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Report to Congressional Requesters

May 2012

HEALTH CENTER PROGRAM

Improved Oversight Needed to Ensure Grantee Compliance with Requirements

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GAO-12-546

May 2012

HEALTH CENTER PROGRAM

Improved Oversight Needed to Ensure Grantee Compliance with Requirements

GAO Accountability * Integrity * Reliability

Highlights

Highlights of GAO-12-546, a report to congressional requesters

Why GAO Did This Study

Under the Health Center Program, HRSA provides grants to eligible health centers. HRSA is responsible for overseeing over 1,100 health center grantees to ensure their compliance with Health Center Program requirements. GAO was asked to examine HRSA's oversight. This report (1) describes HRSA's oversight process and (2) assesses the extent to which the process identifies and addresses noncompliance with what HRSA refers to as the 19 key program requirements. GAO reviewed and analyzed HRSA's policies and procedures and available programwide data related to HRSA's oversight of health centers, interviewed HRSA officials, and reviewed documentation of HRSA's oversight from 8 selected grantees that varied in their compliance experience, as well as other factors.

What GAO Recommends

GAO recommends that, among other things, HRSA improve its documentation of compliance decisions, strengthen its ability to consistently identify and cite grantee noncompliance, and periodically assess whether its new process for addressing grantee noncompliance is working as intended. HHS concurred with all of GAO's recommendations, and stated that HRSA has already begun implementing many of them. HHS, however, did not concur with what it characterized as certain conclusions drawn from the findings. HHS based its comments on only some of the evidence. GAO's analysis of all the evidence and HRSA's planned implementation of the recommendations confirm the validity of the findings and conclusions.

View GAO-12-546. 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) relies on three main methods to oversee grantees' compliance with the 19 key program requirements.

- Annual compliance reviews. HRSA project officers review available information, including that submitted by grantees, to determine whether the grantee is in compliance with each of the 19 program requirements.
- Site visits. HRSA and its consultants visit grantees to review documentation, meet with officials, and tour the health center. Some of these visits are intended to assess compliance with some or all program requirements.
- Routine communications. Project officers communicate with grantees via phone and e-mail to learn about issues that may affect their compliance.

When HRSA identifies noncompliance with program requirements, it uses a process, implemented in April 2010, to address this with a grantee. This process provides a grantee with defined time frames for addressing any identified noncompliance. If a grantee is unable to correct the compliance issue by the end of the process, HRSA's policy is to terminate the health center's grant.

HRSA's ability to identify grantees' noncompliance with Health Center Program requirements is insufficient.

- HRSA does not require project officers to document their basis for determining that a grantee is in compliance with a requirement. When project officers are uncertain about compliance, HRSA instructs them to consider a grantee in compliance and to note the lack of certainty in a text field of their evaluation tool. However, HRSA has no centralized mechanism to ensure this occurs. Thus, it is unclear whether project officers' decisions that a grantee is in compliance with a requirement are because there was sufficient evidence demonstrating compliance or the project officer failed to document that compliance was uncertain.
- The number of compliance-related visits conducted may be limited. HRSA's available data indicates that only 11 percent of grantees had a compliance-related site visit from January through October 2011; less than half of which had a visit that assessed compliance with all 19 program requirements.
- HRSA's project officers do not consistently identify and document grantee noncompliance. Project officers GAO interviewed had different interpretations of what constitutes compliance with some program requirements and therefore when they should cite a grantee for noncompliance.

HRSA's process for addressing grantee noncompliance with program requirements seems to provide both the agency and grantees with a uniform structure for addressing noncompliance. However, the extent to which this process is adequately resolving grantee noncompliance or terminating grantee funding is unclear because HRSA's experience with this process is too recent for GAO to make an overall assessment.

Contents

Figures

Abbreviations

BPHC	Bureau of Primary Health Care
HHS	Department of Health and Human Services
HRSA	Health Resources and Services Administration
PPACA	Patient Protection and Affordable Care Act
UDS	uniform data system

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Accountability * Integrity * Reliability

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, people who are uninsured, and others who may have difficulty obtaining access to health care. To fulfill the Health Center Program's mission of providing comprehensive, quality primary health care services for the medically underserved, the Department of Health and Human Services' (HHS) Health Resources and Services Administration (HRSA) provides grants to eligible health centers under Section 330 of the Public Health Service Act.[1] These grants are an important part of successful health center operations and viability. In 2010, Health Center Program grants helped fund more than 1,100 health center grantees that provided services at more than 8,100 health care delivery sites and served nearly 19.5 million people—72 percent of whom had income at or below the federal poverty level. These grants made up over 20 percent of all health center grantees' revenues in 2010.

[1] 42 U.S.C. § 254b.

To continue receiving program funds, health center grantees must comply with a number of requirements. For example, HRSA identified what it refers to as the 19 key program requirements, which the agency indicated are based on requirements outlined in the Public Health Service Act and regulations.[2] HRSA groups these 19 program requirements into four broad categories: patient need, the provision of services, management and finance, and governance. For example, the provision of services category includes requirements for health center grantees to provide comprehensive primary health care services, including preventive, diagnostic, treatment, and emergency services; provide professional coverage after normal business hours; and have a system for adjusting fees based on a patient's ability to pay. Project officers in HRSA's Bureau of Primary Health Care (BPHC) are primarily responsible for overseeing health center grantees to ensure their compliance with the Health Center Program requirements.

Funding for the Health Center Program has increased substantially during the past decade. The Health Center Program's annual funding more than doubled from approximately $1.3 billion to about $2.8 billion, from fiscal year 2002 through fiscal year 2012. This funding includes the amount of program funds HRSA allocated from its annual appropriations during the period, as well as amounts the agency received through other legislation.[3] Specifically, the program's fiscal year 2009 funding included $2 billion that HRSA received through the American Recovery and Reinvestment Act of 2009,[4] and its fiscal years 2011 and 2012 funding included a total of $2.2 billion HRSA received through the Patient Protection and Affordable

[2]The 19 key program requirements are among those that HRSA reviews as part of its oversight of health center grantees. In this report, we refer to the 19 key program requirements as either the 19 program requirements or Health Center Program requirements. There are other requirements for health center grantees, including periodic reporting requirements to HRSA, which are outside the scope of our work.

[3]HRSA allocates funds to the Health Center Program out of the annual appropriations made to the agency for its programs. Annual appropriations allocated to the Health Center Program increased between fiscal year 2002 and 2010. However, in fiscal year 2011, Health Center Program funding was reduced by 27 percent (or $604 million) as a result of a reduction to HRSA appropriations and a rescission of appropriations made for that year for non-defense programs. HRSA allocated $1.6 billion of its fiscal year 2012 appropriation to the Health Center Program.

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

Care Act (PPACA).[5] Furthermore, for fiscal years 2013 through 2015, PPACA appropriated an additional $7.3 billion to HRSA to provide grants for the operation and expansion of health centers.[6] As a result, health center capacity is expected to expand over the next several years.

Given the past and expected increases in program funding, you asked us to examine HRSA's oversight of health center grantees. In this report, we (1) describe the process HRSA uses to oversee grantee compliance with Health Center Program requirements, and (2) assess the extent to which HRSA's process identifies and addresses noncompliance with these program requirements.

To describe the process HRSA uses to oversee compliance with the Health Center Program requirements, we reviewed key documents related to HRSA's oversight process. These documents included regulations governing the Health Center Program, HRSA's standard operating procedures for monitoring and assessing grantees' compliance, and guidance that HRSA provides to its project officers and grantees regarding compliance with the 19 program requirements. We also interviewed knowledgeable HRSA officials about the agency's oversight process, as well as any significant changes to this process over the past several years.

