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Report to Congressional Requesters

May 2012

HEALTH CENTER PROGRAM

2011 Grant Award Process Highlighted Need and Special Populations and Merits Evaluation

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Highlights

Highlights of GAO-12-504, a report to congressional requesters

May 2012

HEALTH CENTER PROGRAM

2011 Grant Award Process Highlighted Need and Special Populations and Merits Evaluation

Why GAO Did This Study

Health centers funded in part by grants from HRSA's Health Center Program, under Section 330 of the Public Health Service Act, provide comprehensive primary care services for the medically underserved, including many poor, uninsured, and Medicaid patients. Legislation enacted in 2009 and 2010 provided additional funding that could significantly expand health center capacity over the next several years. GAO was asked to review HRSA's process for awarding grants for new delivery sites and possible effects of health centers, such as competition, on other providers. This report examines (1) the actions HRSA has recently taken to target its grants for new delivery sites to health centers in communities with demonstrated need and the outcome of HRSA's award process in recent years, and (2) the extent to which HRSA-funded health centers collaborate and compete with other health care providers in their service area. GAO focused its work on NAP grants, HRSA's primary means of establishing new health centers and delivery sites, during fiscal years 2008 through 2011. GAO analyzed HRSA documents and interviewed HRSA officials, and interviewed officials from 11 health centers and providers and officials in their service areas.

What GAO Recommends

The Secretary of HHS should direct the Administrator of HRSA to evaluate the fiscal year 2011 NAP grant award process for effectiveness and transparency, identify lessons learned, and incorporate any improvements for future funding cycles. HHS agreed with GAO's findings and recommendation and said HRSA has begun to take action.

View GAO-12-504. For more information, contact Debra A. Draper at (202) 512-7114 or draperd@gao.gov.

What GAO Found

The Department of Health and Human Services' (HHS) Health Resources and Services Administration (HRSA) revised its New Access Point (NAP) competitive award process in fiscal year 2011 to increase the emphasis on the need for services in the applicant's proposed service area, and on the three special populations—migrant and seasonal farmworkers, homeless people, and residents of public housing—designated by the Public Health Service Act. The act requires that certain proportions of Health Center Program funding go to health centers serving the special populations. To increase the emphasis on need, HRSA increased the weight given to need in the application review process. To target health centers serving special populations, HRSA gave extra points in the application process to applicants proposing to serve them. When this was insufficient to meet the required proportions, HRSA moved some applicants ahead of others in the award rank order list, a method it had used in the past. The effect of HRSA's actions on the award outcome was magnified in fiscal year 2011 because (1) HRSA received less program funding than it had anticipated, and (2) it needed to increase the share of grants going to health centers serving the special populations because HRSA had not applied the statutory proportions when it used American Recovery and Reinvestment Act funding to award grants in fiscal year 2009. As a result, HRSA awarded 67 NAP grants in fiscal year 2011, 57 of which went to applicants proposing to serve at least one special population; 13 of the 57 received grants by being moved ahead of other applicants with equal or higher review scores. HRSA announced the extra points in application guidance, but not the potential moving of some applicants ahead of others. As HRSA has periodically needed to take actions to meet its statutory obligations and may need to do so again, evaluating the effectiveness and transparency of its most recent New Access Point grant award process could help it identify lessons and possible improvements for the future.

Health centers in the communities GAO studied collaborate with other providers and generally do not compete with them for patients, but GAO found greater potential for competition in rural areas. Health center officials described collaborative relationships with other providers that give patients access to services not available through the health center. Health centers and other providers told GAO they generally do not compete for patients; health centers typically serve patients not treated elsewhere, such as uninsured and Medicaid patients. However, because the health center grant covers, on average, about 20 percent of a center's budget, other funding must also be secured, such as by serving insured patients, for the center to be financially sustainable. This can result in competition with other providers in its service area. During the award process, HRSA takes steps to reduce competition by identifying nearby safety net providers and assessing whether the level of unmet need in the area warrants a grant for a new health center or delivery site. Greater potential for competition exists in rural areas because patients there are more likely to be insured and rural health clinics and certain hospitals might seek to serve some of the same patients as health centers, although they may not offer all of the services required of health centers.

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Abbreviations

ACS	American Community Survey
HHS	Department of Health and Human Services
HPSA	health professional shortage area
HRSA	Health Resources and Services Administration
MUA	medically underserved area
MUP	medically underserved population
PCA	primary care association
PCO	primary care office
PPACA	Patient Protection and Affordable Care Act
UDS	Uniform Data System

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United States Government Accountability Office
Washington, DC 20548

May 29, 2012

The Honorable Michael B. Enzi
Ranking Member
Committee on Health, Education, Labor, and Pensions
United States Senate

The Honorable Richard Burr
Ranking Member
Subcommittee on Children and Families
Committee on Health, Education, Labor, and Pensions
United States Senate

The Honorable Tom Coburn
Ranking Member
Permanent Subcommittee on Investigations
Committee on Homeland Security and Governmental Affairs
United States Senate

The nationwide network of health centers in the federal Health Center Program is an important component of the health care safety net for vulnerable populations, including Medicaid beneficiaries,[1] people who are uninsured, and others who may have difficulty obtaining access to health care. In 2010, more than 1,100 health centers operated more than 8,100 delivery sites across all the states[2] and served more than 19 million people. These health centers provide comprehensive primary health care services—preventive, diagnostic, treatment, and emergency services, as well as referrals to specialty care—without regard to a patient's ability to pay. Through its Health Center Program, the Department of Health and Human Services' (HHS) Health Resources and Services Administration (HRSA) awards grants to eligible health centers under Section 330 of the Public Health Service Act.[3] HRSA funds the establishment of new health

[1]Medicaid is a joint federal and state program that finances health insurance for certain low-income adults and children.

[2]In this report, "state" refers to the 50 states, the District of Columbia, and Puerto Rico. There are also delivery sites in six territories.

[3]42 U.S.C. § 254b.

center delivery sites—for both new and existing grantees—through its New Access Point grants.

To be eligible for a grant, an applicant must serve a federally designated medically underserved area (MUA) or a federally designated medically underserved population (MUP).[4] Among other things, HRSA is required to ensure that an applicant has made efforts to establish and maintain collaborative relationships with other health care providers in its service area before awarding a grant.[5] The scope of a health center's activities is delineated in its grant application and consists of its services, delivery sites, providers, target population, and service area. In addition, applicants must describe a specific need for services in the area they plan to serve, based on factors such as unique health care needs of the target population or particular provider shortages. There are four types of health centers funded through the Health Center Program: community health centers, funded to serve all members of an underserved community, and three types specifically funded to serve designated special populations—migrant and seasonal farmworkers, homeless people, and residents of public housing.[6] The four types of health centers were consolidated into a single program in 1996;[7] prior to the consolidation, the grantees serving the three designated special populations were funded through separate programs.

[4]HRSA designates MUAs based on a geographic region, such as a county, and it designates MUPs based on a specific population that demonstrates economic, cultural, or linguistic barriers to primary care services. Criteria for designating a medically underserved area or population include the ratio of primary care physicians per 1,000 population, infant mortality rate, percentage of the population with incomes below the federal poverty level, and percentage of the population age 65 and older. In 1998 and again in 2008, HRSA proposed new rules for designation of medically underserved communities and populations with health professional shortages and/or high unmet needs for health services. In both cases, HRSA received a large volume of critical comments upon publication of the proposed rules, and ultimately withdrew them. Subsequently, the 2010 Patient Protection and Affordable Care Act required the formation of a negotiated rulemaking committee to develop a comprehensive methodology and criteria for MUP and Health Professional Shortage Area (HPSA) designations. The Negotiated Rulemaking Committee on the Designation of MUPs and HPSAs completed its work in October 2011, and HRSA is drafting an interim final rule.

[5]42 U.S.C. § 254b(k)(3)(B).

[6]HRSA guidance states that to be funded as an organization that serves a special population, a health center must devote at least 25 percent of its HRSA funding to serving one or more of the three designated special populations.

[7]Health Centers Consolidation Act of 1996, Pub L. No. 104-299, 110 Stat. 3626.

For each of fiscal years 2009 and 2010, HRSA allocated almost $2.2 billion in annual appropriations to the Health Center Program;[8,9] of that amount, nearly $2 billion each year was used for health center grants.[10] In addition, the American Recovery and Reinvestment Act of 2009 (Recovery Act)[11] appropriated $2 billion for health centers to be used over those 2 years. In fiscal year 2011, HRSA allocated $1.6 billion in annual appropriations to the Health Center Program. This amount reflected a reduction of $604 million as a result of a reduction in appropriations to HRSA and a rescission of appropriations made for that year for nondefense programs; these reductions occurred after the fiscal year had begun and resulted in HRSA receiving less funding for the Health Center Program than it had anticipated. However, the Patient Protection and Affordable Care Act (PPACA), as amended by the Health Care and Education Reconciliation Act of 2010, provided an additional $11 billion over 5 years—beginning with $1 billion for fiscal year 2011—for the operation, expansion, and construction of health centers.[12] As a result, health center capacity is expected to expand significantly over the next several years.

In light of the additional funds provided to the Health Center Program through the Recovery Act and PPACA, you asked us to review HRSA's awarding of new grants to communities with a need for services, and about possible effects, such as competition, on other providers resulting from the increased support for health centers. In this report, we examine (1) the actions HRSA has recently taken to target its grants for new delivery sites to health centers in communities with demonstrated need, and the outcome of HRSA's award process in recent years; and (2) the extent to which federally funded health centers collaborate and compete with other health care providers in their service area.

[8]HRSA allocates funds to the Health Center Program out of the annual appropriation made to the agency for its programs.

[9]In fiscal year 2008, the Health Center Program's allocation was nearly $2.1 billion.

[10]The remainder was used to fund other activities that support the Health Center Program, such as cooperative agreements with nonprofit organizations that assist health centers.

[11]Pub. L. No. 111-5, 123 Stat. 115.

[12]Pub. L. No. 111-148, § 10503, 124 Stat.119, 1004 (2010); Pub. L. No. 111-152, § 2303, 124 Stat. 1029, 1083. In this report, references to "PPACA" are to the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010.

To examine the actions HRSA has recently taken to target its grants for new delivery sites to health centers in communities with demonstrated need and the outcome of HRSA's award process in recent years, we focused our work on New Access Point grants, because these grants are HRSA's primary means of establishing new health centers and delivery sites,[13] and because applicants are required to demonstrate the need for health care services in a newly proposed service area. We reviewed HRSA program documents and web-based resources and interviewed HRSA officials to obtain information about the agency's process for awarding grants, including any changes HRSA made between fiscal years 2008 and 2011 to the New Access Point grant application guidance and the criteria used for reviewing and scoring applications. We also reviewed applicant scores and rankings during that period. We interviewed health center officials and reviewed grant applications from nine selected health centers that received New Access Point grants during fiscal years 2008 through 2011 to obtain the health centers' perspective on their experience applying for a grant and to review the information they provided to HRSA.[14] We chose the health centers based on criteria that included geographic diversity, patient demographics (e.g., percentage of population in poverty and insurance status), and site-specific information (e.g., number of delivery sites operated by the grantee and U.S. Census Bureau urban/rural continuum category).[15] We obtained data used in our selection process from HRSA's 2010 Uniform Data System (UDS) and 2009-2010 Area Resource File (ARF), the most

[13]HRSA can also award funds through a competitive process to a new health center grantee to serve an existing grantee's service area under certain circumstances, such as when the existing health center grantee's grant period expires or when the existing grantee is no longer able to serve its service area.

