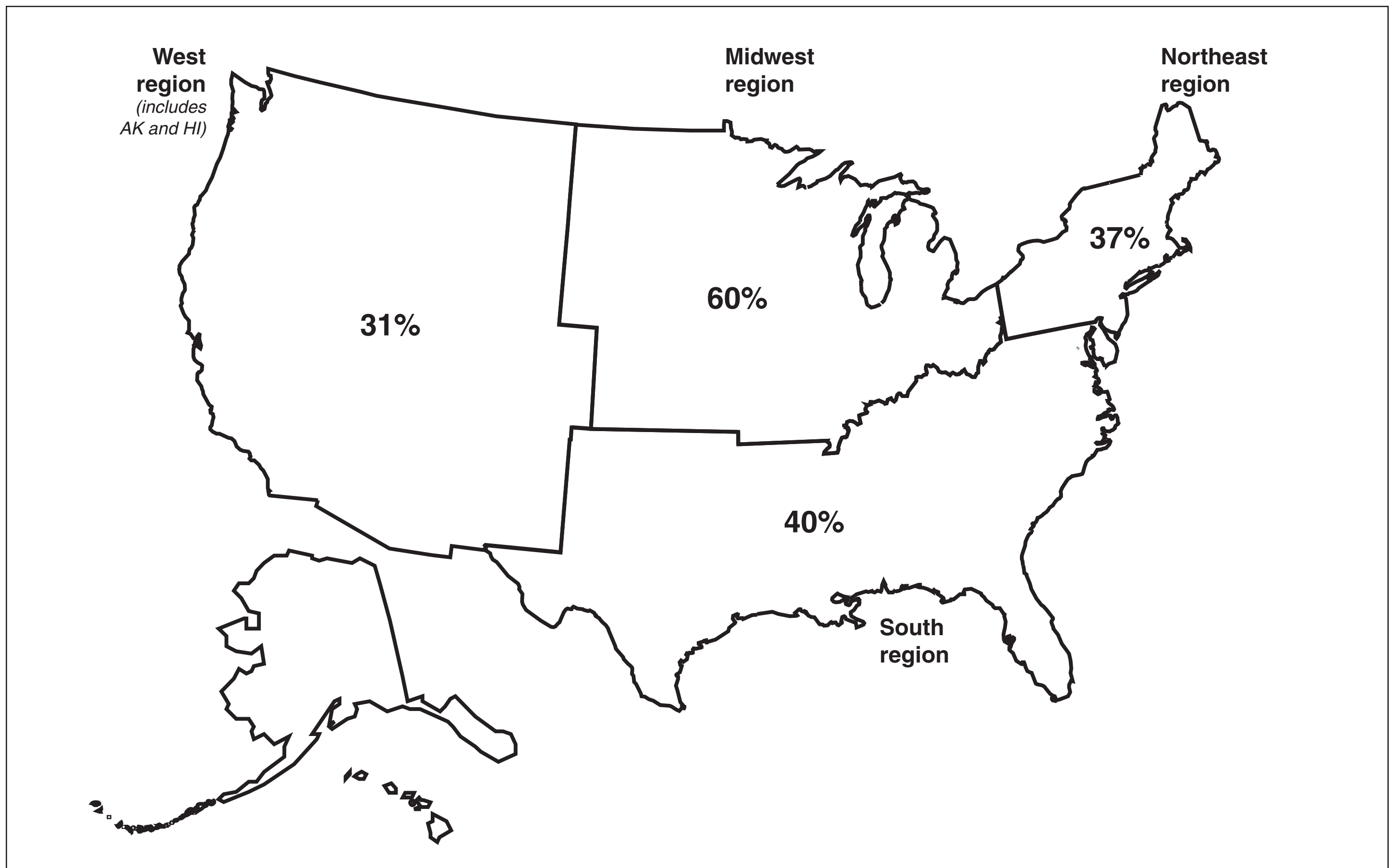
2007 Awards Reduced the Number of MUAs That Lacked a Health Center Site, but Wide Geographic Variation Remained

Our analysis of new access point grants awarded in 2007 found that these awards reduced the number of MUAs that lacked a health center site by about 7 percent. Specifically, 113 fewer MUAs in 2007—or 1,487 MUAs in all—lacked a health center site when compared with the 1,600 MUAs that lacked a health center site in 2006. As a result, 43 percent of MUAs nationwide lacked a health center site in 2007.[27]

Despite the overall reduction in the percentage of MUAs nationwide that lacked health center sites in 2007, regional variation remained. The West and Midwest census regions continued to show the lowest and highest percentages of MUAs that lacked health center sites, respectively. (See fig. 2.) Three of the census regions showed a 1 or 2 percentage point change since 2006, while the South census region showed a 5 percentage point change.

[27]When we included the 265 health center look-alike sites operating in 2007, we found that 1,462 MUAs lacked a health center site or health center look-alike site in 2007, which did not change the overall percentage (43 percent) of MUAs in 2007 that lacked a health center site.

Figure 2: Percentage of MUAs That Lacked a Health Center Site, by Census Region, 2007



Source: Copyright © Corel Corp. All rights reserved (map); GAO analysis of HRSA and U.S. Census Bureau data.