To assess the extent to which HRSA's process identifies and addresses noncompliance with Health Center Program requirements, we reviewed and analyzed HRSA's standard operating procedures, and the tools and guidance HRSA provides to project officers related to its oversight process. We also discussed the oversight process with cognizant HRSA officials. To gain a more in-depth understanding of the extent to which HRSA's process identifies and addresses noncompliance, we also reviewed and analyzed HRSA's oversight of eight selected health center grantees. The grantees were selected to provide variation in: size, as determined by the number of delivery sites; length of time as a Health Center Program grantee; and the number of findings of noncompliance—

[5]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 Education and Reconciliation Act of 2010.

[6]PPACA also appropriated $1.5 billion for the construction and renovation of health centers for fiscal years 2011 through 2015.

referred to as conditions—that HRSA had cited for each grantee that were unresolved as of July 11, 2011.[7] (See app. I for additional information about the grantees we selected.) We also selected the eight grantees to ensure that each of the eight had a different HRSA project officer and was located in a different state. For each of the selected grantees, we reviewed documentation of HRSA's oversight activities; including documentation of the most recently completed assessment of the grantees' compliance with the 19 program requirements. During our review, we identified whether HRSA staff were following the agency's procedures for identifying and addressing noncompliance, and whether the process was consistent with internal control standards for the federal government.[8] For part of our review, we focused on HRSA's oversight of the eight selected grantees' compliance with 6 of the 19 program requirements; we judgmentally selected 2 requirements from each of the provision of services, management and finance, and governance categories.[9] Some of the selected requirements pertain to how health center grantees operate, such as the requirement that grantees provide sliding discounts to patients based on their ability to pay (known as the "sliding fee discounts" requirement), and the requirement that a health center grantee has a governing board, the majority of whose members are patients of the health center (board composition).[10] Other requirements we selected are important because compliance with them helps to ensure the financial viability of health center grantees, such as the requirement that grantees implement systems to maximize revenue collections to cover the costs of providing services (billing and collections). The remaining 3 requirements we selected for review were those requiring grantees to: provide professional coverage, such as access to a physician, for patients after normal health center hours (after

[7]We looked at the number of documented compliance issues that grantees had as of July 11, 2011, which were still unresolved more than 90 days after HRSA notified the grantee about the area of noncompliance.

[8]See GAO, *Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: Nov. 1999).

[9]We did not review requirements from the fourth category—patient need. For information on actions HRSA has recently taken to target grants to health centers in communities with demonstrated need see *GAO, Health Center Program: 2011 Grant Award Process Highlighted Need and Special Populations and Merits Evaluation*, GAO-12-504 (Washington, D.C.: May 29, 2012).

[10]HRSA may waive the board composition requirement for certain centers upon a showing of good cause. 42 U.S.C. § 254b(k)(3)(H).

hours coverage); possess sufficient management expertise to run the health center (key management staff); and have a policy to prevent conflicts of interest (conflict of interest). Additionally, we interviewed the relevant HRSA project officers and their supervisors, known as branch chiefs, about the criteria they used to assess whether grantees were in compliance with the 6 selected program requirements. Collectively, these project officers and branch chiefs were responsible for overseeing or supervising the oversight of almost 500 grantees.

We also assessed the extent to which HRSA's process identifies and addresses noncompliance with the 19 program requirements by reviewing and analyzing programwide data HRSA had available on its use of site visits to health center grantees and the conditions issued to grantees for noncompliance with these requirements. We obtained and analyzed HRSA's data on site visits—on-site assessments of grantees' performance in providing services to patients or compliance with Health Center Program requirements—conducted between January 1, 2011, and October 27, 2011, and determined the frequency with which visits were conducted over this period.[11] In addition, we analyzed programwide data on noncompliance issues HRSA cited from April 9, 2010, through October 7, 2011, and determined, among other things, the number and types of issues, and proportion of grantees cited for noncompliance.[12] We discussed both the site visit and noncompliance data with knowledgeable HRSA officials and reviewed the data for accuracy and consistency. We found a number of anomalies with the site visit data, including that certain data fields could not be updated for changes, and concluded that the data were of an undetermined reliability. We determined that the noncompliance data were sufficiently reliable for the purposes of our review.

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

[11]HRSA did not have readily accessible, comprehensive data on site visits conducted prior to 2011.

[12]At the time of our data request, this represented the most recent data available. In addition, the time period of the data reviewed corresponded with the time that HRSA's current process for addressing noncompliance had been implemented.

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 Center Program grantees are private, nonprofit community-based organizations or, less commonly, public organizations such as public health department clinics. Health centers funded through HRSA's Health Center Program are typically managed by an executive director, a financial officer, and a clinical director, and provide comprehensive primary care services including enabling services, such as translation and transportation, that help facilitate access to health care.

HRSA's Health Center Program

HRSA identified 19 program requirements, which it indicated were based on Section 330 of the Public Health Service Act and regulations, which health center grantees must meet to continue receiving grant funding. HRSA groups these 19 program requirements into four broad categories: patient need, the provision of services, management and finance, and governance. Table 1 provides a summary of the 19 requirements.

Table 1: Summary of HRSA's 19 Key Health Center Program Requirements

Requirement	Description of requirement
Patient need	
Needs assessment	Health center demonstrates and documents the needs of its target population.
Provision of services	
Required and additional services	Health center provides (either directly or through established referral arrangements) all required primary, preventive, and enabling health services, and additional health services as appropriate and necessary.
Staffing requirement	Health center maintains a core staff necessary to carry out all required, and additional services, either directly or through referral arrangements; the staff must be appropriately credentialed and licensed.
Accessible hours of operation/locations	Health center provides services at times and locations that ensure accessibility, and meets the needs of population served.
After hours coverage	Health center provides professional coverage during hours when the center is closed.
Hospital admitting privileges and continuum of care	Health center physicians have admitting privileges at one or more referral hospitals, or other arrangements to ensure continuity of care.
Sliding fee discounts	Health center has a system to determine eligibility for patient discounts adjusted on the basis of a patient's ability to pay. The system must provide a full discount to individuals with incomes at or below the federal poverty level, and a sliding level of discount to those with incomes up to twice the federal poverty level. No discounts may be provided to individuals with incomes over 200 percent of the federal poverty level.
Quality improvement/assurance plan	Health center has an ongoing quality improvement/assurance program that includes clinical services and management, and that maintains the confidentiality of patient records.
Management and finance	
Key management staff	Health center maintains a fully staffed management team.
Contractual/affiliation agreements	Health center exercises appropriate oversight and authority over all contracted services, including ensuring that the entities it contracts with meet Health Center Program requirements.
Collaborative relationships	Health center makes effort to establish and maintain collaborative relationships with other providers in its service area.
Financial management and control policies	Health center maintains accounting and internal controls systems. Health center ensures that an annual independent financial audit is performed in accordance with federal audit requirements.
Billing and collections	Health center has systems to maximize collections and reimbursements for its costs of providing health services.
Budget	Health center has developed a budget that reflects the costs of operations, expenses, and revenues.
Program data reporting systems	Health center has systems that accurately collect and organize data for program reporting.
Scope of project	Health center is providing the scope of services covered by its grant, including any increases in the scope based on recent grant awards.

Requirement	Description of requirement
Governance	
Board authority	Health center governing board maintains appropriate authority to oversee the operations of the center.
Board composition	The health center has a governing board of between 9 and 25 members. A majority of the governing board members are patients of the center and they represent the individuals served by the center in terms of demographic factors such as race, ethnicity, and sex. The non-consumer members of the board must be representative of the community, and no more than half of them may derive more than 10 percent of their annual income from the health care industry.
Conflict-of-interest policy	Health center bylaws or written governing board approved policy includes provisions prohibiting conflicts of interest by board members, employees, consultants and those who furnish goods or services to the health center. No board member shall be an employee of the health center or an immediate family member of an employee.

Source: GAO analysis of information from HRSA.

HRSA uses a competitive process to award Health Center Program grants. This process applies both to health centers receiving a grant for the first time—known as new starts—and to existing health center grantees that must compete periodically for grants. In either case, prospective or existing grantees are required to submit the applicable grant application to HRSA, and if approved, receive grants to provide services to individuals located in a specified area, known as their service area.