[14]We selected grantees that received grants for new health centers, rather than existing grantees that received grants for new delivery sites, to focus on grantees whose applications described all their funded delivery sites. The selected grantees were located in the following states: California, Florida, Illinois, Kansas, New York, North Carolina, Oklahoma, Vermont, and Virginia.

[15]Because HRSA does not collect data on the population served and types of services provided at individual health center sites, we used the grantee's main address as a proxy for the site's location. We eliminated from consideration grantees for which the main address is a site that serves a purely administrative function.

recent data available.[16] To assess the reliability of the UDS and ARF data elements that we used in our selection, we performed checks, such as examining the data for missing values, and reviewed related documentation. We determined that the UDS and ARF data were sufficiently reliable for our purposes. We chose three grantees each from fiscal years 2008, 2009, and 2011 to represent various funding sources.[17] (HRSA did not award any New Access Point grants in fiscal year 2010.)

To identify the level of need in the communities served by applicants that received New Access Point grants, we also analyzed data on selected socioeconomic characteristics (e.g., the percentage of the population living in poverty and the unemployment rate) for all delivery site locations funded through these grants from fiscal years 2008 through 2011. To do this, we determined the county in which each delivery site was located based on its zip code, and reviewed and analyzed county-level data from the U.S. Census Bureau's 2006-2010 and 2008-2010 American Community Survey (ACS), which contained the most recent available data.[18] To assess the reliability of the ACS data elements that we used in our analysis, we performed checks, such as examining the data for missing values, and reviewed related documentation. We determined that the ACS data were sufficiently reliable for our purposes.

To examine the extent to which federally funded health centers collaborate and compete with other health care providers in their service area, we reviewed HRSA program documentation, policies, and guidance

[16]We also obtained data from the 2008 and 2009 UDS for grantees funded in those years. The UDS is the Health Center Program's administrative database, through which all grantees are required to submit data on their operations each year, including data on their delivery sites, patients, revenues, and expenses. The ARF is a county-based health resources database that contains data from many sources, including the U.S. Census Bureau and the American Medical Association.

[17]New Access Point grants in fiscal year 2008 were funded by the Consolidation Appropriations Act, 2008. Pub. L. No. 110-161, 121 Stat. 1877 (2007). All New Access Point grants in fiscal years 2009 and 2011 were funded with Recovery Act and PPACA funds, respectively.

[18]County-level data may not provide a fully accurate depiction of the socioeconomic characteristics for some delivery site locations because the health center's service area may be smaller than the county as a whole, and other locations in the county may have different characteristics. This could result in data linked to the delivery site being diluted by overall county data and certain characteristics, such as the percentage of the population living in poverty, being underestimated. However, county-level data are the best data available.

related to collaboration and service area overlap and interviewed HRSA officials. For this objective, we interviewed officials from the six health center grantees selected for our first objective that received New Access Point grants in fiscal years 2008 and 2009, but we did not include the three 2011 grantees. We did not interview officials from the fiscal year 2011 grantees because these grantees received their awards in August 2011 and were not yet fully operational, although we did review their grant applications for discussions of collaborative efforts. We also interviewed officials from two additional grantees that were funded prior to 2008—which were selected using criteria similar to those used for the other grantees.[19] We asked the officials from both groups of health centers about their relationships with other providers in their communities, including any collaboration or competition with them. To obtain information on the eight health centers' communities and their relationships with other providers, we also interviewed officials from primary care associations (PCA)—nonprofit organizations that support health centers at the state or regional level—and state primary care offices (PCO)—state government entities that work toward addressing the needs of the medically underserved in their states and receive funding from HRSA and other sources. We also interviewed representatives of hospitals and other providers, such as rural health clinics and private physician practices, and officials from community organizations with knowledge of the local health care environment in the health centers' communities. The information obtained about individual health centers and their communities through our interviews with officials from health centers, PCAs, PCOs, hospitals, other providers, and community organizations cannot be generalized to other health centers. In addition, we interviewed officials from national stakeholder groups, including the National Association of Community Health Centers, American Hospital Association, National Association of Rural Health Clinics, and National Rural Health Association about the extent to which there is collaboration and competition between health centers and other providers in general.

[19]We added the two additional grantees that were initially funded prior to 2008 because they had been in operation longer than the other selected grantees and could provide the perspective of grantees with more years of experience. These two grantees had been funded through the Health Center Program for 28 and 29 years, respectively. The two additional grantees were located in Alabama and New York.

We conducted this performance audit from July 2011 to May 2012 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.

Background

Health centers are private, nonprofit community-based organizations or, less commonly, public organizations such as public health department clinics. Section 330 of the Public Health Service Act, which authorizes the Health Center Program, requires health centers to provide a comprehensive set of primary health care services, including enabling services—such as language translation and transportation—that facilitate access to health care. Among other things, health centers are also required to have a sliding fee scale based on a patient's ability to pay and to be governed by a community board of which at least 51 percent of the members are patients of the health center.[20]

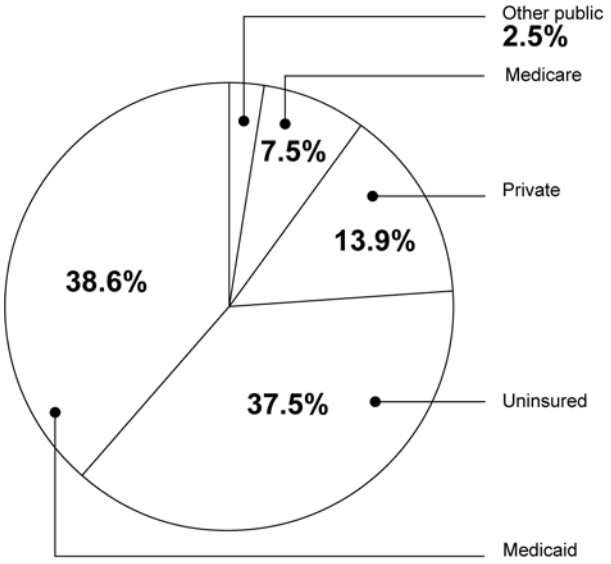
Health Center Patients, Revenue, and Grants

In 2010, nearly 93 percent of all health center patients had incomes at or below 200 percent of the federal poverty level, and nearly 72 percent had incomes at or below 100 percent.[21] About 39 percent of patients were insured by Medicaid, and nearly 38 percent were uninsured. See figure 1 for more information on insurance coverage of health center patients.

[20]HRSA may waive the governing board requirement for certain centers upon a showing of good cause. For information on HRSA's oversight of the Health Center Program, see GAO, *Health Center Program: Improved Oversight Needed to Ensure Grantee Compliance with Requirements*, GAO-12-546 (Washington, D.C.: May 29, 2012).

[21]The characteristics of individual health centers' patient populations—such as insurance coverage and income level—vary.

Figure 1: Insurance Coverage of Health Center Patients, Nationwide, 2010



Source: HRSA.

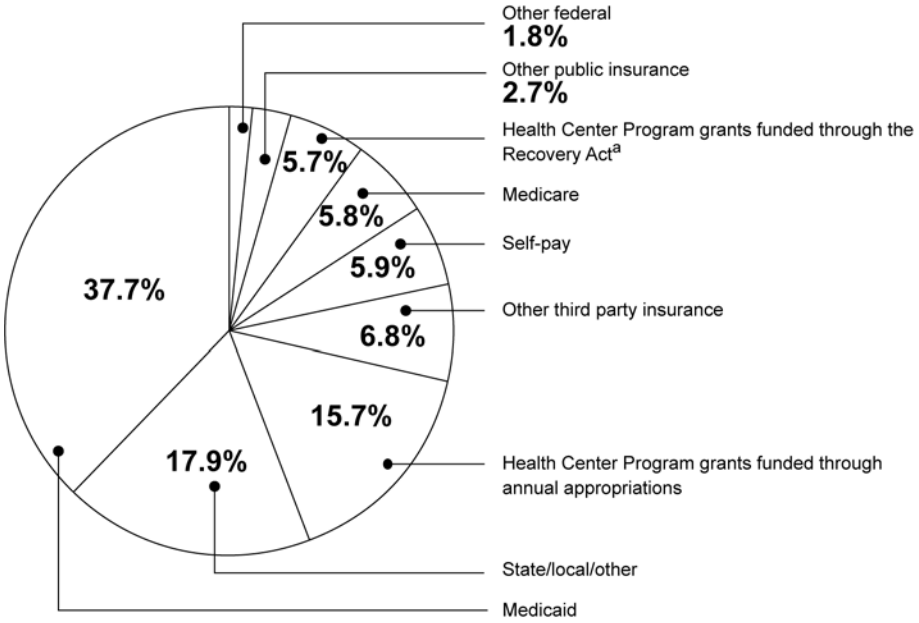
Notes: The most recent available data on health center patients' insurance coverage come from the 2010 Uniform Data System (UDS).

Children covered under the State Children's Health Insurance Program (CHIP)—a joint federal and state insurance program for certain low-income, uninsured children whose family income is too high for Medicaid eligibility—are included in either the Medicaid or Other public categories.

Health center revenue comes from multiple sources, including public and private insurance and grants from federal, state, and local governments and private organizations. The single largest source of health center revenue is Medicaid, which provided nearly 38 percent of health center revenue in 2010. (See fig. 2.) Together, HRSA Health Center Program grants funded through annual appropriations and grants funded through the Recovery Act constituted about 21 percent of total health center revenue in that year.[22]

[22]The revenue from grants funded through annual appropriations accounted for 15.7 percent of the total, and the revenue from grants funded through the Recovery Act accounted for 5.7 percent of the total.

Figure 2: Health Center Revenue Sources, Nationwide, 2010



Source: HRSA.

Note: The most recent available data on health centers' revenue sources come from the 2010 Uniform Data System (UDS).

[a]The Recovery Act is the American Recovery and Reinvestment Act of 2009. Pub. L. No. 111-5, 123 Stat. 115 (Feb. 17, 2009).

The Health Center Program provides several types of grants, and New Access Point grants are used to establish new health center delivery sites—whether for a new health center grantee or an existing grantee.[23] Grantees may request funding to operate one or more types of health centers, such as a community health center and one serving migrant and seasonal farmworkers. Once a health center is an established grantee, it must compete periodically to maintain its grant funding for its specific service area. The vast majority of health center grant funds distributed

[23]Other types of competitive grants that the Health Center Program provides include grants to expand the types of services available at a given delivery site and planning grants to assist organizations in planning a potential HRSA-supported health center. In addition, HRSA has provided competitive grants to health centers to support construction and renovation, which were funded through the Recovery Act and PPACA.

each year by HRSA—for example, 96 percent in fiscal year 2008—are used to support continuing operations for established grantees and their existing delivery sites; New Access Point grants made up about 1 percent of the funds distributed in fiscal year 2008, the last year these grants were funded through annual appropriations. In fiscal years 2009 and 2011, HRSA used additional resources provided through the Recovery Act and PPACA, respectively, to fund New Access Point grants. See table 1 for more information on the New Access Point grants HRSA awarded in fiscal years 2008 through 2011.