The minimal impact of the 2007 awards on regional variation is due, in large part, to the fact that more than two-thirds of the nationwide decline in the number of MUAs that lacked a health center site—77 out of the 113 MUAs—occurred in the South census region. (See table 2.) In contrast, only 24 of the 113 MUAs were located in the Midwest census region, even though the Midwest had nearly as many MUAs that lacked a health center site in 2006 as the South census region. Overall, while the South census region experienced a decline of 12 percent in the number of MUAs that lacked a health center site, the other census regions experienced declines of approximately 4 percent.

Table 2: Number of MUAs That Lacked a Health Center Site for 2006 and 2007, and 2006 to 2007 Decrease in MUAs That Lacked a Health Center Site by Number and Percentage, by Census Region

	Number of MUAs that lacked a health center site		Decrease in MUAs that lacked a health center site, 2006 to 2007	
Census region	**2006**	**2007**	**Number**	**Percentage**
Northeast	153	147	6	4
Midwest	641	617	24	4
South	651	574	77	12
West	155	149	6	4
Nationally	**1,600**	**1,487**	**113**	**7**

Source: GAO analysis of HRSA data.

The South census region experienced the greatest decline in the number of MUAs lacking a health center site in 2007 compared to other census regions, in large part, because it was awarded more new access point grants that year than any other region. (See table 3.) Specifically, half of all new access point awards made in 2007—from two separate new access point competitions—went to applicants from the South census region.

Table 3: Number and Percentage of All New Access Point Grants Awarded in 2007, by Census Region

	Grants awarded	
Census region	**Number**	**Percentage**
Midwest	39	19
Northeast	15	7
South	101	50
West	47	23
Total	**202**	**100**[a]

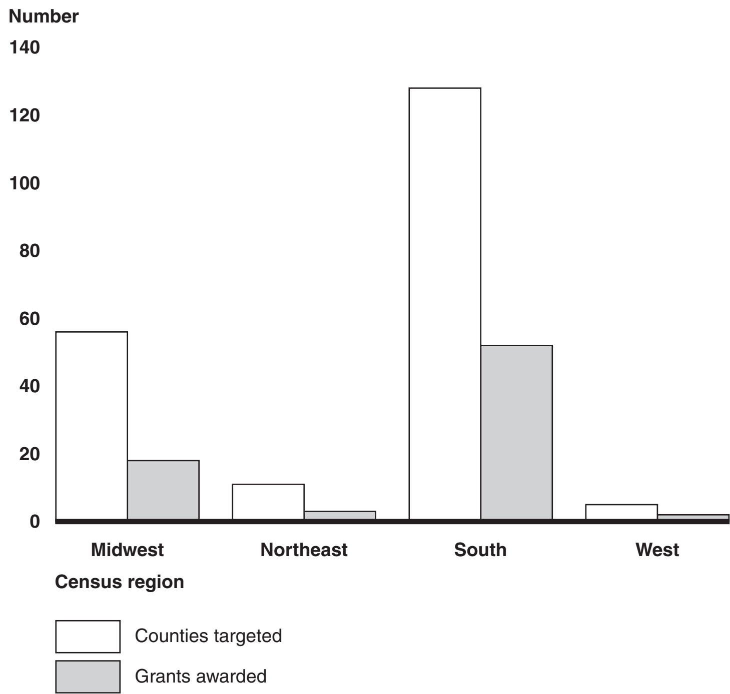
Source: GAO analysis of HRSA data.

[a]Percentages do not add to 100 because of rounding.

When we examined the High Poverty County new access point competition, in which 200 counties were targeted by HRSA for new health center sites, we found that 69 percent of those awards were granted to applicants from the South census region. (See fig. 3.) The greater number of awards made to the South census region for this competition may be explained by the fact that nearly two-thirds of the 200 counties targeted were located in the South census region. (For detail on the High Poverty

County new access point competition by census region and state, see app. II.)

Figure 3: Geographic Distribution of Counties Targeted and Grants Awarded for the 2007 High Poverty County New Access Point Competition



Source: GAO analysis of HRSA data.

When we examined the open new access point competition, which did not target specific areas, we found that the South census region also received a greater number of awards than any other region under that competition. Specifically, the South census region was granted nearly 40 percent of awards; in contrast, the Midwest received only 17 percent of awards. (See table 4.)

Table 4: Number and Percentage of New Access Point Grants Awarded in Fiscal Year 2007 for the Open New Access Point Competition, by Census Region

	Grants awarded	
Census region	**Number**	**Percentage**
Midwest	21	17
Northeast	12	9
South	49	39
West	45	35
Total	**127**	**100**

Source: GAO analysis of HRSA data.

HRSA Oversees Cooperative Agreement Recipients but Oversight Is Limited in Key Respects, and Its Feedback to Unsuccessful Applicants Is Not Always Clear

HRSA oversees cooperative agreement recipients, but the agency's oversight is limited because it does not have standardized performance measures to assess the performance of the cooperative agreement recipients in assisting new access point applicants and the agency is unlikely to meet its policy timeline for conducting comprehensive on-site reviews. Although HRSA officials told us that they were developing standardized performance measures, they provided no details on the specific measures that may be implemented. Moreover, more than a third of the summary statements sent to unsuccessful applicants for new access point competitions held in fiscal years 2005 and 2007 contained unclear feedback.