HRSA approves funding for health centers for a specified time period, known as a project period. Currently, HRSA approves new start grantees funding for a 2-year project period, and existing grantees funding for project periods of 1, 3, or 5 years. The length of the project period for existing grantees is determined, in part, based on how well grantees are complying with the 19 program requirements. Each year of a project period is referred to as a budget period. After the competitive award of a grant for the first year, or budget period, HRSA awards noncompetitive continuation grants for each remaining budget period if funds are available, and the grantee demonstrates satisfactory progress in providing its services. A grantee demonstrates satisfactory progress by submitting a budget period progress report for HRSA's review. In both the competitive grant application and the budget period progress report, a grantee is, among other things, required to describe the services offered, provide a listing of its key management staff, and include a detailed narrative description of the current status and any changes in its operations related to the 19 program requirements.

In addition to maintaining compliance with the 19 program requirements and submitting annual budget period progress reports, health center grantees are required to periodically submit other information to HRSA. For example, grantees are required to submit to HRSA an annual independent financial audit in accordance with federal audit requirements. In addition, in the first quarter of every year, grantees must submit a variety of information to HRSA's Uniform Data System (UDS); UDS tracks a variety of information on Health Center Program grantees, including information on their patient demographics (e.g., race/ethnicity, insurance status, income level); revenues; expenses; quality of care measures; and health center staffing and patient utilization patterns.

HRSA's Bureau of Primary Health Care

HRSA's BPHC has primary responsibility for overseeing health center grantees' compliance with program requirements.[13] This includes monitoring grantees to determine if they are in compliance with the 19 program requirements and addressing cases of grantee noncompliance. BPHC has four operating divisions, each containing five branches; the branches correspond to specified geographic locations. Within each branch there are project officers who are responsible for the ongoing oversight of an assigned portfolio of grantees. As of March 2012, HRSA had 111 project officers, whose portfolios ranged from 4 to 17 health center grantees; the average portfolio size was 10 grantees per project officer. Each project officer reports to a supervisor, known as a branch chief. HRSA project officers use an on-line electronic system, called the Electronic Handbook, to document their oversight activities, as well as correspond with and exchange documents with health center grantees. The system contains several different modules within which project officers record such information.

To help them conduct their oversight, project officers have a variety of internal and external resources. For example, officials from the BPHC's Office of Policy and Program Development can assist project officers in interpreting program guidance and Health Center Program requirements. In addition, project officers have access to consultants through an over $30-million, 4-year contract with Management Solutions Consulting Group, a nationwide management consulting firm that provides HRSA

[13]HRSA's Office of Federal Assistance Management is responsible for awarding and administering the grant.

access to approximately 300 to 350 consultants. The consultants are to provide a range of services, including conducting site visits and helping assess the results of health center grantees' annual financial audits.

HRSA Uses Three Main Methods to Oversee Grantee Compliance and Has a Process to Address Noncompliance

HRSA primarily relies on three main methods to oversee grantees' compliance with Health Center Program requirements: annual compliance reviews, site visits, and routine communications. Additionally, when HRSA identifies noncompliance with these requirements, the agency has a recently revised process to address this with its grantees.

HRSA Primarily Relies on Annual Compliance Reviews, Site Visits, and Routine Communications to Oversee Grantees

HRSA relies on three main methods to oversee grantees' compliance with Health Center program requirements.

Annual Compliance Reviews

To oversee health center grantees' compliance with the 19 program requirements, HRSA requires project officers to conduct an annual compliance review for each of the grantees in their assigned portfolios. During this review, project officers are responsible for determining whether a health center grantee is in compliance with each of the 19 program requirements. The annual compliance review process begins when a health center grantee submits an application for a competitive grant or submits a budget period progress report to HRSA. When conducting a compliance review, HRSA project officers are responsible for reviewing information contained in the grantee's submission, such as information on the grantee's policies and a narrative explaining how the grantee believes it meets, or plans to meet, the 19 program requirements. HRSA also expects project officers to review other available information about the grantee, such as results from the grantee's annual financial audit and UDS information. Project officers generally have the option to contact the grantee during their annual review if they need clarification

about the information in a grantee's application or budget period progress report.[14]

HRSA provides guidance to project officers for determining whether grantees are meeting each of the 19 program requirements. In particular, HRSA provides project officers with a list of key factors and questions related to the 19 program requirements to consider when making their assessment of compliance. Table 2 includes examples of the factors and questions provided to project officers for the 6 program requirements we selected for more in-depth review.

[14]According to HRSA's policy, project officers are not allowed to contact grantees for additional information when reviewing a competitive grant application in which more than one organization has submitted an application for the same service area.

Table 2: Examples of HRSA Guidance to Project Officers for Assessing Compliance with Six Selected Program Requirements

Requirement	Examples of key factors and questions project officers should consider when assessing compliance
After hours coverage	Key Factors: • At a minimum, the grantee should ensure telephone access to a clinician who can exercise professional judgment in assessing a patient's need for emergency medical care and who can refer patients to an appropriate location for such care, including emergency rooms, when warranted. • Grantee should have an established mechanism for patients needing care to be seen after hours in an appropriate location and ensure that health center clinicians conduct timely follow up with patients seen after hours.
Sliding fee discounts	Key Factors: • Grantee should have a fee schedule that provides varying levels of discounts on charges to patients with incomes between 101 and 200 percent of the federal poverty level. • No fee or only a nominal fee that would not be a major barrier to care should be charged to patients with incomes at or below the federal poverty level. • No discount should be provided to patients with incomes above 200 percent of the federal poverty level. • Fee schedule must be based on the most recent federal poverty level guidelines.
Key management staff	Key Factors: • Grantee should maintain a fully staffed management team that is appropriate for the size and needs of the health center. Key Questions: • Does the grantee have a Chief Executive Officer, Executive Director, or Project Director? • Does the management team include other key management staff as appropriate, such as a Chief Financial Officer, Chief Operating Officer, Clinical Director, or Chief Information Officer? • Is the management team fully staffed, with each of the listed positions filled as appropriate?
Billing and collections	Key Factors: • Grantee should maintain documented billing and collections policies and procedures. • Grantee must have the ability to bill Medicaid and Medicare.
Board composition	Key Questions: • Do a majority of board members (at least 51 percent) receive services (i.e. are patients) of the health center? • Do the patient board members reasonably represent—in terms of race, ethnicity and sex—the individuals who are served by the health center? • Does the board have between 9 and 25 members? • Is the size of the board appropriate for the complexity of the health center and diversity of the community served? • Does the board include at least one member with expertise in a variety of fields, such as finance and banking or legal affairs? • Do less than half of the non-consumer board members receive over 10 percent of their annual income from the health care industry?

Requirement	Examples of key factors and questions project officers should consider when assessing compliance

Conflict-of-interest policy	Key Questions:
	• Do the grantee's bylaws or other policy documents include a conflict-of-interest provision(s)?
	• Does the grantee's conflict-of-interest policy address issues such as:
	  • Disclosure of relationships that create actual or potential conflict of interests;
	  • Extent to which board members can participate in decisions where the member has a personal or financial interest;
	  • Using board members to provide services to the health center;
	  • Board member expense reimbursement policies;
	  • Acceptance of gifts and gratuity;
	  • Personal political activities of members; and
	  • Statement of consequences for violating the conflict-of-interest policy?

Source: GAO analysis of Information from HRSA.