Table 1: HRSA's New Access Point Grants to Health Centers, Fiscal Years 2008-2011

Fiscal year	Number of New Access Point grant awards	Total dollar amount provided through New Access Point grants
2008	41	$22.0 million
2009	126[a]	$154.9 million
2010	None[b]	N/A
2011	67[c]	$28.8 million

Source: GAO analysis of HRSA data.

[a]In fiscal year 2009, HRSA used Recovery Act funds for all New Access Point grants.

[b]In fiscal year 2010, HRSA did not award any New Access Point grants.

[c]In fiscal year 2011, HRSA used PPACA funds for all New Access Point grants.

HRSA has cooperative agreements with PCAs to provide training and technical assistance to health centers and other safety net providers, support the development of health centers in their state, and enhance the operations and performance of health centers. PCAs also assist in planning for the growth of health centers in their states and help communities apply for and obtain funds for new health centers and delivery sites. HRSA also relies on PCAs to identify underserved areas and populations in their state/region.

HRSA's Award Process for New Access Point Grants

HRSA uses a competitive process to award New Access Point grants.[24]

Announcement and Assistance. After announcing a funding opportunity via its website and Grants.gov, HRSA issues grant application guidance, which includes the forms applicants need to submit and a detailed description of the application review criteria and process. HRSA also provides applicants with access to technical assistance during the development of grant applications. For example, through cooperative agreements with HRSA, PCAs and the National Association of Community Health Centers offer training sessions on topics such as proposal writing and conducting a community assessment, which may include an analysis of the other providers in an area and any unmet health care needs.

Application Preparation and Submission. Applicants must prepare and submit the application materials to HRSA through Grants.gov and the agency's website. The application materials include several narrative sections as outlined in the guidance from HRSA, as well as attachments such as a proposed budget, organizational chart, and summary of any current or proposed contracts to provide services outlined in the application.

Eligibility. Grant applications undergo an initial review for eligibility in which HRSA screens applications based on specific criteria, as described in the funding announcement. For example, the applicant must be applying for a grant for which it is eligible (e.g., certain HRSA grants are available only to existing grantees), and the application must include all required documents.

Review. Independent reviewers who are not affiliated with the Health Center Program, but have experience in a field relevant to the program, are selected by HRSA to review and score all eligible applications against established criteria, each of which has a specified point range. (We discuss the review criteria and point ranges in greater detail below.) For example, reviewers assess the description of the specific need for services in the area the applicant plans to serve—including the characteristics of its target population, the availability of services from

[24]The process HRSA uses to award New Access Point grants is generally the same process it uses for its other competitive grant awards.

other providers, and any gaps in the availability of services—as well as the applicant's capacity and readiness to initiate the proposed services. After reviewers score the applications, all applicants are ranked in an initial rank order list, which is provided to HRSA officials for grant award consideration.

Assessment of Service Area Overlap. Once applications have been scored and ranked, HRSA conducts a review of the potential for service area overlap between proposed delivery sites and certain existing safety net providers, including hospitals.[25] HRSA has a policy describing this process. HRSA first identifies the existing safety net providers and the patient population in the area to determine whether there is any unmet need. This step includes determining the size of the population with incomes below 200 percent of the federal poverty level and the size of the population without health insurance. HRSA then assesses the applicant's ability to fill any service gaps identified in the area. On rare occasions, HRSA may also conduct a site visit to an area to collect additional information to inform its decision. After its assessment, the agency may determine that there is not sufficient unmet need in the area to warrant a grant award or it may choose to award a grant despite service area overlap if it determines that the level of unmet need exceeds the capacity of existing providers.

Award Decisions. The Associate Administrator for Primary Health Care in HRSA makes final award decisions.

- **Basis of Award Decisions**. The Associate Administrator bases award decisions on the ranked application scores, while also taking into account a variety of factors such as whether the applicant is located in a sparsely populated rural area, the urban/rural mix of grant

[25]According to HRSA, the safety net providers included in its review are federally qualified health centers, public hospitals/health department primary care clinics, critical access hospitals with primary care capacity, and rural health clinics. Generally, critical access hospitals are small hospitals—with no more than 25 inpatient beds—in rural communities. Rural health clinics provide primary care services similar to those provided by health centers in underserved rural communities; however, they are not required to provide the range of services offered by health centers or to serve all individuals. Both critical access hospitals and rural health clinics are certified as such by the Centers for Medicare & Medicaid Services and receive enhanced payments for the services they provide to Medicare and Medicaid patients. Rural health clinics receive enhanced payments that are lower than the rate health centers receive.

awards,[26] and the distribution of funds across the different types of health centers.

- **Required Funding Proportions for Designated Special Populations**. The Public Health Service Act requires that HRSA ensure that a certain proportion of the total annual appropriation allocated to the Health Center Program is made available for grants serving each of the three designated special populations—migrant and seasonal farmworkers, homeless people, and residents of public housing.[27] These populations are particularly vulnerable and often have specific health and access problems. The proportions of funding that must be maintained are 8.6 percent for health centers serving migrant and seasonal farmworkers, 8.7 percent for health centers serving homeless people, and 1.2 percent for health centers serving residents of public housing.[28] These proportions were established when the Health Center Program was consolidated in 1996 and were generally maintained in subsequent legislation authorizing appropriations for the Health Center program. Most recently, legislation authorizing appropriations in 2008 and 2010 did not alter these proportions.[29]

[26]HRSA is required to make awards so that 40 to 60 percent of patients expected to be served reside in rural areas. 42 U.S.C. § 254b(k)(4).

[27]42 U.S.C. § 254b(r)(2)(B).

[28]In previous years, HRSA has taken actions when making New Access Point grant awards to ensure that these proportions were met. For example, in fiscal year 2004, it chose to award grants only to applicants requesting funding to serve migrant and homeless populations. See GAO, *Health Centers: Competition for Grants and Efforts to Measure Performance Have Increased*, GAO-05-645 (Washington, D.C.: July 13, 2005), 40.

[29]The proportional funding requirement was established when the Health Center Program was consolidated in 1996 to maintain for fiscal year 1997 the proportions of funding that previously were provided for these same designated populations when they were funded through separate programs. HRSA was permitted to increase or decrease these proportions by 10 percent for fiscal years 1998 and 1999, but during those years HRSA maintained the 1997 proportions without adjusting them, and HRSA continued to award grants in the same proportions in fiscal years 2000 and 2001. In 2002, legislation authorizing appropriations for the Health Center Program required that the proportions be maintained going forward.

- **Required Consideration of Sparsely Populated Areas**. The Public Health Service Act also requires that HRSA give special consideration to applicants in sparsely populated areas.[30] HRSA defines these as areas with seven or fewer residents per square mile.

Funding for Grant Awards. For New Access Point grants, HRSA approves funding for a 2-year project period; prior to fiscal year 2009, the project period for New Access Point grants was up to 3 years. HRSA provides an initial grant for the first year of the project; a health center grantee obtains grants for each subsequent year in the project period through a noncompetitive process in which the grantee must demonstrate that it has made satisfactory progress in providing services.[31] A grantee demonstrates its progress by submitting a progress report for HRSA's review. At the end of the New Access Point project period, new health center grantees compete to continue receiving Health Center Program funding to serve their service area; the project period for these competitive continuing operations grants is typically 3 or 5 years.[32]

HRSA Revised 2011 Award Process, and Most New Access Point Grants Went to Health Centers Serving Special Populations

HRSA revised its New Access Point award process for fiscal year 2011 to increase the emphasis on need and on the designated special populations. As a result of these changes and HRSA's receiving less fiscal year 2011 funding than it had anticipated, a high proportion of grants went to health centers serving the designated special populations.

[30]42 U.S.C. § 254b(p).

[31]Noncompetitive continuation funding is also contingent on the availability of funds.

[32]These competitive continuing operations grants are known as Service Area Competition grants.

HRSA Increased Weight Given to Need and Emphasized Special Populations in 2011 Award Process

HRSA revised the New Access Point grant application and award process for fiscal year 2011. According to HRSA officials, it did so to better target resources to communities with high need because it found that the previous process did not adequately factor need into the application score, and because past applicants and grantees expressed concerns about this issue. One step HRSA took was to increase the need score from 10 to 30 points, out of a maximum of 100 base points. (See table 2.) Twenty of the 30 points are available for applicant responses provided on an attached form that documents barriers to access to care and various health indicators in the proposed service area, and the remaining 10 points are available based on the applicant's narrative describing health care need.[33]

[33]Independent reviewers assess only the 10 points from the application's narrative on need. The 20 points from the attached form are based on data submitted by the applicant and converted to predetermined point values as detailed in HRSA's application guidance.

Table 2: HRSA's Scoring Criteria and Maximum Base Points Awarded for New Access Point Grant Applications, Fiscal Years 2008, 2009, and 2011

Scoring criterion	Description	Maximum base points for fiscal years 2008 and 2009	Maximum base points for fiscal year 2011
Need	The applicant's description of health care need in the proposed service area.	10	30
Response	The applicant's proposal to respond to the health care need.	30	20
Collaboration	The applicant's plans for coordinating services with other providers in its proposed service area.	N/A[a]	10
Evaluative measures	The applicant's ability to measure its own performance.	10	5
Impact	The applicant's justification for requested funding and explanation of how it will increase access to care.	10	5
Resources/Capabilities	The applicant's organizational and financial plan and past accomplishments.	15	10
Support requested	The applicant's budget.	10	10
Governance	The applicant's plans for establishing a governing board.	10	10
Readiness	The applicant's ability to begin providing services.	5	N/A[b]
	Total	**100**	**100**

Source: GAO analysis of HRSA documents.

Note: HRSA did not award any New Access Point grants in fiscal year 2010.

[a]For fiscal year 2011 New Access Point applications, HRSA included a separate criterion for Collaboration that formerly was part of the Response criterion in fiscal year 2008 and 2009 applications.

[b]For fiscal year 2011 New Access Point applications, HRSA eliminated the Readiness criterion; some of the Readiness provisions became a part of the Resources/Capabilities criterion.

HRSA also revised its award process in fiscal year 2011 to award extra points, which HRSA calls priority points, over the maximum 100 base points to applicants seeking to serve the three designated special populations and sparsely populated areas. HRSA did this to help it continue to meet the Public Health Service Act requirements regarding these populations.[34] In addition, HRSA decided to award extra points to applicants seeking to serve high-poverty areas to further increase the emphasis on need in the award process. This was the first time HRSA

[34]42 U.S.C. §§ 254b(r)(2)(B), (p).

awarded such extra points, and the application guidance described how the points would be awarded, providing transparency for this aspect of the process. (See table 3.) HRSA officials applied the extra points to applicants' base scores out of 100;[35] these adjusted scores were used to update and finalize the rank order list of all applicants. HRSA awarded from 5 to 10 extra points for serving one or more of the designated special populations, 5 extra points for serving a sparsely populated area, and up to 5 extra points for serving a high-poverty area.

[35]For each application, HRSA averages the scores assigned by each reviewer in the panel. Depending on the number of applications it receives, HRSA may use multiple review panels during a funding cycle. When this occurs, HRSA uses a statistical method to adjust the scores for variation among different review panels. This process could result in adjusted scores of over 100 before extra points have been awarded.