HRSA Oversees Cooperative Agreement Recipients but Lacks Standardized Performance Measures and Likely Will Not Complete All Comprehensive On-site Reviews in a Timely Manner

HRSA oversees the activities of its cooperative agreement recipients using a number of methods. HRSA officials told us that over the course of a budget period, project officers use regular telephone and electronic communications to discuss cooperative agreement recipients' activities as specified in work plans, review the status of these activities, and help set priorities.[28] According to HRSA officials, there is no standard protocol for these communications, and their frequency, duration, and content vary over the course of a budget period and by recipient. HRSA staff also reviews annual noncompeting continuation applications to determine whether the cooperative agreement recipients provided an update on their progress, described their activities and challenges, and developed a suitable work plan and budget for the upcoming budget period. The progress reports submitted by cooperative agreement recipients in these annual applications serve as HRSA's primary form of documentation on the status of cooperative agreement recipients' activities.[29]

HRSA's oversight of training and TA cooperative agreement recipients is based on performance measures tailored to the individual organization rather than performance measures that are standardized across all recipients. Specifically, HRSA uses individualized performance measures in cooperative agreement recipients' work plans and comprehensive on-site reviews to assess recipients' performance. For cooperative agreement recipients' work plans, recipients propose training and technical assistance activities in response to HRSA's cooperative agreement application guidance, in which the agency provides general guidelines and

[28]For the Health Center Program, HRSA has five project officers assigned to 17 national training and TA cooperative agreement recipients—of which eight organizations target assistance to grant applicants—and nine project officers for the 52 regional and state PCAs with training and TA cooperative agreements.

[29]In addition to annual reports, HRSA also uses semiannual reports and midyear assessments to monitor the progress of cooperative agreement recipients. Semiannual reports were discontinued in 2006 for state PCAs, and semiannual progress reports were required for only four of the eight national organizations that provided training and technical assistance to health center applicants for the budget period of 2006-2007. According to HRSA officials, semiannual reports for state PCAs were phased out in 2006 because of their limited usefulness and the reporting burden they posed to cooperative agreement recipients, and they intend to oversee cooperative agreement recipients primarily through reports provided on an annual basis. In addition, HRSA may conduct midyear assessments if there are concerns with a cooperative agreement recipient's performance. According to HRSA officials, only two midyear assessments have been conducted for training and TA cooperative agreement recipients since 2005 and no cooperative agreements have been terminated for fiscal years 2006 and 2007 for issues with performance.

goals for the provision of training and technical assistance to health center grant applicants. The guidance requires recipients to develop performance measures for each activity in their work plans.[30] When we analyzed the work plans of the 8 national organizations and 10 PCAs with training and TA cooperative agreements, we found that these measures varied by cooperative agreement recipient. For example, we found that for national organizations, performance measures varied from (1) documenting that the organization's marketing materials were sent to PCAs to (2) recording the number of specific technical assistance requests the organization received to (3) producing monthly reports for HRSA detailing information about potential applicants. For state PCAs, measures varied from (1) the PCA providing application review as requested to (2) holding specific training opportunities—such as community development or board development—to (3) identifying a specific number of applicants the PCA would assist during the budget period. Because these performance measures vary for cooperative agreement recipients' activities, HRSA does not have comparable measures to evaluate the performance of these activities across recipients.

HRSA's oversight of cooperative agreement recipients is limited in some key respects. One limitation is that the agency does not have standardized measures for its assessment of recipients' performance of training and technical assistance activities. Without standardized performance measures, HRSA cannot effectively assess the performance of its cooperative agreement recipients with respect to the training and technical assistance they provide to support Health Center Program goals. For example, HRSA does not require that all training and TA cooperative agreement recipients be held to a performance measure that would report the number of successful applicants each cooperative agreement recipient helped develop in underserved communities, including MUAs. Standardized performance measures could help HRSA identify how to better focus its resources to help strengthen the performance of cooperative agreement recipients.

HRSA officials told us that they are developing performance measures for the agency's cooperative agreement recipients, which they plan to implement beginning with the next competitive funding announcement, scheduled for fiscal year 2009. However, HRSA officials did not provide

[30]The work plan is further refined by both HRSA and the recipient in accordance with the Health Center Program's priorities.

details on the particular measures that it will implement, so it is unclear to what extent the proposed measures will allow HRSA to assess the performance of cooperative agreement recipients in supporting Health Center Program goals through such efforts as developing successful new access point grant applicants.

HRSA's oversight is also limited because the agency's comprehensive on-site reviews of cooperative agreement recipients do not occur as frequently as HRSA policy states.[31] According to HRSA's stated policy, the agency will conduct these reviews for each cooperative agreement recipient every 3 to 5 years. The reviews are intended to assess—and thereby potentially improve—the performance of the cooperative agreement recipients in supporting the overall goals of the Health Center Program. This support can include helping potential applicants apply for health center grants, identifying underserved areas and populations across the country, and helping HRSA increase access to primary care services for underserved populations.