To conduct and document their compliance review, project officers use an electronic evaluation tool that is contained in the Electronic Handbook. The evaluation tool lists each of the 19 program requirements, and, among other things, asks project officers to indicate whether the grantee is in or out of compliance.[15] If after reviewing available information, the project officer remains uncertain whether or not the grantee has demonstrated compliance with a requirement, then, according to HRSA's guidance, the project officer should indicate that the grantee is in compliance until noncompliance is clearly determined. In such cases, HRSA's guidance instructs project officers to document their concerns about compliance by writing a comment in a text field of the evaluation tool. In addition, as part of the review, a project officer may decide to designate a performance improvement area.[16] According to HRSA, performance improvement areas are actions or other measures that project officers recommend to help grantees improve their delivery of services and, ultimately, patient outcomes. Performance improvement areas are intended to promote continuous improvement for grantees above and beyond compliance with the 19 program requirements; they are not intended to address findings of noncompliance with these requirements. Once project officers complete their review, branch chiefs are responsible for reviewing and approving project officers'

[15]HRSA refers to this evaluation tool as the Program Analysis and Recommendations.

[16]During annual reviews, project officers must identify at least one clinical measure and one financial performance measure as a performance improvement area for each grantee. Performance improvement areas are optional for all other aspects of the program.

assessments, including their determinations regarding compliance and the identification of performance improvement areas. According to HRSA officials, branch chiefs are responsible for providing leadership and guidance in areas such as program evaluation and monitoring, which establishes an important quality control for the annual compliance reviews.

While HRSA has conducted annual reviews of grantees' compliance for several years, the process for conducting these reviews has changed. To improve their oversight process, in 2008 HRSA officials revised the annual compliance evaluation tool to link the annual compliance reviews to each of the Health Center Program requirements. As a result of this change, project officers now make an assessment of whether grantees are in compliance with each requirement, rather than just an overall assessment of compliance. In addition, HRSA officials indicated that they continually assess the annual review process, and have recently made changes such as requiring grantees to submit more detailed narrative descriptions and an updated sliding fee discount schedule for the fiscal year 2012 reviews.

Site Visits

HRSA also relies on site visits, which it refers to as onsite technical assistance, as a method to oversee health center grantees' compliance with the Health Center Program requirements. According to HRSA, there are seven types of site visits, some of which are designed specifically to assess compliance and others which are focused on providing a grantee with technical assistance or training to improve its performance. Two of the seven types of site visits—new start initial and operational assessment visits—are intended to review compliance with all 19 program requirements. In addition, three other types of visits—new start follow-up, operational follow-up, and diagnostic assessment visits—may involve an assessment of compliance with some, but not all, of the 19 program requirements. The remaining two types of visits—targeted technical assistance and routine project officer visits—are not intended to assess compliance.[17] (See table 3 for information on the seven types of site visits.)

[17]HRSA officials indicated that although not intended to assess compliance, it is possible that information obtained during a targeted technical assistance or routine project officer visit could raise questions about grantees' compliance.

Table 3: Types of HRSA Site Visits Conducted for the Health Center Program

Type of visit	Purpose	Frequency of visit	Duration of visit
Site visit types intended to assess compliance with all 19 program requirements			
New start initial	To assess new start grantees' compliance with the 19 program requirements and provide technical assistance	Generally occurs 90 to 120 days after initial funding is awarded	3 days
Operational assessment	To assess existing health center grantees' compliance with the 19 program requirements	Occurs as needed	3 days
Site visit types that may include an assessment of compliance with some of the 19 program requirements			
New start follow-up	To monitor new start grantees' progress in addressing prior site visit findings and provide additional technical assistance	Generally occurs 120 to 180 days after the new start initial visit	Varies based on grantee needs
Operational follow-up	To monitor existing health center grantees' progress in addressing prior site visit findings and provide additional technical assistance	Occurs as needed	Varies based on grantee needs
Diagnostic assessment	To perform an in-depth assessment of an aspect of health center grantees' operation or compliance	Occurs as needed	2 to 3 days
Site visit types not intended to assess compliance with the 19 program requirements			
Targeted technical assistance	To provide technical assistance in specified area(s) to help health center grantees improve performance	Occurs as needed	Varies based on grantee needs
Routine project officer	To provide a general overview of health center grantees' operations and performance	Occurs as needed, with a goal of once per project period	1 day

Source: GAO analysis of HRSA's standard operating procedures.

According to HRSA's procedures, project officers attend new start initial and routine project officer site visits; however, they are not required to participate in the other types of visits. Rather, HRSA primarily relies on its consultants—who have financial, management, and clinical expertise—to conduct many of the site visits, including those that involve assessing whether a grantee is in compliance with Health Center Program requirements. As part of compliance-related site visits, consultants are responsible for reviewing documentation, meeting with health center officials, and touring some or all of the grantee's health care delivery sites. For example, HRSA officials indicated that consultants may review key operating policies and procedures, and review a sample of billing records to test the grantee's system for providing sliding fee discounts to patients. Additionally, according to HRSA officials, the consultants may check to see whether the grantee has posted signage in the patient

waiting areas regarding its provision of after hours coverage, and may call the health center when it is closed to test its provisions for providing this coverage. HRSA officials indicated that compliance-related site visits, such as an operational assessment, are critical tools for assessing a health center grantee's compliance with Health Center Program requirements and verifying that the policies and documentation submitted by health center grantees are appropriately implemented.

After a site visit is completed, the consultant and project officer—if one attends—are responsible for preparing separate reports documenting their findings. The consultant's report—which is first provided to HRSA for review and then transmitted to the grantee for comment—is used to document, among other things, any areas of noncompliance that the consultant identified during the site visit and, if necessary, information on steps the grantee can take to come into compliance with requirements or improve its performance. When project officers participate in any type of site visit, HRSA requires them to prepare a separate, brief internal report to document their observations from the visit and inform the branch chiefs and other HRSA officials about any major findings, recommendations, or concerns.

HRSA's current approach for conducting site visits has been in place since 2010. Prior to that time, many of the site visits were performed by a different HRSA office, the Office of Performance Review, which focused on assessing the overall performance of HRSA grantees. According to HRSA officials, the transition of site visit responsibility to BPHC has resulted in placing a greater emphasis on assessing compliance with Health Center Program requirements during site visits.

Routine Communications

HRSA project officers also use routine communications to oversee health center grantees' compliance with the 19 program requirements. Routine communications consist of regular e-mail correspondence and, according to HRSA policy, at a minimum, quarterly phone calls between project officers and health center grantees. During these communications, project officers may learn about significant changes that might affect a grantee's compliance with the 19 program requirements. For example, HRSA officials indicated that during a quarterly phone call a grantee may inform the project officer that its CEO position is vacant, which would place the grantee out of compliance with the key management staff requirement that it maintain a fully staffed management team appropriate for the size and needs of the health center. Project officers are required to document their communications with grantees in HRSA's Electronic Handbook.

HRSA's Process to Address Grantee Noncompliance Recently Changed

In April 2010, HRSA implemented a uniform process intended to standardize how the agency works with grantees to address noncompliance with Health Center Program requirements. This process, referred to as the progressive action process, begins when HRSA documents an area of noncompliance by placing what it refers to as a "condition" on the health center's grant.[18] Through this process a grantee is provided with a "progressive" series of time frames within which it must address the noncompliance.[19]

When HRSA places a condition(s) of noncompliance on a grant, it alerts the health center grantee by sending a notice specifying for which of the 19 program requirement(s) the grantee is noncompliant, the nature of corrective action required, time frames for achieving compliance, and the consequences if the grantee fails to achieve and document compliance. HRSA then provides grantees a series of sequential phases to resolve the condition(s) by demonstrating compliance, with each phase providing the grantee with less time than the prior phase. Specifically, the progressive action process consists of the following three phases. Phase 1 provides the grantee with 90 days to submit documentation demonstrating that it has complied with, or developed an action plan to comply with, the specified program requirement(s). Phase 2 provides an additional 60 days, and phase 3 another 30 days, for grantees to submit the appropriate documentation. If the nature of the condition of noncompliance requires the grantee to develop and implement a plan for achieving compliance, then the grantee is provided additional implementation phases—the first of which is 120 days in length—to implement its plan and document compliance with the specified program