Table 3: Extra Points Awarded by HRSA to New Access Point Applicants in Fiscal Year 2011

Population served	Description	Percentage of funding to be used to serve special populations	Extra points awarded
Designated special populations	The applicant intends to serve one or more of the three designated special populations—migrant and seasonal farmworkers, homeless, or public housing—with at least 25 percent of its HRSA funding.	≥25% - 35%	5
		>35% - 45%	6
		>45% - 55%	7
		>55% - 65%	8
		>65% - 75%	9
		>75%	10
Sparsely populated area	The applicant is located in a sparsely populated area of seven or fewer people per square mile.	N/A[a]	5
		Percentage of population at or below 100 percent of the federal poverty level	
High-poverty area	The applicant serves a high-poverty area—over 30 percent of the population is at or below 100 percent of the federal poverty level.	>30% - 42%	1
		>42% - 46.6%	2
		>46.6% - 50.9%	3
		>50.9% - 56%	4
		>56%	5

Source: GAO analysis of HRSA application guidance.

Note: The Public Health Service Act requires that HRSA award a certain proportion of funds to serve each of the designated special populations, and that it give special consideration to applicants in sparsely populated areas when making awards.

[a]Applicants that met the sparsely populated area description received 5 extra points. HRSA did not offer a range for this population.

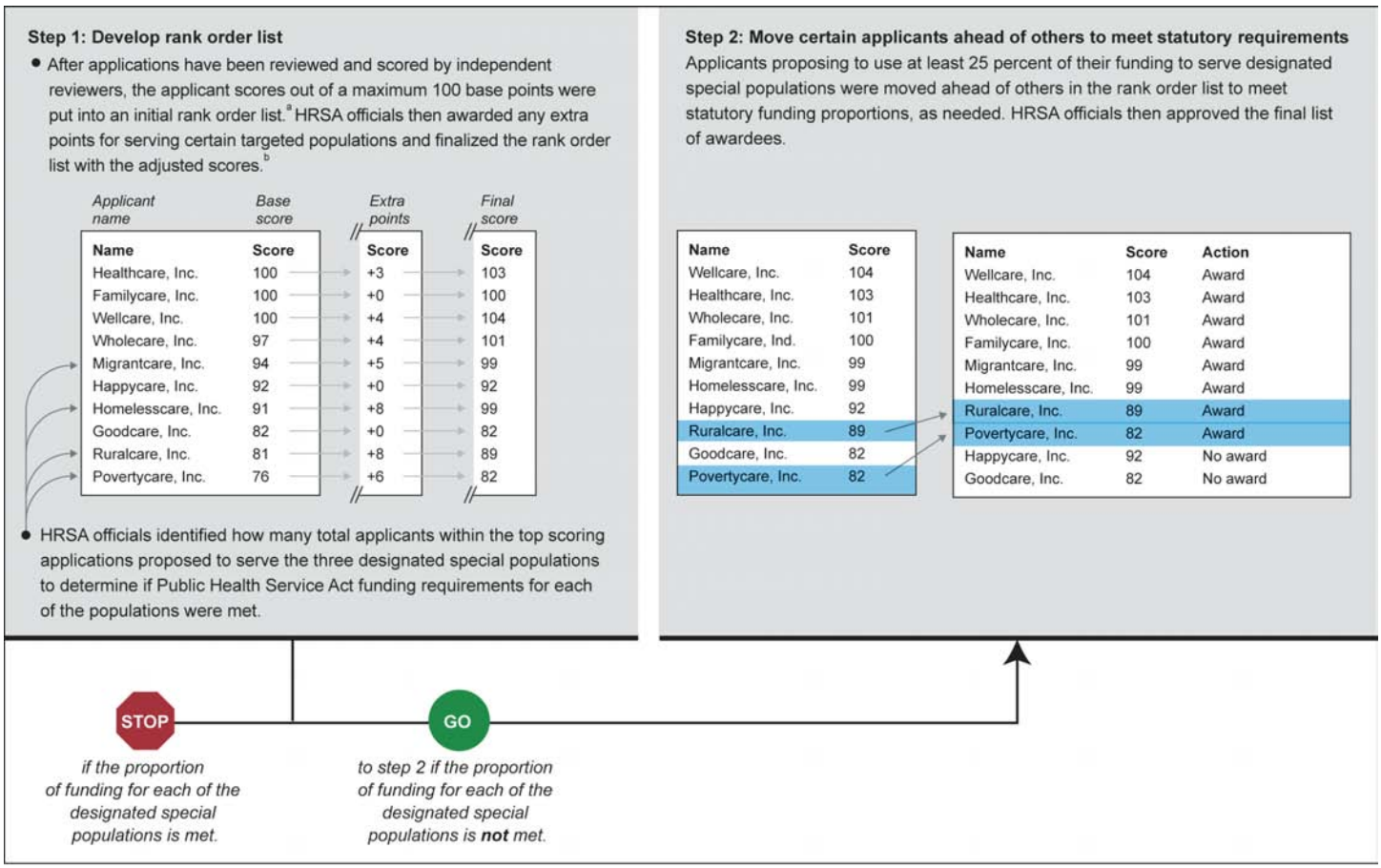
In fiscal year 2011, HRSA also used a method it had used before to produce its final list of applicants awarded funding—moving certain applicants proposing to use at least 25 percent of their grant funding to serve one or more of the designated special populations ahead of other applicants in the rank order list. HRSA used this method to ensure that it met the statutory requirement that the specified proportion of funds be provided to applicants serving the three designated special populations. HRSA's application guidance in fiscal years 2008 and 2011 stated that HRSA would consider the need to meet proportional requirements for the designated special populations and would give special consideration to

applicants serving them in making awards.[36] However, the guidance did not specifically describe the method that HRSA would use to do so, limiting the transparency of this aspect of the award process. HRSA had used this method for the designated special populations in fiscal year 2008, as well as in the past. In addition, in fiscal year 2008 HRSA gave a preference to applicants in sparsely populated areas, which moved these applicants ahead of others in the rank order list; HRSA eliminated the preference for the fiscal year 2011 funding cycle.[37] (See fig. 3 for a depiction of the award process in fiscal year 2011.)

[36]HRSA took action in fiscal year 2011 to encourage applications from organizations proposing to serve these special populations by highlighting the topic in its application guidance, describing the new extra points in its national conference calls with potential applicants to discuss grant opportunities, and working with partners such as national organizations focused on migrant farmworkers and the homeless.

[37]HRSA did not use the method of moving applicants ahead of others in the rank order list for any of these populations in fiscal year 2009.

Figure 3: HRSA's New Access Point Grant Award Process in Fiscal Year 2011



Source: GAO analysis of HRSA information.

[a]During the application scoring process, HRSA averages the scores assigned by each independent reviewer in the panel. Depending on the number of applications it receives, HRSA may use multiple review panels during a funding cycle. When this occurs, HRSA uses a statistical method to adjust the scores for variation among different review panels. This process could result in adjusted scores of over 100 before extra points have been awarded. This illustration does not reflect this process.

[b]For fiscal year 2011 New Access Point applications, grantees were able to score over the maximum 100 base points by indicating that they intended to serve: any of the three designated special populations—migrant and seasonal farmworkers, homeless people, and residents of public housing—and sparsely populated or high-poverty areas.

In part, HRSA needed to target the designated special populations when awarding fiscal year 2011 New Access Point grants because of its fiscal year 2009 award funding process and results. HRSA did not apply the Public Health Service Act's funding proportions to the New Access Point grants awarded in fiscal year 2009.[38] Few of these grants went to applicants proposing to serve the designated special populations. When the fiscal year 2009 New Access Point project periods ended in fiscal year 2011, continuing operations grants for the fiscal year 2009 grantees were funded through PPACA. HRSA applied the required funding proportions for designated special populations to the fiscal year 2011 grants made with PPACA funding, including grants for continued operations and New Access Point grants. As a result, HRSA determined that in fiscal year 2011 it needed to increase the share of New Access Point grant funding dedicated to special populations to help the agency meet the required funding proportions. This need influenced HRSA's decision to award extra points to applicants proposing to serve these special populations. HRSA officials told us that they made the grants funded through PPACA in the same manner they would have if they used annual appropriations, and, as a result, had to take the required funding proportions into account.

In addition to making application and award process changes in fiscal year 2011, HRSA used a new tool in assessing service area overlap. In 2010, HRSA began using a web-based tool—UDS Mapper—in its assessment of potential service area overlap between proposed delivery sites and certain existing safety net providers, to better facilitate its ability to target New Access Point awards to areas with need and to minimize service area overlap. The agency uses UDS Mapper to identify existing safety net providers, including hospitals, in the service area of an applicant's proposed delivery site.[39] UDS Mapper includes data from federal sources such as HRSA's UDS, the U.S. Census Bureau, and the Centers for Medicare & Medicaid Services. However, UDS Mapper does not include information about private physician practices, except for those

[38]HRSA determined at that time that the proportions were not required for grants made with Recovery Act funding.

[39]In addition to safety net hospitals, UDS Mapper also includes the locations of non-safety net hospitals.

participating in the National Health Service Corps program.[40] HRSA officials told us this information is challenging to obtain because there is no good data source on such providers and their patient populations. HRSA officials said that in its service area overlap assessment, the agency relies in part on information submitted by applicants about the locations of private physician practices.

HRSA's Increased Focus on Special Populations and Receipt of Less Funding than It Had Anticipated Resulted in Large Proportion of 2011 Awards Going to Health Centers Serving These Populations

As a result of the increased focus on designated special populations and HRSA's receiving less fiscal year 2011 funding than it had anticipated, HRSA awarded over 80 percent of fiscal year 2011 New Access Point grants to applicants seeking to serve the designated special populations. HRSA had announced that it expected to award about 350 New Access Point grants in fiscal year 2011, based on increased funding from PPACA, but after the total amount of funding the agency anticipated being available was reduced, it instead awarded 67 grants, which represented 8 percent of the 810 applications HRSA received. Of the 810 applications, 210—about 26 percent—proposed serving at least one of the three designated special populations. HRSA officials said the number of applications proposing to serve the special populations was the largest the agency had ever received. Fifty-seven of the 67 successful applicants proposed serving one or more of these populations.[41] Of the 10 remaining successful applicants, 3 received either one or two extra points for serving a high-poverty area and an additional 1 received the five extra points for being in a sparsely populated area.

All of the grantees receiving New Access Point awards in fiscal year 2011 had high scores that placed them at or near the top of the rank order list, including the 57 grantees seeking to serve one or more designated

[40]The National Health Service Corps program, administered by HRSA, offers school loan repayment and scholarships to primary care providers who serve in underserved areas. Awards are made to providers in locations designated as health professional shortage areas.

[41]An applicant can propose to use at least 25 percent of its grant to serve one or more of the three designated special populations. In total, 39 percent of successful applicants in fiscal year 2011 proposed serving the homeless population, 37 percent proposed serving migrant and seasonal farmworkers, and 21 percent proposed serving residents of public housing. Of the 57 applicants that proposed serving one or more of the special populations, 9 received additional extra points for serving a high-poverty area and 2 received additional extra points for serving a sparsely populated area.

special populations.[42] However, because HRSA's awarding of extra points was not sufficient to ensure that it met its statutorily required funding proportion for serving the migrant farmworker population, 13 of the
57 grantees received awards by being moved ahead of other applicants to meet the required proportion of funds awarded for serving this population; all of these 13 grantees also served the general health center population with a portion of their funding. Although these 13 grantees had high-scoring applications, they were placed ahead of 177 other applicants with the same or higher scores on the rank order list.