As part of the comprehensive on-site reviews, HRSA officials consult with the relevant project officer, examine the scope of the activities cooperative agreement recipients have described in their work plans and reported in their progress reports, and develop performance measures in collaboration with the recipient. Similar to the performance measures in cooperative agreement recipients' work plans, the performance measures used during comprehensive on-site reviews are also individually tailored and vary by recipient. For example, during these reviews, some recipients are assessed using performance measures that include the number of training and technical assistance hours the recipients provided; other recipients are assessed using measures that include the number of applicants that were funded after receiving technical assistance from the recipient or the percentage of the state's uninsured population that is served by health center sites in the Health Center Program.

After an assessment, HRSA asks the recipient to develop an action plan. In these action plans, the reviewing HRSA officials may recommend additional activities to improve the performance of the specific measures they had identified during the review. For example, if the agency concludes that a cooperative agreement recipient needs to increase the

[31]According to HRSA policy, the agency conducts periodic comprehensive on-site reviews of all funding recipients that support the agency's programs.

percentage of the state's uninsured population served by health center sites in the Health Center Program, it may recommend that the recipient pursue strategies to develop a statewide health professional recruitment program and identify other funding sources to improve its ability to increase access to primary care for underserved people.

Although HRSA's stated policy is to conduct on-site comprehensive reviews of cooperative agreement recipients every 3 to 5 years, HRSA is unlikely to meet this goal for its training and TA cooperative recipients that target assistance to new access point applicants. In the 4 years since HRSA implemented its policy for these reviews in 2004, the agency has evaluated only about 20 percent of cooperative agreement recipients that provide training and technical assistance to grant applicants. HRSA officials told us that they have limited resources each year with which to fund the reviews. However, without these reviews, HRSA does not have a means of obtaining comprehensive information on the performance of cooperative agreement recipients in supporting the Health Center Program, including information on ways the recipients could improve the assistance they provide to new access point applicants.

HRSA Provided Unclear Written Feedback to More Than a Third of Unsuccessful Applicants

More than a third of summary statements sent to unsuccessful applicants from new access point grant competitions held in fiscal years 2005 and 2007 contained unclear feedback. Based on our analysis of 69 summary statements, we found that 38 percent contained unclear feedback associated with at least one of the eight evaluative criteria, while 13 percent contained unclear feedback in more than one criterion. We defined feedback as unclear when, in regard to a particular criterion, a characteristic of the application was noted as both a strength and a weakness without a detailed explanation supporting each conclusion. We found that 26 summary statements contained unclear feedback. We found 41 distinct examples of unclear feedback in the summary statements. (See table 5.) HRSA's stated purpose in providing summary statements to unsuccessful applicants is to improve the quality of future grant applications. However, if the feedback HRSA provides in these statements is unclear, it may undermine the usefulness of the feedback for applicants and their ability to successfully compete for new access point grants.

Table 5: Total Number of Distinct Examples of Unclear Feedback by Criterion for New Access Point Grant Applications from Fiscal Years 2005 and 2007

Criterion	Total number of distinct examples of unclear feedback
Need	11
Response	7
Impact	5
Support requested	5
Evaluative measures	4
Governance	4
Readiness	3
Resources/capabilities	2
Total	**41**

Source: GAO analysis of a sample of HRSA summary statements from new access point competitions from fiscal years 2005 and 2007.

Based on our analysis, the largest number of examples of unclear feedback was found in the need criterion, in which applications are evaluated on the description of the service area, communities, target population—including the number served, encounter information, and barriers—and the health care environment. For example, one summary statement indicated that the application clearly demonstrated and provided a compelling case for the significant health access problems for the underserved target population. However, the summary statement also noted that the application was insufficiently detailed and brief in its description of the target population.

Seven of the examples of unclear feedback were found in the response criterion, in which applications are evaluated on the applicant's proposal to respond the target population's need. One summary statement indicated that the application detailed a comprehensive plan for health care services to be provided directly by the applicant or through its established linkages with other providers, including a description of procedures for follow-up on referrals or services with external providers. The summary statement also indicated that the application did not provide a clear plan of health service delivery, including accountability among and between all subcontractors.

Conclusions

Awarding new access point grants is central to HRSA's ongoing efforts to increase access to primary health care services in MUAs. From 2006 to 2007, HRSA's recent new access point awards achieved modest success in reducing the percentage of MUAs nationwide that lacked a health center site. However, in 2007, 43 percent of MUAs continue to lack a health center site, and the new access point awards made in 2007 had little impact on the wide variation among census regions and states in the percentage of MUAs lacking a health center site. The relatively small effect of the 2007 awards on geographic variation may be explained, in part, because the South census region received a greater number of awards than other regions, even though the South was not the region with the highest percentage of MUAs lacking a health center site in 2006.