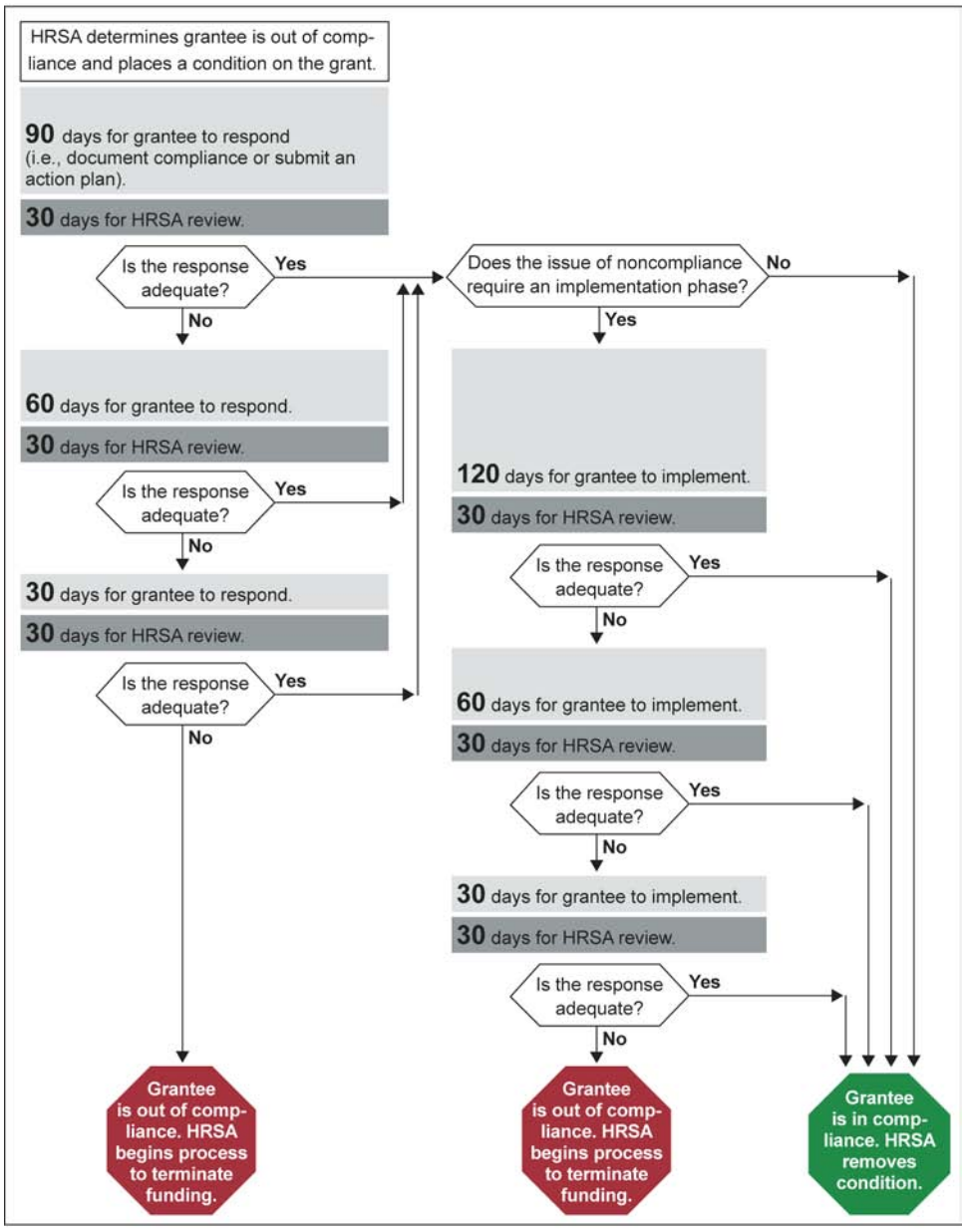
[18]HRSA uses conditions to address specific findings of noncompliance; these are different than performance improvement areas, which are intended to help promote continuous improvement for grantees above and beyond compliance with the 19 program requirements.

[19]Prior to April 2010, HRSA did not have a uniform series of time frames in which grantees were required to address noncompliance.

requirement(s).[20] In between each phase, HRSA provides itself with 30 days to review the grantee's response and determine whether or not the response is acceptable. (See fig. 1 for an illustration of the progressive action process.)

[20]HRSA has a list of conditions that it utilizes for issues of noncompliance with the 19 program requirements; some of the program requirements have multiple associated conditions each of which is related to a different component of the requirement. Over half of these conditions—approximately 60 percent—provide the grantee with additional implementation phases.

Figure 1: HRSA's Process for Addressing Health Center Grantee Noncompliance



Source: GAO analysis of information from HRSA.

Note: Once HRSA places a condition of noncompliance on a grant, it provides health center grantees a series of sequential phases to resolve the condition by demonstrating compliance. Depending on the issue of noncompliance, the initial phases of the process will either require the grantee to submit documentation demonstrating compliance with the program requirement or submit an action plan demonstrating how the grantee plans to come into compliance. For the latter, the grantee is provided additional time to implement its action plan, i.e., implementation phases. Between each phase, HRSA provides itself with 30 days to review the grantee's response to determine if the response is adequate—that is, whether the grantee demonstrated compliance or, if applicable, provided an adequate plan for achieving compliance.

During the different phases of the progressive action process, HRSA recommends that project officers contact grantees to advise them on specific actions needed to address deficiencies, and provide technical assistance as needed to help the grantee achieve compliance. Overall, the number of phases a particular grantee goes through depends on the nature of the corrective action required and how quickly the grantee addresses the noncompliance issue. If a grantee is unable to correct the compliance issue by the end of the progressive action process, HRSA's policies require it terminate the health center's grant.

HRSA's Process for Identifying Noncompliance Is Insufficient, and It Is Too Soon to Assess the Revised Process for Addressing Noncompliance

HRSA's process for identifying noncompliance is insufficient as annual compliance reviews do not identify all instances of noncompliance and the extent to which HRSA uses site visits to assess compliance is unclear, but appears to be limited. Moreover, HRSA's project officers do not consistently identify and document grantee noncompliance. Finally, HRSA's ability to address noncompliance is unclear as the agency's process for doing so has recently changed.

Annual Compliance Reviews Do Not Identify All Instances of Noncompliance

HRSA's annual compliance reviews do not identify all instances of health center grantee noncompliance that other methods, such as site visits, have identified. Among the eight grantees included in our review, we identified 10 instances where the project officer determined that a grantee was in compliance with a program requirement during the annual compliance review, but a site visit a short time later found the grantee to be noncompliant with the same requirement. For example, in April 2010, a project officer completed an annual compliance review and found that a grantee was in compliance with 16 of the 19 program requirements. However, in July 2010, just 3 months later, a HRSA consultant completed an operational assessment site visit and found that the grantee was not in

compliance with 10 of the 19 requirements; this included 7 requirements for which the project officer had previously concluded the grantee was in compliance. During the annual compliance review, for instance, the project officer determined that the grantee was in compliance with both the board composition and board authority program requirements. However, the site visit found, among other things, that the board had less than the minimum number of required members, did not meet monthly as required, and was not fulfilling its required duties and responsibilities to oversee the operations of the center—key aspects of these 2 program requirements.[21] HRSA officials could not definitively explain why the site visit identified these issues of noncompliance, when the annual compliance review had failed to do so. HRSA officials speculated that because this grantee was having management problems, its performance may have rapidly deteriorated since the annual review was completed. Although the grantee may have been experiencing management problems, the consultant's site visit report indicates that the grantee did not fall out of compliance with all 7 of these requirements in the intervening 3 months. Rather, the report indicated that several of these noncompliance issues were ongoing, including one that had existed for several years. Additionally, none of the 10 annual compliance review decisions included an indication that the project officer was uncertain about whether or not the grantee demonstrated compliance. Thus, it does not appear that the affirmative compliance decisions were due to project officers indicating that a grantee is in compliance until noncompliance is clearly determined.