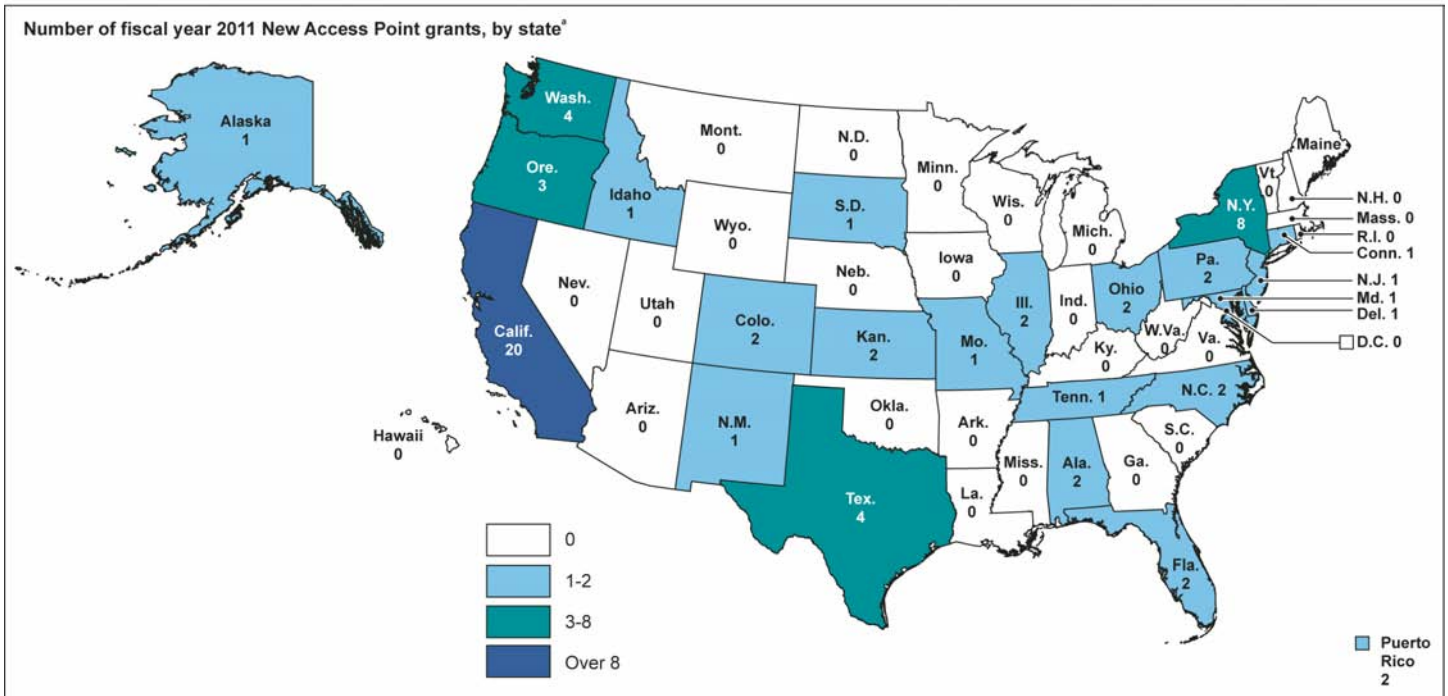
Another outcome of the fiscal year 2011 award process was that all New Access Point grants went to applicants in 24 states. (See fig. 4.) Most of these states had either 1 or 2 successful applicants; California had 20 successful applicants, or 30 percent of all grants. (See app. I.) HRSA officials told us that if the program had been able to award the $250 million for New Access Point grants officials had anticipated rather than the $28.8 million the program did award, the geographic dispersion of grants would have been different. For example, in one potential scenario HRSA shared with us, applicants in 46 states and one territory might have received funding. Although California applicants received the largest share of all New Access Point grants in fiscal year 2011—and 10 percent of all health centers nationwide in 2010 were located in California[43]—the state has a low ratio of health centers to the population in poverty, a measure of the availability of care for the medically underserved. Compared to the other states, California ranks 36.[44] (See app. II for information on the ratio of health centers to the population in poverty, by state.)

[42]Successful applicants had final scores ranging from 95 to 114 points, including applicants that were moved ahead of other applicants in the rank order list to meet statutory requirements for the designated special populations.

[43]The total number of health centers is based on 2010 UDS data, which include health centers funded through fiscal year 2009 and represent the states and the territories.

[44]The California poverty estimate is based on the 2006-2010 ACS.

Figure 4: HRSA New Access Point Grant Awards, Fiscal Year 2011, and Total Health Center Grantees, 2010



Total number of health center grantees, 2010, by state and territory[b]

Alabama	14	Idaho	11	Nebraska	6	South Carolina	20
Alaska	25	Illinois	36	Nevada	2	South Dakota	6
American Samoa	1	Indiana	19	New Hampshire	10	Tennessee	23
Arizona	16	Iowa	13	New Jersey	20	Texas	64
Arkansas	12	Kansas	13	New Mexico	15	Utah	11
California	118	Kentucky	19	New York	51	Vermont	8
Colorado	15	Louisiana	24	North Carolina	27	Virgin Islands	2
Connecticut	13	Maine	18	North Dakota	4	Virginia	25
Delaware	4	Marshall Islands	1	Northern Mariana Islands	0	Washington	25
District of Columbia	5	Maryland	16	Ohio	32	West Virginia	28
Federated States of Micronesia	2	Massachusetts	36	Oklahoma	17	Wisconsin	16
		Michigan	29	Oregon	25	Wyoming	6
Florida	44	Minnesota	15	Palau	1		
Georgia	27	Mississippi	21	Pennsylvania	35		
Guam	1	Missouri	21	Puerto Rico	19		
Hawaii	14	Montana	15	Rhode Island	8		

Sources: GAO analysis of HRSA information (data); Map Resources (map).

Note: In this map, "state" refers to the 50 states, the District of Columbia, and Puerto Rico.

[a]In fiscal year 2011, HRSA awarded 67 New Access Point grants—10 to establish new health centers and 57 to establish new delivery sites for existing grantees. In total, 108 delivery sites were funded through the 67 grants.

[b]The total number of health center grantees includes the states and the territories. The counts are based on 2010 Uniform Data System (UDS) data—the most current available data on health center grantees—and include new health center grantees funded through fiscal year 2009, but do not include the 10 new health center grantees funded in fiscal year 2011.

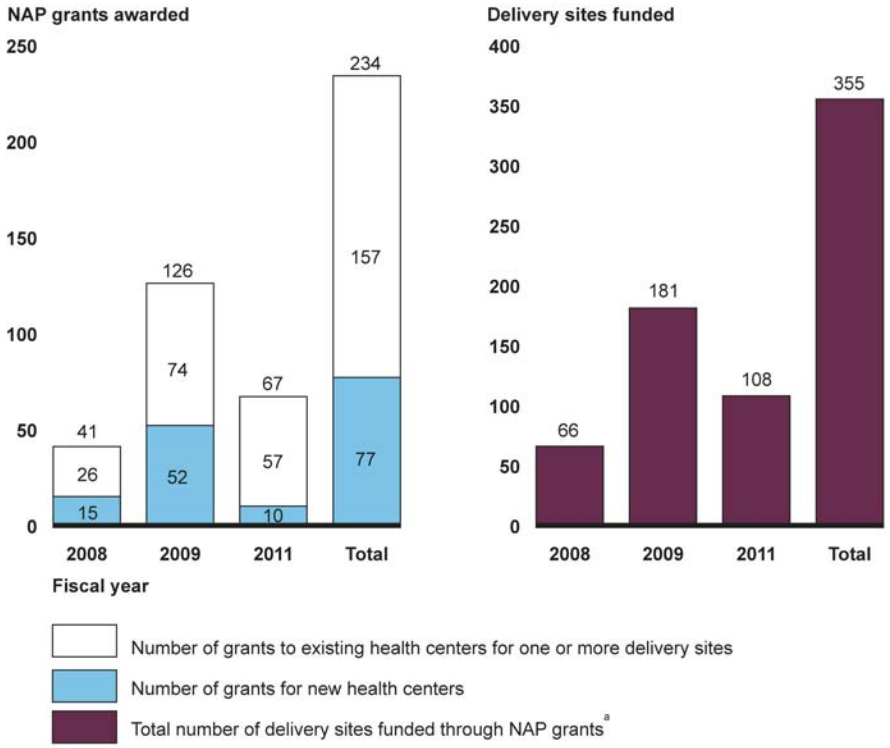
HRSA officials told us that they plan to award New Access Point grants in fiscal year 2012, and instead of offering a new grant award competition, they plan to use the fiscal year 2011 rank order list of applicants to make about $145 million to $150 million in awards to approximately 220 applicants that were approved in that year but did not receive an award.[45] HRSA had used a similar process for its fiscal year 2009 New Access Point grant awards, when additional funding became available through the Recovery Act. Specifically, HRSA funded 126 applicants that had initially applied in fiscal year 2008 but had not received one of the 41 grants awarded that year. In 2008, all eligible applicants that did not receive a grant were notified that their application would remain active for a year, with the possibility of a grant award if HRSA received additional funding.[46] The agency used the 2008 rank order list to provide grants to additional applicants in 2009 without soliciting and reviewing new applications, which enabled HRSA to quickly award Recovery Act funding.

Overall, during fiscal years 2008 through 2011, HRSA awarded a total of 234 New Access Point grants, with 77 grants to establish new health centers and 157 grants to fund existing health centers to establish new delivery sites. (See fig. 5.) New Access Point applicants, regardless of whether they are seeking to establish a new health center or a new delivery site for an existing grantee, may propose to serve their area with one or more delivery sites. In total, 355 new delivery sites were funded in fiscal years 2008 through 2011. A greater percentage of grants—about 85 percent—went to existing health centers to establish one or more new delivery sites in fiscal year 2011 than in fiscal years 2008 and 2009—about 63 percent and 59 percent, respectively.

[45]HRSA officials told us that they plan to take into account the statutory funding requirements for special populations when they award grants in fiscal year 2012.

[46]HRSA sent a comparable letter to all 2011 eligible applicants that did not receive a grant.

Figure 5: Number of New Access Point (NAP) Grants Awarded by HRSA and Delivery Sites the Grants Funded, by Fiscal Year



Source: GAO analysis of HRSA data.

Note: HRSA did not make any New Access Point grant awards in fiscal year 2010.

[a]New Access Point grantees may have received funding for more than one delivery site. The grant application asks applicants to provide information on each delivery site it proposes to use in serving its target population.

HRSA awarded grants in the fiscal years we studied to health centers serving areas with unemployment and poverty rates higher than the national average. (See table 4.) HRSA also awarded grants in these fiscal years in areas where patients were more likely to be uninsured or to receive Medicaid, compared to the national average. Over 36 percent of the population was below 200 percent of the federal poverty level in areas receiving New Access Point grants in fiscal year 2011, compared with about 31 percent nationwide. For example, of the grantees whose applications we reviewed, one successful applicant in Brooklyn, New York, applied for extra points for serving a high-poverty area because, according to its application, more than 34 percent of the residents in the local community live below 100 percent of the federal poverty level and

more than 56 percent live below 200 percent of the federal poverty level. Another successful applicant, in rural North Carolina, serves three counties whose combined population has an average uninsured rate of 20 percent, in comparison to the national rate of 15 percent.