HRSA awards new access point grants to open new health center sites, thus increasing access to primary health care services for underserved populations in needy areas, including MUAs. However, HRSA's ability to target these awards and place new health center sites in locations where they are most needed is limited because HRSA does not collect and maintain readily available information on the services provided at individual health center sites. Having readily available information on the services provided at each site is important for HRSA's effective consideration of need when distributing federal resources for new health center sites because each health center site may not provide the full range of comprehensive primary care services. This information can also help HRSA assess any potential overlap of services provided by health center sites in MUAs.

HRSA could improve the number and quality of grant applications it receives—and thereby broaden its potential pool of applicants—by better monitoring the performance of cooperative agreement recipients that assist applicants and by ensuring that the feedback unsuccessful applicants receive is clear. However, limitations in HRSA's oversight of the training and TA cooperative agreement recipients hamper the agency's ability to identify recipients most in need of assistance. Because HRSA does not have standardized performance measures for these recipients—either for their work plan activities or for the comprehensive on-site reviews—the agency cannot assess recipients' performance using comparable measures and determine the extent to which they support the overall goals of the Health Center Program. One standardized performance measure that could help HRSA evaluate the success of cooperative agreement recipients that assist new access point applicants is the number of successful grant applicants each cooperative agreement recipient develops; this standardized performance measure could assist HRSA in

determining where to focus its resources to strengthen the performance of cooperative agreement recipients.

HRSA's allocation of available resources has made it unlikely that it will meet its goal of conducting comprehensive on-site reviews of each cooperative agreement recipient every 3 to 5 years. Without these reviews, HRSA does not have comprehensive information on the effectiveness of training and TA cooperative agreement recipients in supporting the Health Center Program, including ways in which they could improve their efforts to help grant applicants. Given the agency's concern regarding available resources for its comprehensive on-site reviews, developing and implementing standardized performance measures for training and TA cooperative agreement recipients could assist HRSA in determining the cost-effectiveness of its current comprehensive on-site review policy and where to focus its limited resources.

HRSA could potentially improve its pool of future applicants by increasing the extent to which it provides clear feedback to unsuccessful applicants on the strengths and weaknesses of their applications. HRSA intends for these summary statements to be used by applicants to improve the quality of future grant applications. However, the unclear feedback HRSA has provided to some unsuccessful applicants in fiscal years 2005 and 2007 does not provide those applicants with clear information that could help them improve their future applications. This could limit HRSA's ability to award new access point grants to locations where such grants are needed most.

Recommendations for Executive Action

We recommend that the Administrator of HRSA take the following four actions to improve the Health Center Program:

- Collect and maintain readily available data on the types of services provided at each health center site to improve the agency's ability to measure access to comprehensive primary care services in MUAs.

- Develop and implement standardized performance measures for training and TA cooperative recipients that assist applicants to improve HRSA's ability to evaluate the performance of its training and TA cooperative agreements. These standardized performance measures should include a measure of the number of successful applicants a recipient assisted.

- Reevaluate its policy of requiring comprehensive on-site reviews of Health Center Program training and TA cooperative agreement recipients every 3 to 5 years and consider targeting its available resources at comprehensive on-site reviews for cooperative agreement recipients that would benefit most from such oversight.

- Identify and take appropriate action to ensure that the discussion of an applicant's strengths and weaknesses in all summary statements is clear.

Agency Comments and Our Evaluation

In commenting on a draft of this report, HHS raised concerns regarding the scope of the report and one of our recommendations and concurred with the other three recommendations. (HHS's comments are reprinted in app. III.) HHS also provided technical comments, which we incorporated as appropriate.

HHS said its most significant concern was with our focus on MUAs and the exclusion of MUPs from the scope of our report. In our analysis, we included the health center sites of 90 percent of all Health Center Program grantees. We excluded from our review sites that were associated with the remaining 10 percent of grantees that received HRSA funding to serve specific MUPs only because they are not required to serve all residents of the service area.[32] Given our research objective to determine the location of health center sites that provide services to residents of an MUA, we excluded these specific MUPs and informed HRSA of our focus on health center sites and MUAs. We agree with HHS's comment that it could be beneficial to have information on the number of grants awarded to programs serving both MUAs and MUPs generally to fully assess the coverage of health center sites.

HHS also commented that our methodology did not account for the proximity of potential health center sites located outside the boundary of an MUA. While we did not explicitly account for the proximity of potential health center sites located outside an MUA, we did include the entire area of all zip codes associated with an MUA. As a result, the geographic boundary of an MUA in our analysis may be larger than that defined by HRSA, so our methodology erred on the side of overestimating the number of MUAs that contained a health center site.

[32]The specific populations served by these grantees are migrant farmworkers, public housing residents, and homeless persons.

With regard to our reporting on the percentage of MUAs that lacked a health center site, HHS stated that this indicator may be of limited utility, because not all programs serving MUAs and MUPs are comparable to each other due to differences in size, geographic location, and specific demographic characteristics. Specifically, HHS commented that our analysis presumed that the presence of one health center site was sufficient to serve an MUA. In our work, we did not examine whether MUAs were sufficiently served because this was beyond the scope of our work. Moreover, since HRSA does not maintain site-specific information on services provided and each site does not provide the same services, we could not assess whether an MUA was sufficiently served. HHS also noted that a health center site may not be the appropriate solution for some small population MUAs; however, we believe it is reasonable to expect that residents of an MUA—regardless of its size, geographic location, and specific demographic characteristics—have access to the full range of primary care services.