In addition to finding instances where the annual compliance review failed to identify grantee noncompliance, our review of HRSA's oversight documentation of selected grantees revealed that project officers frequently determined a grantee was in compliance with selected program requirements without having sufficient information to make such decisions. Our analysis of 48 compliance decisions that project officers made during their fiscal year 2011 annual compliance reviews for our eight selected grantees found that in 43 cases (90 percent) project

[21]The other five program requirements for which the site visit found the grantee noncompliant were the needs assessment, required and additional services, hospital admitting privileges and continuum of care, contractual/affiliation agreements, and budget requirements.

officers determined grantees were in compliance with requirements.[22] However, in 23 of these 43 cases (53 percent), we were unable to find sufficient information to support the project officer's compliance decision and the project officers did not indicate that they were unable to clearly determine compliance, which is what HRSA guidance instructs them to do if they are uncertain about whether or not the grantee demonstrated compliance, for example:

- Project officers determined that all eight selected health center grantees were in compliance with the after hours coverage requirement. However, it appears that six of the eight project officers had insufficient information when making their assessments. Our review of HRSA's oversight documentation found that information grantees provided ranged from a sentence or two in their budget period progress report narrative stating they had a 24-hour answering service that will arrange for contact with an on-call clinician, to no mention of how they were meeting the after hours coverage requirement. In contrast, we found the other two project officers had information from recent site visits to assess compliance with this requirement.

- Project officers determined that six of the eight selected health center grantees were in compliance with the sliding fee discounts requirement. However, we found that four of six project officers who made this determination did not, at the time, have a current, updated version of their grantees' sliding fee discount schedule to review. These project officers made their compliance decisions based on limited information, including grantee assertions that they had a current and up-to-date schedule. According to HRSA officials, beginning with the fiscal year 2012 annual compliance reviews, grantees will be required to submit an updated sliding fee discount schedule.

While HRSA requires project officers to document their basis for finding a grantee out of compliance with a requirement, it does not require project officers to document their basis for finding a grantee in compliance. Therefore, there were often no records documenting how or why a project

[22]For each of the eight selected grantees, we reviewed the compliance decisions that the project officers made for the following six program requirements—after hours coverage, sliding fee discounts, key management staff, billing and collections, board composition, and conflict-of-interest policy; a total of 48 compliance decisions.

officer determined a health center grantee was in compliance with the requirements. In 26 of the 43 compliance decisions (60 percent) we reviewed in which project officers determined grantees were in compliance with selected program requirements, the project officers had not documented the basis for their decisions. The lack of documentation is not consistent with internal control standards for the federal government, which indicate "that all transactions and other significant events need to be clearly documented" and stress the importance of "the creation and maintenance of related records which provide evidence of execution of these activities as well as appropriate documentation."[23]

The absence of such documentation may limit HRSA's ability to ensure that project officers have identified all cases of grantee noncompliance during the annual compliance review and make it more difficult for HRSA to keep track of issues affecting grantee compliance especially when oversight responsibilities transfer among staff. For example, without such documentation, it is difficult for supervisors to appropriately assess the basis for project officers' decisions. Further, according to HRSA, about 40 percent of grantees have had a change in their assigned project officer and branch chief over the past few years due in part to HRSA's hiring of a significant number of new project officers to meet the expected increase in the number of health center grantees. While HRSA officials indicated they have a process to ensure a smooth transition between oversight staff, we found the absence of documentation can present challenges. For example, each of the eight project officers we interviewed had been assigned to their grantee for 2 years or less, and some of the project officers were unable to answer questions about why previous project officers determined their grantees were in compliance with specific requirements.

Additionally, when project officers are uncertain about compliance, HRSA instructs project officers to consider grantees in compliance. As noted earlier, HRSA's guidance indicates that project officers are to document these instances when compliance is unclear by writing a comment in a text field of the evaluation tool, but HRSA has no centralized or automated mechanism to ensure this occurs. The lack of such a mechanism, coupled with the lack of documentation of project officers' basis for finding a grantee in compliance, limits HRSA's ability to

[23]See GAO/AIMD-00-21.3.1.

determine whether a project officer decided a grantee was in compliance with a requirement because the file contained evidence demonstrating compliance, or because the project officer was unsure about compliance and simply defaulted to an affirmative compliance decision without including documentation of his or her concerns.

HRSA's Use of Site Visits to Assess Compliance Is Unclear, but Appears to Be Limited

Data limitations make it difficult to determine the extent to which HRSA uses site visits to assess compliance; however, our analysis of these data suggest that the number of compliance-related site visits is limited. HRSA does not have aggregate, readily available data on site visits conducted prior to January 2011. Consequently, to determine which health center grantees had compliance-related site visits prior to January 2011, HRSA officials would have to manually compile a list by accessing each site visit report located in each individual grantee's file.

To help the agency in planning site visits, HRSA began requiring that all site visits be recorded in its on-line Electronic Handbook in January 2011. However, the reliability of at least some of the data elements, including the type of site visit, is uncertain. After a site visit record is created in the Electronic Handbook, which is the first step for documenting a planned a site visit, the system prevents project officers from editing certain fields, including the field for the type of site visit conducted.[24] As a result, if the site visit type changes after project officers create the site visit record, the record will be inaccurate. Further, project officers are not required to update certain other fields, such as the site visit start and end dates, which increases the potential for data inaccuracies. While HRSA officials indicated that the type of site visit does not frequently change, when we compared the site visit data to information contained in site visit reports, we found that the type of site visit had changed for one of the five visits that took place at our selected grantees since January 2011. After discussing this with HRSA officials, the officials indicated that they would alter their electronic system to allow project officers to revise the site visit type; however, they have yet to do so. In addition, HRSA officials indicated the electronic system does not have a mechanism to ensure that a cancelled site visit is properly recorded. Therefore, when a planned site visit is cancelled, the record is removed only if a project officer

[24]According to HRSA officials, the on-line Electronic Handbook contains certain business rules to help safeguard site visit data. One of these rules was that the type of site visit could not be modified after a site visit record was created.

proactively takes action to remove it. If the project officer fails to remove the record, the database will contain inaccurate information. From the programwide site visit data we received, we determined that the data included at least one site visit that had been cancelled, but not removed from the database. However, there may be other instances that we were unable to identify based on the available data.

As noted earlier, HRSA considers site visits an important tool for assessing and assuring grantee compliance with Health Center Program requirements. According to our analysis, site visits were conducted at 417 (37 percent) of the 1,128 health center grantees between January 1, 2011 and October 27, 2011.[25] A total of 472 site visits were conducted during this period because some grantees had multiple visits. Although HRSA's data on the type of site visit conducted has inaccuracies, these data suggest that only a small portion of grantees had compliance-related visits. HRSA's data indicate that 58 grantees, or 5 percent of all health center grantees, had site visits to review compliance with all 19 program requirements during this time period.[26] An additional 70 grantees (6 percent) had a site visit that may have assessed compliance with some of the 19 program requirements. The remaining grantees either did not have a site visit during the period or had a site visit which was not intended to assess compliance with the 19 program requirements.

Although HRSA's standard operating procedures do not currently specify how frequently compliance-related site visits should be conducted, HRSA officials indicated that, beginning in 2012, the agency is requiring that project officers schedule an operational assessment—a site visit intended to assess compliance with all 19 program requirements—for each grantee at least every 5 years. At their current rate and assuming the number of grantees remains the same, it would take HRSA over 15 years to conduct an operational assessment visit at each of the over 1,100 health center grantees. HRSA officials recognized that in order to meet this goal, they will have to increase the number of operational assessment site visits which are conducted annually. Along those lines, officials indicated that

[25]According to HRSA, the number of grantees in the Health Center Program was 1,127 in July 2010 and 1,129 as of November 1, 2011—we used the average of the two figures, which is 1,128.

[26]All of these visits were operational assessment visits, as HRSA did not conduct any new start site visits during the time period for which data were available.

HRSA increased the amount of funding and planned number of operational assessment site visits to be provided through their current nationwide contract for conducting site visits.