Table 4: Selected Socioeconomic Characteristics for New Access Point Grantees' Delivery Sites, in Aggregate, Compared to National Average, Fiscal Years 2008, 2009, and 2011

Selected characteristic	National average	Fiscal year 2008 New Access Point grantee delivery sites, in aggregate	Fiscal year 2009 New Access Point grantee delivery sites, in aggregate	Fiscal year 2011 New Access Point grantee delivery sites, in aggregate
Percentage of population below 100 percent of the federal poverty level, 2006-2010[a]	13.5	14.8	14.7	16.8
Percentage of population below 200 percent of the federal poverty level, 2006-2010[a]	31.2	34.5	34.3	36.2
Unemployment rate, 2006-2010[a]	7.9	8.4	8.6	8.6
Percentage of population uninsured, 2008-2010[b]	15.0	19.7	19.4	17.1
Percentage of population with Medicaid coverage, 2008-2010[b]	16.0	18.6	18.3	21.6

Source: GAO analysis of U.S. Census Bureau American Community Survey (ACS) data.

Note: For each grantee delivery site, we used the site's zip code as a proxy for the location where the services would be provided, matched each zip code to the county where the majority of the zip code fell, and analyzed county-level data from the ACS. We used the 2006-2010 ACS when possible, which had the most recent data for all counties, and used the 2008-2010 ACS for selected characteristics for which data were not available in the 2006-2010 ACS; the 2008-2010 ACS had recent data only for counties with populations of 20,000 or more. The socioeconomic characteristics for which we used the 2008-2010 ACS did not include data for 31 counties, and these communities were subsequently excluded from our aggregate analysis.

[a]The selected socioeconomic characteristic comes from the 2006-2010 ACS, which includes data for all counties.

[b]The selected socioeconomic characteristic comes from the 2008-2010 ACS, which includes data for counties with populations of 20,000 or more.

Health Centers and Other Providers Reported Collaboration and Little or No Competition, but Rural Areas Have Greater Potential for Competition

Health centers in the communities we studied collaborate with other providers in their service area. Health centers and other providers said they generally did not compete for patients, but we found greater potential for competition in rural areas.

Health Centers in Communities We Studied Collaborate with Other Providers

Health centers in the communities we studied collaborate with other providers to meet the health care needs of patients in the health center's service area. Officials we interviewed from each of the health centers described at least one collaborative relationship with another provider—such as local hospitals and specialty care providers—to provide access to services not available through the health center. For example, officials from one of the health centers told us they collaborate with specialists such as a pediatric cardiologist, podiatrist, and ophthalmologist. In addition, officials from several hospitals said that collaborating with health centers is important because the centers help reduce the non-urgent use of hospital emergency departments.[47] However, in some of the rural communities we studied we also found that the relationship between the health center and a nearby hospital was strained. For example, officials from a hospital in one community we studied told us that the health center did not always send the medical records of admitted patients in a timely way.

HRSA has encouraged health centers to collaborate with other providers in their service area. HRSA issued a Program Assistance Letter in fiscal year 2011 that provides guidance to health centers on collaborating and establishing contractual agreements with other providers to maximize

[47]We previously reported on strategies health centers have implemented that may help reduce the non-urgent use of emergency departments. See GAO, *Hospital Emergency Departments: Health Center Strategies That May Help Reduce Their Use*, GAO-11-414R (Washington, D.C.: Apr. 11, 2011).

resources and efficiencies in their service area. For example, the letter includes a list of suggested resources to help health centers maximize collaboration with other safety net providers, such as the UDS Mapper tool, PCAs, and HRSA project officers, who are responsible for overseeing health centers and providing technical assistance.

For fiscal year 2011, HRSA added a collaboration component to the New Access Point application scoring to encourage collaboration by health centers. The fiscal year 2008 and 2009 applicants had been required to include a written description of existing collaborative relationships with other providers and had also been encouraged to submit letters of support, but these were not scored separately. However, in fiscal year 2011, applicants could receive up to 10 points for submitting letters of support—from other providers or community organizations—and a written description of their existing and proposed efforts to establish collaborative relationships with other providers in their proposed service area. During the period included in our study, letters of support were written by, among others, neighboring health centers, local hospitals, private physicians, local government agencies, and PCAs. The letters of support generally included similar types of information—such as a description of the specific health care needs of the community and support for the applicant's efforts to care for underserved patients—regardless of the type of organization expressing support. A few letters included information about specific support the writer had provided or planned to provide to a health center, such as pediatric or obstetrical care to health center patients.

PCAs often work with applicants and grantees to help them develop collaborative relationships. Officials from several PCAs told us they used applicants' requests to the PCA for a letter of support as an opportunity to assist them in developing relationships with other providers. For example, officials from one PCA told us that for the fiscal year 2011 New Access Point award cycle, they hosted over 20 town hall meetings in applicants' communities to facilitate community involvement, collaboration, and understanding of the Health Center Program. Several PCAs told us they also work with potential applicants to determine whether it would be better for them to combine efforts with an existing health center grantee or to establish a new health center. Officials from one PCA explained that it may be better for a new organization to become a satellite site of an existing organization because existing organizations already have the resources and infrastructure in place to operate a health center.

Officials we interviewed identified various factors that contribute to successful collaboration between health centers and other providers. Officials from hospitals, other providers, and community groups said that leadership commitment to collaboration, community participation in developing a new health center, and other providers' understanding of the role of health centers are important factors that contribute to successful collaboration. For example, officials from one hospital and a community group in the same area noted improved collaboration as a result of a new director coming to a health center. They told us that the previous director was difficult to collaborate with and did not acknowledge the abilities of other primary care providers to serve the safety net population. These officials also said that the current relationship is much more collaborative and that the health center and hospital share a board member and a physician. In addition, officials from one PCA told us that a former state government official had, over many years, discouraged hospitals from collaborating on efforts to establish new health centers in their communities, warning the hospitals that they could lose patients to the health centers. Regarding the importance of community participation, officials from one hospital said that the hospital led the effort to develop the health center in its community, because previously physicians voluntarily provided services for low-income patients two evenings a week, and that effort was unsustainable.

Health Centers and Other Providers Generally Did Not Encounter Significant Competition for Patients, but Rural Areas Have Greater Potential for Competition

In the communities we studied, health centers and other providers in their service area generally do not compete for patients. HRSA and PCA officials told us that health centers typically serve patients not treated elsewhere, such as uninsured and Medicaid patients. Nationwide, 37.5 percent of health center patients are uninsured, and for the eight health centers we studied, the rate of uninsured patients averaged 30.4 percent. Similarly, Medicaid patients make up 38.5 percent of health center patients nationwide, and 35 percent in the health centers we studied. Officials from most of the PCAs we spoke with said health centers and other providers generally do not compete for uninsured patients; some also noted that other providers rarely provide care for uninsured patients. Similarly, officials from one health center told us that Medicaid patients in their area had difficulty finding other providers that would accept them. We have previously reported on the difficulties certain

Medicaid patients, such as children, face in finding providers who are willing to serve them.[48]

HRSA's service area overlap policy is designed to help the agency avoid awarding grants for new delivery sites in areas where other safety net providers are already serving the population's need, and this may reduce competition between health centers and other safety net providers. The agency did not award grants to two applicants in fiscal years 2008 and 2009—one in each year—because awarding grants to these applicants would have resulted in overlap with existing providers that had the capacity to meet the needs of the area. HRSA officials told us that they did not find any significant service area overlap during the fiscal year 2011 award cycle. They also said that since the agency increased its emphasis on collaboration—and applicants have increased their outreach in their communities—it has received fewer complaints from other safety net providers about service area overlap than it received in prior years.[49]

Because the health center grant covers, on average, about 20 percent of a health center's budget, health centers also must secure other funding, such as by serving privately insured and Medicaid patients, to be financially sustainable;[50] this necessity can occasionally result in competition with and complaints from other providers in their service area. For example, HRSA officials told us that some private dentists have complained about competing with health centers for Medicaid patients; the officials added that many patients might have to go without dental

[48]See GAO, *Medicaid and CHIP: Most Physicians Serve Covered Children but Have Difficulty Referring Them for Specialty Care*, GAO-11-624 (Washington, D.C.: June 30, 2011). The report notes that physicians participating in Medicaid and the State Children's Health Insurance Program (CHIP)—a joint federal and state insurance program for certain low-income, uninsured children whose family income is too high for Medicaid eligibility—are generally more willing to accept privately insured children as new patients than Medicaid and CHIP children. For example, about 79 percent were accepting all privately insured children as new patients, while about 47 percent were accepting children in Medicaid and CHIP as new patients.

[49]HRSA does not maintain records of all the complaints the agency receives that are related to competition and service area overlap.

[50]See GAO, *Community Health Centers: Adapting to Changing Health Care Environment Key to Continued Success*, GAO/HEHS-00-39 (Washington, D.C.: Mar. 10, 2000).

care if health centers did not offer these services, because some dentists are unwilling to serve Medicaid patients.[51]

Greater potential for competition exists in rural areas, where in general a higher proportion of health center patients are insured and therefore more likely to be a source of competition with other providers. Among the health centers we studied, the rate of insured patients was higher in rural areas than in urban areas. For example, more than 76 percent of patients served by the health centers we studied in rural areas had some type of insurance coverage,[52] compared to about 61 percent of the patients at the health centers in urban areas.

Competition may exist between health centers and hospitals in rural areas under certain circumstances. For example, a recent HRSA report discussed the potential for competition between health centers and critical access hospitals.[53] It suggested that duplicative services by health centers and critical access hospitals (e.g., primary care and laboratory services) could lead to detrimental competition, but that both types of providers would benefit if they collaborated with each other instead of competing. The report also said that health centers and critical access hospitals can benefit from sharing resources that foster infrastructure, access, and quality of care improvements. In addition, while most hospital officials we interviewed said their hospitals do not compete with health centers, officials from the hospitals in rural communities we studied told us that health centers receive certain benefits that could lead to increased competition with their local hospital. For example, officials from a few hospitals in rural communities said that hospitals generally finance construction or renovation costs on their own, but health centers may

[51]We previously reported that obtaining dental care for children remains a challenge because most dentists treat few or no Medicaid and CHIP patients. See GAO, *Oral Health: Efforts Under Way to Improve Children's Access To Dental Services, but Sustained Attention Needed to Address Ongoing Concerns*, GAO-11-96 (Washington, D.C.: Nov. 30, 2010).

[52]Insurance coverage for patients served by the health centers we studied includes coverage by Medicaid, CHIP, Medicare, other public insurance (such as state insurance programs), and private insurance.

[53]HMS Associates, *A Manual on Effective Collaboration Between Critical Access Hospitals and Federally Qualified Health Centers*, a report prepared for the U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy (Getzville, N.Y.: April 2010).

receive grant funding for construction or renovations, which gives them a competitive advantage. They said the health centers might be better able to attract insured patients because of the improved facilities or might be able to attract staff because these grant funds free up resources that can be used for higher salaries.