With regard to our first recommendation that HRSA collect and maintain site-specific data on the services provided at each health center site, HHS acknowledged that site-specific information would be helpful for many purposes, but it said collecting this information would place a significant burden on grantees and raise the program's administrative expenses. We believe that having site-specific information on services provided would help HRSA better measure access to comprehensive primary health care services in MUAs when considering the placement of new health center sites and facilitate the agency's ability to evaluate service area overlap in MUAs.

HHS concurred with our three other recommendations. With regard to our second recommendation, HHS stated that HRSA will include standardized performance measures with its fiscal year 2009 competitive application cycle for state PCAs and that HRSA plans to develop such measures for the national training and TA cooperative agreement recipients in future funding opportunities. With regard to our third recommendation, HHS commented that HRSA has developed a 5-year schedule for reviewing all state PCA grantees. HHS also stated that HRSA is examining ways to better target onsite reviews for national training and TA cooperative agreement recipients that would most benefit from such a review. Finally, HHS agreed with our fourth recommendation and stated that HRSA is continuously identifying ways to improve the review of applications.

As arranged with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution of it until 30 days after its issue date. At that time, we will send copies of this report to the Secretary of HHS, the Administrator of HRSA, appropriate congressional committees, and other interested parties. We will also make copies of this report available to others upon request. In addition, the report will be available at no charge on the GAO Web site at http:///www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or bascettac@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Staff members who made major contributions to this report are listed in appendix IV.

Sincerely yours,

Cynthia A. Bascetta
Director, Health Care

Appendix I: Number and Percentage of Medically Underserved Areas (MUA) Lacking a Health Center Site, 2006 and 2007

	Total number of MUAs		Number of MUAs lacking a health center site		Percentage of MUAs lacking a health center site	
	2006	**2007**	**2006**	**2007**	**2006**	**2007**
Midwest census region	**1,027**	**1,029**	**641**	**617**	**62**	**60**
Illinois	146	143	71	63	49	44
Indiana	61	61	35	34	57	56
Iowa	73	73	60	56	82	77
Kansas	66	71	49	52	74	73
Michigan	89	89	44	43	49	48
Minnesota	96	97	74	75	77	77
Missouri	116	116	62	58	53	50
Nebraska	82	82	75	73	91	89
North Dakota	55	55	40	39	73	71
Ohio	111	110	48	42	43	38
South Dakota	65	65	40	40	62	62
Wisconsin	67	67	43	42	64	63
Northeast census region	**395**	**400**	**153**	**147**	**39**	**37**
Connecticut	17	17	1	1	6	6
Maine	30	32	10	11	33	34
Massachusetts	40	40	10	9	25	23
New Hampshire	5	5	1	1	20	20
New Jersey	28	28	1	1	4	4
New York	115	116	56	53	49	46
Pennsylvania	137	139	63	61	46	44
Rhode Island	7	7	0	0	0	0
Vermont	16	16	11	10	69	63
South census region	**1,435**	**1,441**	**651**	**574**	**45**	**40**
Alabama	96	96	24	19	25	20
Arkansas	92	93	38	33	41	35
Delaware	4	4	0	0	0	0
District of Columbia	9	8	1	1	11	13
Florida	35	35	17	15	49	43
Georgia	147	149	88	78	60	52
Kentucky	78	78	51	45	65	58
Louisiana	73	73	39	33	53	45
Maryland	38	38	11	10	29	26
Mississippi	91	91	18	17	20	19

	Total number of MUAs		Number of MUAs lacking a health center site		Percentage of MUAs lacking a health center site	
	2006	2007	2006	2007	2006	2007
North Carolina	107	108	59	55	55	51
Oklahoma	65	66	34	30	52	45
South Carolina	68	69	17	15	25	22
Tennessee	101	101	38	35	38	35
Texas	282	283	167	145	59	51
Virginia	92	93	38	34	41	37
West Virginia	57	56	11	9	19	16
West census region	**485**	**487**	**155**	**149**	**32**	**31**
Alaska	17	17	0	0	0	0
Arizona	33	33	13	13	39	39
California	165	167	33	31	20	19
Colorado	42	42	9	9	21	21
Hawaii	4	4	0	0	0	0
Idaho	35	35	15	14	43	40
Montana	44	44	34	33	77	75
Nevada	8	8	4	4	50	50
New Mexico	36	36	5	4	14	11
Oregon	42	42	17	16	40	38
Utah	17	17	7	7	41	41
Washington	31	31	12	12	39	39
Wyoming	11	11	6	6	55	55
U.S. territories	**79**	**79**	**0**	**0**	**0**	**0**
American Samoa	4	4	0	0	0	0
Guam	0	0	n/a	n/a	n/a	n/a
Northern Mariana Islands	0	0	n/a	n/a	n/a	n/a
Puerto Rico	72	72	0	0	0	0
U.S. Virgin Islands	3	3	0	0	0	0

Source: GAO analysis of Health Resources and Services Administration (HRSA) and U.S. Census Bureau data.