HRSA's Project Officers Do Not Consistently Identify and Document Grantee Noncompliance

HRSA's project officers do not consistently identify noncompliance and document it through the placement of conditions. For three of the six program requirements we reviewed, the HRSA project officers we interviewed did not have consistent interpretations of what constitutes compliance and what should therefore result in the placement of a condition on a health center's grant, raising concerns about the adequacy of HRSA's guidance and training for project officers. The project officers we spoke with had different interpretations regarding the board composition, after hours coverage, and key management requirements.

- Health center grantees are required, by statute and regulations, to have a governing board, the majority of whose members are patients of the center and who demographically represent the population served by the grantee. However, some project officers we spoke with indicated that the lack of an appropriately representative board would not result in a condition; these project officers did not consider the lack of an appropriately representative board an issue of noncompliance.

- While HRSA's guidance for project officers indicates that, at a minimum, a grantee's after hours coverage system should ensure that patients have telephone access to a clinician who can assess whether they need emergency medical care, some of the project officers we spoke with indicated that they would consider using a performance improvement area, not a condition, if a health center had only an answering machine directing patients to the emergency room. Other project officers stated that if a grantee had only an answering machine directing patients to the emergency room they would not be in compliance with this requirement.

- HRSA guidance instructs project officers to assess whether a health center grantee maintains a fully staffed management team as appropriate for the size and need of their health center. When asked about the criteria they use for determining whether grantees are in or out of compliance with the key management staff requirement, two project officers told us that they base their compliance decision on whether the grantee's management staff includes a Chief Executive, Financial, and Medical Officer. In contrast, the other six project

officers said that a grantee did not necessarily need to have all of these positions staffed.

We also found one instance where HRSA's guidance on what constitutes compliance is inconsistent with Health Center Program requirements, and thus project officers may not be making correct decisions regarding grantee compliance and appropriately addressing noncompliance. In this particular instance, HRSA guidance instructs project officers to use a performance improvement area, not a condition, if a grantee has not used the most recent federal poverty guidelines for developing their sliding fee discounts; the guidance therefore indicates that grantees are to be considered in compliance with the requirement even if their sliding fee discount schedule is outdated. Health Center Program regulations, however, require a grantee's sliding fee discounts to be based on the most recent guidelines. As a result, a grantee that has not used the correct federal poverty guidelines should be deemed noncompliant with this program requirement and a condition should be placed on its grant. When we raised this issue with HRSA officials, they acknowledged that the guidance was not consistent with requirements, and that it would be revised. They also confirmed that if a grantee has not used the correct federal poverty guidelines in its sliding fee discount schedule, a project officer should deem the grantee noncompliant and that a condition should be issued. HRSA officials further indicated they are developing a policy notice on the sliding fee discounts program requirement, and the guidance will specify that a grantee's sliding fee discounts must be revised annually to reflect updates to the most recent federal poverty guidelines.

Finally, we found instances where grantee noncompliance was identified through site visits, but HRSA failed to place conditions on the grant. According to HRSA's standard operating procedures, when a site visit determines that a grantee is noncompliant with at least one of the 19 program requirements, a project officer must place a condition on the health center's grant. However, as part of our review of the eight selected grantees, we identified five site visits from 2009 through August 2011 that clearly identified findings of noncompliance with some of the 19 program requirements, but HRSA did not issue conditions to grantees for the majority of these findings. For example, one site visit found that a grantee was not in compliance with 16 of the 19 requirements, but HRSA did not issue any conditions to the grantee. At the time of the site visit, this grantee had been receiving HRSA funding for about 15 months, and had been experiencing compliance issues for at least 12 months. Despite this, HRSA officials told us that because it was a new grantee that was

receptive to technical assistance, HRSA wanted to give the grantee more time to address their compliance issues before placing numerous conditions on it. Another site visit found that a grantee was not in compliance with the board authority and conflict-of-interest policy requirements, but HRSA did not issue any conditions to the grantee as a result of this site visit. Instead, HRSA arranged for a consultant to provide the grantee with technical assistance to revise and update its bylaws to address these issues.

HRSA's Ability to Address Noncompliance Is Unclear As the Agency's Process Has Recently Changed

The extent to which HRSA's revised process—the progressive action process—is adequately resolving conditions or terminating grantee funding is unclear because HRSA's experience with this revised process is too recent to make any overall assessment. The progressive action process, which was implemented in April 2010, can potentially take over a year to move through all of the phases. Completing the first three phases of the progressive action process can take up to 9 months, while grantees with conditions that allow for a 120-day implementation phase can take up to 19 months to fully complete the process.[27] Thus, HRSA has limited experience with the process to date, and does not have sufficient data to assess the extent to which the process is effective in bringing grantees into compliance or in addressing those grantees that have failed to achieve compliance by the end of the final phase.

During the first 18 months that the progressive action process has been in place—from April 9, 2010, through October 7, 2011—HRSA issued 1,017 conditions for grantee noncompliance to a total of 417 different grantees (approximately 37 percent of all grantees), with some grantees having multiple conditions. Over half of the conditions were for grantee noncompliance with requirements related to the management and finance category. (See app. II for additional information about the conditions

[27]The maximum allotted time available to a grantee depends on the nature of the issue of noncompliance and the corrective action the grantee needs to take to establish compliance. Specifically, when an issue of noncompliance can be directly addressed by providing specific documentation (e.g., updated service map), the progressive action process consists of three phases and, when including time for HRSA to review grantees' submission, can take up to 9 months. However, when a grantee has a condition that requires it to both develop and implement a plan for achieving compliance (e.g., develop and implement a financial recovery plan), the process may include up to three additional implementation phases, and can take up to 19 months to complete when including time for HRSA to review grantees' submissions between each phase.

placed during this time period.) As of November 10, 2011, 775 conditions (76 percent) were resolved and 240 conditions (24 percent) were still in process. The remaining 2 conditions, which belonged to the same grantee, were not resolved in the allotted time; thus, HRSA officials indicated that the agency was is in the process of terminating the grantee's funding.[28]

Conclusions

HRSA's Health Center Program provides access to health care for people who are uninsured or who face other barriers to receiving needed care. Over the past decade the program has expanded and, given the additional funding appropriated by PPACA, will likely continue to do so over the next few years. As such, it will play an increasingly greater role as a health care safety net for vulnerable populations. Particularly in light of the growing federal investment in health centers, it is important for HRSA to ensure that health centers are operating effectively and in compliance with Health Center Program requirements. HRSA has taken steps to improve its oversight of health center grantees over the past few years, such as by standardizing its process for addressing grantee noncompliance. Despite these efforts, however, HRSA's oversight is insufficient to ensure that it consistently identifies all instances of grantee noncompliance with Health Center Program requirements.

Although HRSA has devoted substantial resources to overseeing grantees—including having over 100 project officers to perform annual compliance reviews and having a more than $30-million contract for consultants who conduct site visits and provide other assistance—limitations in HRSA's oversight methods have affected the agency's performance in identifying issues of noncompliance. The annual compliance reviews place too little emphasis on documenting project officers' basis for making their compliance decisions, while HRSA's guidance instructs project officers to indicate that a grantee is in compliance with Health Center Program requirements, even if the project officer is uncertain about the grantee's compliance. Further, HRSA does not have a systematic process for tracking and following-up on instances when project officers are uncertain about a grantee's compliance to ensure that compliance is ultimately demonstrated. The lack of such a

[28]For the 5 years prior to implementation of the progressive action process, HRSA indicated that it discontinued funding for 37 grantees. Of these, HRSA categorized 12 as involuntary terminations.

process, coupled with the lack of documentation of project officers' basis for finding a grantee in compliance, limits HRSA's ability to assess whether project officers accurately determined that grantees were actually in compliance with a requirement, or whether they were simply unsure about compliance. This is especially problematic because project officers we interviewed had different interpretations of what constitutes compliance with certain requirements and therefore, when they should place a condition on a health center's grant.