PCA and health center officials we interviewed more frequently raised concerns about the potential for competition between health centers and rural health clinics, in part because there are more similarities in the services they provide to patients in rural communities.[54] For example, several PCA officials told us that while there is no competition between health centers and rural health clinics for serving uninsured patients, they do compete for patients with insurance, including Medicaid and Medicare. Although patients in rural areas often face access barriers because of a shortage of providers, HRSA officials said the addition of a health center to an area can increase competition for insured patients when such patients seek treatment from a health center that is more conveniently located than other providers. HRSA officials also told us that they may award grants in rural areas where there are other providers if those providers do not fully meet the needs of the safety net population. For example, existing providers may not offer a sliding fee scale or be willing to serve uninsured people.

Conclusions

Health centers funded by HRSA's Health Center Program are a critical component of the nation's health care safety net, and New Access Point grants provide the agency with an important means for increasing access to health care for vulnerable populations—those who may have difficulty obtaining needed health care services because of financial or other limitations. To better target resources to communities with a high need for health center services, in fiscal year 2011 HRSA increased the weight of the criterion assessing the need for services in the New Access Point grant application. Certain populations—migrant and seasonal farmworkers, homeless people, and residents of public housing—are particularly vulnerable and often have specific health and access problems. In its 1996 consolidation of the Health Center Program, Congress began requiring that specific proportions of the program's funds

[54]Rural health clinics are not required to provide the full range of services that health centers must provide or to accept all patients regardless of their ability to pay.

be used to serve these populations. Over the years, HRSA has taken various actions to ensure it was meeting the required funding proportions. During its fiscal year 2011 New Access Point award process, HRSA for the first time gave extra points to applicants serving these designated special populations. Congress also requires HRSA to give special consideration to organizations serving sparsely populated areas, and in fiscal year 2011 HRSA also gave extra points to applicants serving sparsely populated and high-poverty areas. HRSA's approach of assigning these extra points—and its description in its application guidance of how the points would be awarded—increased the transparency of the grant award process compared to previous years. However, because the extra points were not sufficient to ensure that HRSA met its statutorily required funding proportion for migrant health centers, HRSA also moved applicants serving this population ahead of other applicants to ensure the required proportion was met, a step that was not specifically described in the application guidance. Although HRSA had used such an approach before, the effect in fiscal year 2011 was magnified by the combined effect of the reduction in program funding and HRSA's need to increase the share of funding awarded to the designated special populations as a result of not applying the proportions when awarding grants with Recovery Act funds in fiscal year 2009. HRSA has periodically needed to take actions to meet its statutory obligations and may face such a situation in the future. Evaluating the effectiveness and transparency of the New Access Point grant award process it used most recently could help HRSA identify lessons learned and possible improvements that it could apply to future funding cycles to ensure the most effective use of limited Health Center Program resources.

Recommendation for Executive Action

To ensure that in the future HRSA can effectively target limited Health Center Program resources through a transparent grant award process, the Secretary of HHS should direct the Administrator of HRSA to evaluate the fiscal year 2011 New Access Point grant award process to identify lessons learned and potential improvements for future funding cycles, including consideration of (1) the effect of the change in the need score on targeting grants to communities with demonstrated need, (2) the effect of actions taken to target grants to applicants proposing to serve the designated special populations and sparsely populated and high-poverty areas, and (3) the transparency of the process to applicants, Congress, and the public. The Secretary should also direct the Administrator of HRSA to complete the evaluation before the next New Access Point funding opportunity is announced, make the results of the evaluation

publicly available, and incorporate any improvements identified into the award process for that funding opportunity.

Agency Comments

We provided a draft of this report to HHS for review, and HHS provided written and oral comments. (HHS's written comments are printed in app. III.) HHS agreed with our findings and recommendation. In its general comments, HHS restated and provided additional information on our discussion of the Health Center Program and the New Access Point grant process. HHS said that the increased score for need and use of extra points improved the agency's awarding of New Access Point grants in fiscal year 2011 by targeting resources to higher need communities and populations while still ensuring that organizations with sound health center service delivery plans were funded. HHS also noted that increased emphasis on collaboration contributed to health centers and other area providers maximizing available resources while enhancing the service delivery system to better address the community's primary health care needs. HHS said that these factors support HRSA's goal to expand the current safety net on a national basis by creating new delivery sites in areas not currently served by federally funded health centers. Regarding the GAO recommendation, HHS said HRSA is taking steps to evaluate the effects of the change in the need score and other actions taken to target grants, including for special populations. According to HHS, HRSA plans to use the findings from its evaluation to improve the New Access Point application guidance and will make its findings available to the public. In its oral comments, HHS suggested that the title of the draft report did not fully reflect the contents of the report, which provides a detailed discussion of the changes HRSA made to its fiscal year 2011 New Access Point grant award process, including increased weight given to need. We revised the report title to reflect this. HHS also provided technical comments, and we incorporated information from its general and technical comments as appropriate.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of HHS and the Administrator of HRSA. The report also will be available at no charge on the GAO website at http://www.gao.gov.

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

Debra A. Draper
Director, Health Care

Appendix I: New Access Point Grant Awards, Fiscal Years 2008-2011, and Total Health Center Grantees, 2010

Table 5 shows the distribution of New Access Point grants awarded to applicants in each state and territory in fiscal years 2008 through 2011. It also shows the number of grantees in each state and territory and the percentage of total grantees in each state and territory in 2010.

Table 5: New Access Point Grant Awards, Fiscal Years 2008-2011, and Number and Percentage of Total Health Center Grantees, 2010, by State and Territory

	New Access Point grant awards							
	Fiscal year 2008		Fiscal year 2009		Fiscal year 2011		Total health center grantees, 2010[a]	
State/Territory	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage
Alabama	0	0	3	2	2	3	14	1
Alaska	0	0	1	1	1	1	25	2
American Samoa	0	0	1	1	0	0	1	<1
Arizona	0	0	3	2	0	0	16	1
Arkansas	0	0	3	2	0	0	12	1
California	9	22	12	10	20	30	118	10
Colorado	2	5	1	1	2	3	15	1
Connecticut	1	2	4	3	1	1	13	1
Delaware	0	0	1	1	1	1	4	<1
District of Columbia	0	0	0	0	0	0	5	<1
Federated States of Micronesia	0	0	0	0	0	0	2	<1
Florida	5	12	8	6	2	3	44	4
Guam	0	0	0	0	0	0	1	<1
Georgia	1	2	4	3	0	0	27	2
Hawaii	0	0	0	0	0	0	14	1
Idaho	0	0	0	0	1	1	11	1
Illinois	2	5	4	3	2	3	36	3
Indiana	0	0	2	2	0	0	19	2
Iowa	0	0	1	1	0	0	13	1
Kansas	0	0	2	2	2	3	13	1
Kentucky	0	0	4	3	0	0	19	2
Louisiana	1	2	7	6	0	0	24	2
Maine	0	0	2	2	0	0	18	2
Marshall Islands	0	0	0	0	0	0	1	<1

	New Access Point grant awards							
	Fiscal year 2008		Fiscal year 2009		Fiscal year 2011		Total health center grantees, 2010[a]	
State/Territory	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage
Maryland	1	2	0	0	1	1	16	1
Massachusetts	0	0	1	1	0	0	36	3
Michigan	0	0	2	2	0	0	29	3
Minnesota	0	0	1	1	0	0	15	1
Mississippi	0	0	1	1	0	0	21	2
Missouri	0	0	2	2	1	1	21	2
Montana	1	2	1	1	0	0	15	1
Nebraska	1	2	0	0	0	0	6	1
Nevada	0	0	1	1	0	0	2	<1
New Hampshire	0	0	1	1	0	0	10	1
New Jersey	1	2	2	2	1	1	20	2
New Mexico	1	2	0	0	1	1	15	1
New York	3	7	6	5	8	12	51	5
North Carolina	1	2	2	2	2	3	27	2
North Dakota	0	0	0	0	0	0	4	<1
Northern Mariana Islands	0	0	0	0	0	0	0	0
Ohio	2	5	5	4	2	3	32	3
Oklahoma	1	2	6	5	0	0	17	2
Oregon	1	2	0	0	3	4	25	2
Palau	0	0	0	0	0	0	1	<1
Pennsylvania	0	0	6	5	2	3	35	3
Puerto Rico	0	0	2	2	2	3	19	2
Rhode Island	0	0	2	2	0	0	8	1
South Carolina	0	0	0	0	0	0	20	2
South Dakota	0	0	1	1	1	1	6	1
Tennessee	1	2	2	2	1	1	23	2
Texas	0	0	11	9	4	6	64	6
Utah	1	2	0	0	0	0	11	1
Vermont	1	2	1	1	0	0	8	1
Virgin Islands	0	0	0	0	0	0	2	<1
Virginia	2	5	5	4	0	0	25	2
Washington	2	5	1	1	4	6	25	2
West Virginia	0	0	1	1	0	0	28	2
Wisconsin	0	0	0	0	0	0	16	1

	New Access Point grant awards							
	Fiscal year 2008		Fiscal year 2009		Fiscal year 2011		Total health center grantees, 2010[a]	
State/Territory	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage
Wyoming	0	0	0	0	0	0	6	1
Total	**41**	**100**	**126**	**100**	**67**	**100**	**1124**	**100**

Source: GAO analysis of HRSA data.

Note: In this table, "state" refers to the 50 states, the District of Columbia, and Puerto Rico. Percentages do not total 100 due to rounding.

[a]The number of total health centers comes from HRSA's UDS. The most recently available UDS data were for calendar year 2010.

Appendix II: Ratio of Health Center Grantees to Population Living in Poverty, by State, 2010

We calculated the ratio of total health center grantees to the population living in poverty for every state, a measure of the availability of care for the medically underserved. We then ranked them in order from highest to lowest ratio. (See table 6.)

Table 6: Ratio of Health Center Grantees to Population Living in Poverty, by State, 2010

Ranking	State	Ratio of health centers to population living in poverty (per 100,000)
1	Alaska	38.91
2	Vermont	11.99
3	Wyoming	11.47
4	Hawaii	11.23
5	Maine	11.09
6	Montana	10.86
7	New Hampshire	10.05
8	West Virginia	9.02
9	Rhode Island	6.48
10	South Dakota	5.67
11	Massachusetts	5.47
12	Idaho	5.41
13	North Dakota	5.10
14	District of Columbia	4.91
15	Oregon	4.84
16	Delaware	4.26
17	New Mexico	4.15
18	Connecticut	4.14
19	Utah	3.88
20	Iowa[a]	3.84
21	Kansas[a]	3.84
22	Mississippi	3.48
23	Maryland	3.36
24	Washington	3.21
25	Virginia	3.20
26	Louisiana	3.08
27	Oklahoma	2.95
28	Nebraska	2.91
29	South Carolina	2.79

Ranking	State	Ratio of health centers to population living in poverty (per 100,000)
30	Minnesota	2.77
31	Missouri	2.62
32	Kentucky	2.58
33	Colorado[a]	2.57
34	New Jersey[a]	2.57
35	Wisconsin	2.51
36	California	2.40
37	Arkansas	2.39
38	Pennsylvania	2.32
39	Illinois[a]	2.29
40	Tennessee[a]	2.29
41	Indiana	2.26
42	Ohio	2.02
43	Michigan	2.01
44	North Carolina	1.93
45	New York	1.92
46	Georgia	1.87
47	Alabama	1.78
48	Florida	1.76
49	Arizona	1.71
50	Texas	1.61
51	Puerto Rico	1.13
52	Nevada	0.65

Source: GAO analysis of HRSA and U.S. Census Bureau American Community Survey (ACS) data.