Appendix II: Data on the 2007 High Poverty County New Access Point Competition, by Census Region and State

	Counties targeted by HRSA		Applications submitted		Awards received	
	Number	Percentage	Number	Percentage	Number	Percentage
Midwest census region	**56**	**28**	**25**	**22**	**18**	**24**
Illinois	7	4	3	3	3	4
Indiana	10	5	3	3	3	4
Iowa	4	2	3	3	3	4
Kansas	2	1	0	0	n/a	n/a
Michigan	1	1	3	3	1	1
Minnesota	5	3	0	0	n/a	n/a
Missouri	11	6	6	5	3	4
Nebraska	3	2	1	1	1	1
North Dakota	2	1	1	1	1	1
Ohio	5	3	4	4	2	3
South Dakota	3	2	0	0	n/a	n/a
Wisconsin	3	2	1	1	1	1
Northeast census region	**11**	**6**	**6**	**5**	**3**	**4**
Connecticut	0	0	0	0	n/a	n/a
Maine	0	0	0	0	n/a	n/a
Massachusetts	0	0	0	0	n/a	n/a
New Hampshire	0	0	0	0	n/a	n/a
New Jersey	0	0	0	0	n/a	n/a
New York	6	3	4	4	2	3
Pennsylvania	5	3	2	2	1	1
Rhode Island	0	0	0	0	n/a	n/a
Vermont	0	0	0	0	n/a	n/a
South census region	**128**	**64**	**79**	**70**	**52**	**69**
Alabama	4	2	4	4	3	4
Arkansas	3	2	3	3	2	3
Delaware	0	0	0	0	n/a	n/a
Florida	6	3	4	4	3	4
Georgia	19	10	12	11	10	13
Kentucky	13	7	7	6	2	3
Louisiana	13	7	8	7	5	7
Maryland	0	0	0	0	n/a	n/a
Mississippi	2	1	3	3	1	1
North Carolina	16	8	10	9	4	5

	Counties targeted by HRSA		Applications submitted		Awards received	
	Number	Percentage	Number	Percentage	Number	Percentage
Oklahoma	3	2	3	3	3	4
South Carolina	1	1	0	0	n/a	n/a
Tennessee	3	2	3	3	1	1
Texas	30	15	14	12	10	13
Virginia	14	7	6	5	6	8
West Virginia	1	1	2	2	2	3
West census region	**5**	**3**	**3**	**3**	**2**	**3**
Alaska	0	0	0	0	n/a	n/a
Arizona	0	0	0	0	n/a	n/a
California	0	0	0	0	n/a	n/a
Colorado	1	1	1	1	0	0
Hawaii	0	0	0	0	n/a	n/a
Idaho	1	1	1	1	1	1
Montana	1	1	0	0	n/a	n/a
Nevada	1	1	0	0	n/a	n/a
New Mexico	0	0	0	0	n/a	n/a
Oregon	1	1	1	1	1	1
Utah	0	0	0	0	n/a	n/a
Washington	0	0	0	0	n/a	n/a
Wyoming	0	0	0	0	n/a	n/a

Source: GAO analysis of HRSA and U.S. Census Bureau data.

Appendix III: Comments from the U.S. Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

JUL 10 2008

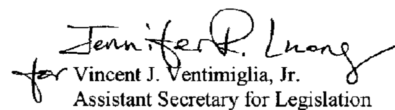
Cynthia A. Bascetta
Director, Health Care
441 G Street NW
U.S. Government Accountability Office
Washington, D.C. 20548

Dear Ms. Bascetta:

Enclosed are the Department's comments on the U.S. Government Accountability Office's (GAO) draft report entitled, "Health Resources and Services Administration: Many Underserved Areas Lack a Health Center Site, and the Consolidated Health Centers Program Needs More Oversight"(GAO 08-723).

The Department appreciates the opportunity to comment on this draft before its publication.

Sincerely,



for Vincent J. Ventimiglia, Jr.
Assistant Secretary for Legislation

Attachment

General Comments for The Department of Health and Human Services' Comments on Government Accountability Office's Draft Report: "HEALTH RESOURCES AND SERVICES ADMINISTRATION: Many Underserved Areas Lack a Health Service Site, and the Consolidated Health Centers Program Needs More Oversight" (GAO-08-723)

The Department of Health and Human Services (HHS) appreciates the opportunity to comment on the Government Accountability Office's (GAO) draft report.

The most significant issue/concern with the report, which cannot be corrected easily, is that the GAO did not investigate the extent to which new projects were awarded to programs serving Medically Underserved Populations (MUPs), as opposed to Medically Underserved Areas (MUAs). This may be the result of the specific request from Congress. MUPs may be within MUAs but also may be populations such as uninsured and/or Medicaid recipients who are living within an area that is not geographically an MUA, and it may be considerably easier for an applicant to meet the MUP test. Knowing the breakdown between grants awarded to MUAs versus MUPs would be useful information for planning and for policy analysis purposes for HRSA. While it would be difficult for the GAO to go back and gather that information now, it might be beneficial to provide a footnote that explains why this study focuses on geography, rather than population.

Please see below our comments on each of GAO's four recommendations.

GAO Recommendation #1

GAO recommends that, in order to improve the agency's ability to ensure access to comprehensive primary care services in MUAs, HRSA collect and maintain readily available data on the types of services provided at each health center site.

HHS Response

The Health Center Program collects information on services by grantee, not by individual site. While having available site specific information would be useful for many purposes, collecting such information at this level of detail would place a significant burden on grantees and added administrative expenses on the program.

Site Data Collection

Health centers are required by statute to assure that all services provided by the centers are available and accessible to patients served by them. Even in cases where health centers have established service delivery sites that provide more limited services, the health center must still assure that all patients receiving care at any site have access to the full range of services offered. For example, patients seen at one site and found to have a need for services not available there are referred to one of the other health center sites in the center's service area for the specific service needed.

1

General Comments for The Department of Health and Human Services' Comments on Government Accountability Office's Draft Report: "HEALTH RESOURCES AND SERVICES ADMINISTRATION: Many Underserved Areas Lack a Health Service Site, and the Consolidated Health Centers Program Needs More Oversight" (GAO-08-723)

Also, regarding the second paragraph on page 16 of the report, HRSA does not ask grantees for site level services information in an application; therefore, data are not available to collect/analyze. HRSA collects this information at the grantee level.

Percentage of MUAs that Lack a Health Center Site

As stated in the draft report, Health Center Program grantees are required to serve a federally designated MUA or MUP. This requirement is implemented via HRSA's policy that a health center must serve, in whole or in part, an MUA, but does not have to be physically located in the MUA to serve it. The methodology to demonstrate MUAs served does not take into account this HRSA policy. Therefore, HRSA suggests that the study examine/account for the proximity of a health center site to the MUA in a standardized method in order to more accurately reflect the HRSA policy for determining eligibility.

Further, the indicator "Percentage of MUAs that Lack a Health Center Site" may be of limited utility, and analysis of this indicator by State or Census Region may produce results that are misleading. This is because all MUAs/MUPs are not necessarily comparable to each other. Some MUAs are whole counties; some are groups of townships or other census county subdivisions in rural areas; some are groups of census tracts within metropolitan or micropolitan areas; and MUPs are population groups, such as the low-income population of a particular geographic area. Some MUA/Ps may have very small populations, others very large; and a health center may not be the appropriate solution for some small population MUAs.

Further, throughout the draft report, there is reference to the agency's inability to evaluate service area overlap in MUAs, which does not consider that service area overlap may be avoidable in serving a MUA given its population and/or geographic size. Thus, it is not always a fair comparison of MUAs and health center sites in MUAs, since there is an assumption by GAO of a one-for-one ratio, i.e., that one site is sufficient to serve one MUA.

GAO Recommendation #2

GAO recommends that the agency, in order to enhance its oversight of training and technical assistance (TA) cooperative agreement recipients, develop and implement standardized performance measures for those recipients, including a measure of the number of grant applicants an organization assisted.

2

General Comments for The Department of Health and Human Services' Comments on Government Accountability Office's Draft Report: "HEALTH RESOURCES AND SERVICES ADMINISTRATION: Many Underserved Areas Lack a Health Service Site, and the Consolidated Health Centers Program Needs More Oversight" (GAO-08-723)

HHS Response

HRSA concurs with this recommendation, and has developed standardized performance measures that will be included as part of the competitive FY 2009 application cycle for Primary Care Associations (PCAs). The measures are designed to provide HRSA with the ability to measure performance across the PCAs in providing training and TA to health centers. As this application is still under review and clearance, HRSA cannot share the measures at this time. HRSA also plans to develop standardized performance measures for the national cooperative agreements for inclusion in future funding opportunities.

GAO Recommendation #3

GAO recommends that HRSA re-evaluate its policy of reviewing training and TA cooperative agreement funding recipients every 3 to 5 years and consider targeting its available resources to focus on comprehensive onsite reviews for cooperative agreement recipients that are most likely to benefit from such oversight.

HHS Response

HRSA has developed a 5-year schedule for reviewing all State PCA grantees through its State strategic partnership reviews. For national cooperative agreements, HRSA is examining ways to better target on-site reviews to those organizations that would most benefit from such a review.

GAO Recommendation #4

GAO recommends that, to improve the clarity of the feedback the agency provides to unsuccessful grant applicants, HRSA identify and take appropriate action to ensure that the discussion of applicants' strengths and weaknesses in all summary statements is clear.

HHS Response

HRSA agrees with this recommendation and is continuously identifying ways to improve the review of applications, including summary review statements.

3

Appendix IV: GAO Contact and Staff Acknowledgments

GAO Contact

Cynthia A. Bascetta, (202) 512-7114 or bascettac@gao.gov

Acknowledgments

In addition to the contact named above, Nancy Edwards, Assistant Director; Stella Chiang; Krister Friday; Karen Howard; Daniel Ries; Jessica Cobert Smith; Laurie F. Thurber; Jennifer Whitworth; Rachael Wojnowicz; and Suzanne Worth made key contributions to this report.

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