Notes: In this table, “state” refers to the 50 states, the District of Columbia, and Puerto Rico. ACS poverty data were not available for the territories. The population living in poverty is that below 100 percent of the federal poverty level, using population estimates from the 2006-2010 ACS. The number of health centers is from HRSA’s UDS and was last updated with calendar year 2010 data.

[a]In cases where states had the same ratio, they are listed in alphabetical order.

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

DEPARTMENT OF HEALTH & HUMAN SERVICES — OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

APR 27 2012

Debra Draper
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. Draper:

Attached are comments on the U.S. Government Accountability Office's (GAO) correspondence entitled: "HEALTH CENTER PROGRAM: Revisions for 2011 Grant Award Process Emphasized Special Populations and Warrant Evaluation" (GAO-12-504).

The Department appreciates the opportunity to review this draft section of the report prior to publication.

Sincerely,

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT CORRESPONDENCE ENTITLED, "HEALTH CENTER PROGRAM: REVISIONS FOR 2011 GRANT AWARD PROCESS EMPHASIZED SPECIAL POPULATIONS AND WARRANT EVALUATION" (GAO-12-504)

The Department appreciates the opportunity to review and comment on this draft report.

HHS concurs with the general GAO findings and conclusions on the Health Resources and Services Administration's (HRSA) efforts to improve the Fiscal Year (FY) 2011 Health Center New Access Point application guidance, as well as our efforts to promote greater program collaboration among health centers and other health care providers. HHS also concurs with the GAO recommendation to evaluate the FY 2011 Health Center New Access Point grant award process to identify lessons learned and potential improvements for future funding cycles. Overall, with the respect to the GAO report, HHS offers the following observations:

Health Center Program:

For more than 45 years, health centers have delivered comprehensive, high-quality preventive and primary health care to patients regardless of their ability to pay. During that time, health centers have become the essential primary care medical home for millions of Americans including some of the nation's most vulnerable populations. As GAO's report outlines, today, more than 1,100 health centers operate over 8,500 service delivery sites that provide care to approximately 19.5 million patients in every State, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin.

This network of community health centers has created one of the largest safety net systems of primary and preventive care in the country with a true national impact. Health centers emphasize coordinated primary and preventive services or a "medical home" that promotes reductions in health disparities for low-income individuals, racial and ethnic minorities, rural communities and other underserved populations. Health centers place emphasis on the coordination and comprehensiveness of care, the ability to manage patients with multiple health care needs, and the use of key quality improvement practices, including health information technology and electronic health records. The health center model overcomes geographic, cultural, linguistic and other barriers through a team-based approach to care that includes physicians, nurse practitioners, physician assistants, nurses, dental providers, midwives, behavioral health care providers, social workers, health educators, and many others. Health centers also reduce costs to the health system; the health center model of care has been shown to reduce the use of costlier providers of care, such as emergency departments and hospitals.

New Access Points:

To support the expansion of the health center network into new medically underserved communities, HRSA primarily uses the Health Center New Access Point (NAP) funding opportunity. The NAP is a competitive Health Center Program funding opportunity to support a new service delivery site(s) for the provision of comprehensive primary and preventive health care services. NAP applicants may request Health Center Program funding to establish a single

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GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT CORRESPONDENCE ENTITLED, "HEALTH CENTER PROGRAM: REVISIONS FOR 2011 GRANT AWARD PROCESS EMPHASIZED SPECIAL POPULATIONS AND WARRANT EVALUATION" (GAO-12-504)

access point or multiple access points and may request funding to support one or multiple types of health centers within a single application based on the population(s) to be served.

Applications may be submitted from new organizations (new start applicants) or existing grantees to expand their network of service delivery sites to serve new underserved populations. Applicants must demonstrate a high level of need in their community/population; a sound proposal to meet this need by ensuring the availability and accessibility of essential primary and preventive health services, including oral health, mental health and substance abuse services; responsiveness to the health care environment; collaboration and coordination with other area health care providers; and readiness to rapidly implement the proposal.

HRSA must also assure that the NAP funding opportunity is consistent with all Health Center Program statutory and regulatory requirements, including: making aggregate awards to support the various types of health centers to ensure continued proportionate distribution of funds across the Health Center Program as set forth in section 330(r)(2)(B) of the PHS Act; urban/rural distribution to ensure that no more than 60 percent and no fewer than 40 percent of the people served come from either rural or urban areas; and special consideration of the unique needs of sparsely populated areas in making new awards. In addition, HRSA reviews Congressional Committee Report Language and feedback from previous applicants on how to improve the NAP application guidance each year.

As noted by GAO in its report, for FY 2011, HRSA made several key changes in its New Access Point application guidance, which included:

- **Need Criteria Scoring:** HRSA placed a greater emphasis on the need portion as part of the final application score. The need portion of the application accounted for 30 of the total 100 point application score (previously Need accounted for 10 points of the final application score). Up to 20 points could be received based on a quantitative presentation of need (e.g., percent below 200 percent of poverty, population to provider ratio, percent uninsured, distance/time to next available provider, as well as core health indicators in such key areas as: diabetes, cardiovascular disease, cancer, child health, and behavioral/oral health) and up to 10 additional points could be received based on a qualitative discussion of need.
- **Priority Points for High Poverty Areas**: HRSA added priority points for those applicants that demonstrated a significant portion of their target population was from a high poverty area to encourage the development of new health center sites in high poverty communities. Applicants could receive up to 5 additional points if the percent of the target population at or below 100 percent of poverty exceeded 30 percent in the entire service area to be served by the proposed NAP.
- **Priority Points for Special Populations:** In order to assure that applicants targeted and expanded services to Health Center Program special populations, HRSA awarded 5 to 10 priority points for applicants that demonstrated that 25 percent or more of the total Federal health center funds requested in the NAP applications were targeted to serve a special population(s). By awarding priority points, HRSA ensured that applicants developed the

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GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT CORRESPONDENCE ENTITLED, "HEALTH CENTER PROGRAM: REVISIONS FOR 2011 GRANT AWARD PROCESS EMPHASIZED SPECIAL POPULATIONS AND WARRANT EVALUATION" (GAO-12-504)

necessary service delivery systems to address the unique health care needs of these populations while also facilitating continued proportionate distribution of funds across the Health Center Program as set forth in section 330(r)(2)(B) of the PHS Act.

- **Priority Points for Sparsely Populated Areas:** Section 330 requires that HRSA consider the unique needs of sparsely populated areas in making new awards; therefore, HRSA added priority points for those applicants that demonstrated the NAP serves a sparsely populated rural area. Applicants could receive 5 additional points if the area to be served by the proposed NAP had 7 or less people per square mile.
- **Collaboration Criteria Scoring:** HRSA established a separate review criteria for program collaboration with up to 10 points assigned to collaborative and coordinated delivery systems for the provision of primary health care services. Applicants were expected to demonstrate actual or proposed partnerships and collaborative activities with other section 330 health centers and Federally Qualified Health Center (FQHC) Look-Alikes, rural health clinics (RHCs), critical access hospitals (CAHs), State and local health services delivery projects, and other programs serving the same population. As part of the NAP application, organizations were expected to provide documentation of formal and informal collaboration and coordination of services with other area providers through letters of commitment, contracts, memoranda of understanding or other materials. Further, applicants were expected to provide letters of support of their application from other area FQHCs, RHCs, CAHs, and other area providers.

The changes to the NAP funding guidance in FY 2011 have improved the awarding of Health Center New Access Points in several important ways. First, the increased score for need and priority points have benefited health center NAP applicants in the neediest communities by targeting resources to higher need communities and populations, while still ensuring that sound health center service delivery plans were funded. Second, the increased emphasis on collaboration ensured that health centers and other area providers are maximizing available resources while enhancing the service delivery system to better address the community's primary health care needs. These factors are also supporting HRSA's goal to expand the current safety net on a national basis by creating new access points in areas not currently served by federally funded health centers.

Outcomes of FY 2011 NAP Funding Opportunity:

The full impact of the changes outlined above and in the report was not realized due to the reduction of approximately $600 million in the Health Center Program appropriation for FY 2011. When the FY 2011 NAP funding opportunity was announced, HRSA anticipated $250 million would be available for the NAP competition. As a consequence of the reduction, HRSA was only able to award $28.8 million in grants to 67 of the 810 applications received with FY 2011 funding rather than the original 350 projected awards.

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GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT CORRESPONDENCE ENTITLED, "HEALTH CENTER PROGRAM: REVISIONS FOR 2011 GRANT AWARD PROCESS EMPHASIZED SPECIAL POPULATIONS AND WARRANT EVALUATION" (GAO-12-504)

However, as indicated in the report, if the original $250 million would have been available to fund NAP applications as anticipated, the full impact of the changes in the application guidance would have been realized, and HRSA would have achieved a broader geographic distribution of health center new service delivery sites into high need, medically underserved communities across the country.

GAO Recommendation:

With respect to the GAO recommendation for HRSA to evaluate the FY 2011 New Access Point grant award process to identify lessons learned and potential improvements for future funding cycles, HRSA concurs. HRSA has already undertaken steps to conduct a review of the funding opportunity process and results.

1. HRSA's evaluation is considering the effect of the change in need score methodology on targeting grants to communities with demonstrated need. As Table 4 of GAO's report illustrates, NAP communities have higher poverty, unemployment, uninsured and Medicaid rates than the national average. However, HRSA's review is utilizing more specific geographic identifiers (i.e., ZIP codes) than counties to calculate NAP service area data, which will likely serve to illustrate an even greater disparity in key socioeconomic characteristics between NAP service areas and national data, compared to the GAO findings based on county-level data.
2. HRSA's evaluation is considering the effect of the actions taken to target grants to applicants proposing to serve the designated special populations, sparsely populated areas, and high poverty areas, including the use of priority points and special considerations.
3. HRSA will ensure that future funding opportunity guidance contains clear information on the application, review and selection process, to ensure the process is transparent to applicants and general public.

HRSA plans to utilize the findings of its review to make additional improvements to the NAP application guidance. HRSA will make its evaluation findings available to GAO and the public.

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Appendix IV: GAO Contact and Staff Acknowledgments

GAO Contact

Debra A. Draper, (202) 512-7114 or draperd@gao.gov

Acknowledgments

In addition to the contact named above, Helene F. Toiv, Assistant Director; Giselle Hicks; Coy J. Nesbitt; Roseanne Price; Julie T. Stewart; E. Jane Whipple; Jennifer Whitworth; and Monique Williams made key contributions to this report.

Related GAO Products

Health Center Program: Improved Oversight Needed to Ensure Grantee Compliance with Requirements. GAO-12-546. Washington, D.C.: May 29, 2012.

Hospital Emergency Departments: Health Center Strategies That May Help Reduce Their Use. GAO-11-643T. Washington, D.C.: May 11, 2011.

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Health Resources and Services Administration: Many Underserved Areas Lack a Health Center Site, and Data Are Needed on Service Provision at Sites. GAO-09-667T. Washington, D.C.: April 30, 2009.

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