Additionally, while HRSA officials indicated, and we found, that site visits are an important tool for overseeing grantees and verifying compliance with Health Center Program requirements, the agency's use of compliance-related site visits appears to be limited. HRSA has a goal of having an operational assessment visit to each grantee at least once every 5 years. The agency's ability to effectively meet this goal, however, is challenged by a lack of comprehensive and reliable data on which grantees have had various types of site visits. To the extent HRSA is able to develop and analyze accurate data on site visits, it will be in a better position to target its resources to those grantees that may be in greater need of such visits. Furthermore, HRSA needs to ensure that when site visits are conducted, the information obtained is appropriately used, for example, by ensuring that instances of noncompliance identified during a site visit result in the placement of a condition on a health center's grant.

Finally, HRSA's recently revised process for addressing grantee noncompliance with the 19 program requirements seems to provide both the agency and grantees with a uniform structure for addressing compliance deficiencies. However, given the length of time the progressive action process provides grantees to address noncompliance, HRSA has had limited experience with the process, and thus it is too early to tell whether this revised process is effective. As HRSA gains more experience with the process, it will be important for the agency to assess whether the process is functioning as intended and whether any changes are needed to make the process more effective.

Recommendations for Executive Action

To improve HRSA's ability to identify and address noncompliance with Health Center Program requirements, the Administrator of HRSA should take the following six actions:

- Develop and implement a mechanism for recording, tracking, and following-up on instances when project officers are unable to determine compliance during the annual compliance review process.

- Require that when completing annual compliance reviews, project officers clearly document their basis for determining that grantees are in compliance with program requirements.

- Clarify agency guidance and provide training, as needed, to better ensure that project officers are accurately and consistently assessing grantees' compliance with program requirements.

- Ensure that site visit data contained in HRSA's electronic system are complete, reliable, and accurate to better target the use of available resources and to help ensure that all grantees have compliance-related site visits at regular and timely intervals.

- Develop and implement procedures to ensure that instances of noncompliance with program requirements consistently result in the placement of a condition on a health center's grant.

- Periodically assess whether its new progressive action process for addressing grantee noncompliance, including the time frames allotted for grantees to respond, is working as intended and make any needed improvements to the process.

Agency Comments and Our Evaluation

We provided a draft of this report to HHS for its review, and HHS provided written comments (see app. III). HHS concurred with all six of our recommendations and indicated that while resource availability may impact the extent of certain actions, HRSA is already in the process of planning and implementing many of the recommendations. For example, HHS indicated that HRSA is in the process of enhancing the electronic evaluation tool, known as the Program Analysis and Recommendations tool, which project officers use to conduct and document annual compliance reviews. HRSA is also working on issuing additional policies, procedures, and guidance documents to better ensure that project officers are consistently assessing grantee compliance and documenting noncompliance.

While HHS concurred with our recommendations and indicated that the report's findings were helpful in informing ongoing efforts to improve oversight of the Health Center Program, it did not concur with what it characterized as some of the central conclusions drawn from the report's findings. First, HHS indicated that it did not concur with what it characterized as our conclusion that HRSA's process for identifying noncompliance is insufficient because annual compliance reviews do not identify all instances of noncompliance. HHS indicated that HRSA's active

monitoring of grantees is not limited to the project officer's annual compliance review, but is accomplished through a variety of available resources including, but not limited to, the review of grantee data reports, independent annual audit reports, quarterly conference calls, site visits, and correspondence from the grant recipient. We agree with HHS's statement, and our report reflects that HRSA uses multiple methods to oversee grantees. However, we believe that HHS mischaracterized the nature of our conclusion. Our conclusion that HRSA's oversight of health center grantees is insufficient was not based solely on our assessment of HRSA's annual compliance reviews, but rather was based on our assessment of several key oversight methods described throughout our report including HRSA's use of site visits, the consistency of project officers' oversight, and the use of programwide data to aid oversight across grantees.

HHS also did not concur with what it characterized as our conclusion that HRSA's process for identifying noncompliance is insufficient because HRSA's project officers do not consistently identify and document grantee noncompliance. In explaining its concerns, HHS focused on instances where project officers cannot definitively determine whether or not grantees are complying with program requirements. For example, HHS noted that when project officers are uncertain about compliance, HRSA's standard operating procedures require project officers to record these areas of uncertainty for follow-up action. However, our findings about the lack of consistency in the identification and documentation of grantee noncompliance are not limited to instances when project officers are uncertain about compliance. Rather, as the report indicates, we found that project officers we interviewed did not have consistent interpretations of the criteria for assessing compliance and what should therefore result in the placement of a condition on a health center's grant. Furthermore, we found one instance where HRSA's guidance on what constitutes compliance is inconsistent with Health Center Program requirements and found several instances where identified noncompliance did not result in the placement of a condition on a health center's grant. As the report notes, in cases when project officers may be uncertain about compliance, we found that HRSA did not have a centralized mechanism to ensure that project officers are recording such instances. Additionally, despite HHS's comment stating that HRSA's procedures provide for such follow-up, it agreed with our recommendation that HRSA should develop a mechanism for ensuring that recording, tracking, and following up on such instances occurs.

Finally, HHS did not concur with our finding that the lack of documentation in the annual compliance review is not consistent with internal control standards for the federal government. HHS indicated that HRSA established its annual compliance review tool to record documented findings of noncompliance and utilizes a standard progressive action process to resolve these areas consistent with its overall internal control procedures. While we agree that HRSA's process provides for both documenting areas of identified noncompliance and a standard process for resolving these issues, our findings were not limited to an assessment of what HRSA has included in its oversight process, but also takes into account what HRSA did not include in this process. Thus, our findings take into account the fact that HRSA does not require project officers to document their basis for finding a grantee in compliance. Therefore, as stated in the report, we found there were often no records documenting how or why a project officer determined a health center grantee was in compliance with the requirements. The lack of such documentation makes it difficult for managers to assess the accuracy of project officers' decisions and assure that grantees are in compliance with applicable laws and regulations, which is a key purpose to having effective internal controls. Thus, we continue to believe that this lack of documentation is not consistent with internal control standards for the federal government, which indicate "that all transactions and other significant events need to be clearly documented" and stress the importance of the creation and maintenance of related records which provide evidence of execution of these activities as well as appropriate documentation.

As noted above, our conclusion that HRSA's oversight of health center grantees is insufficient was based on our overall assessment of HRSA's key oversight methods. In addition to finding limitations with HRSA's annual compliance reviews and a lack of consistency among HRSA project officers, we also found that HRSA's use of site visits to assess compliance has been limited. Thus, we stand by our conclusion that HRSA's process for identifying noncompliance is insufficient. We are pleased that HRSA is already taking steps to implement our recommendations and encourage the agency to continue to take actions to help to improve its oversight of health center grantees.

HHS also provided technical comments, which we incorporated as appropriate.

As agreed with your office, 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 of this report to the Administrator of HRSA. In addition, the report is 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 key contributions to this report are listed in appendix IV.

Debra A. Draper
Director, Health Care

Appendix I: Characteristics of Selected Health Center Grantees

As part of our assessment of the extent to which the Health Resources and Services Administration's (HRSA) process identifies and addresses noncompliance with Health Center Program requirements, we reviewed HRSA's oversight of eight selected health center grantees. The grantees were selected to provide variation in: size, as determined by the number of delivery sites; length of time as a Health Center Program grantee; and compliance experience, as determined by the number of the number of findings of noncompliance—referred to as conditions—that HRSA had cited for each grantee that were unresolved as of July 11, 2011. (See table 4.)

Table 4: Characteristics of the Eight Selected Health Center Grantees

Health center grantee	State	Number of delivery sites	Year became a health center grantee	Documented compliance issues[a]
A	AL	8	1983	No
B	CA	7	1968	Yes
C	IL	10	1983	No
D	NC	1	1980	Yes
E	NY	1	1984	No
F	OK	4	2004	No
G	PA	2	2009	Yes
H	WY	2	2004	No

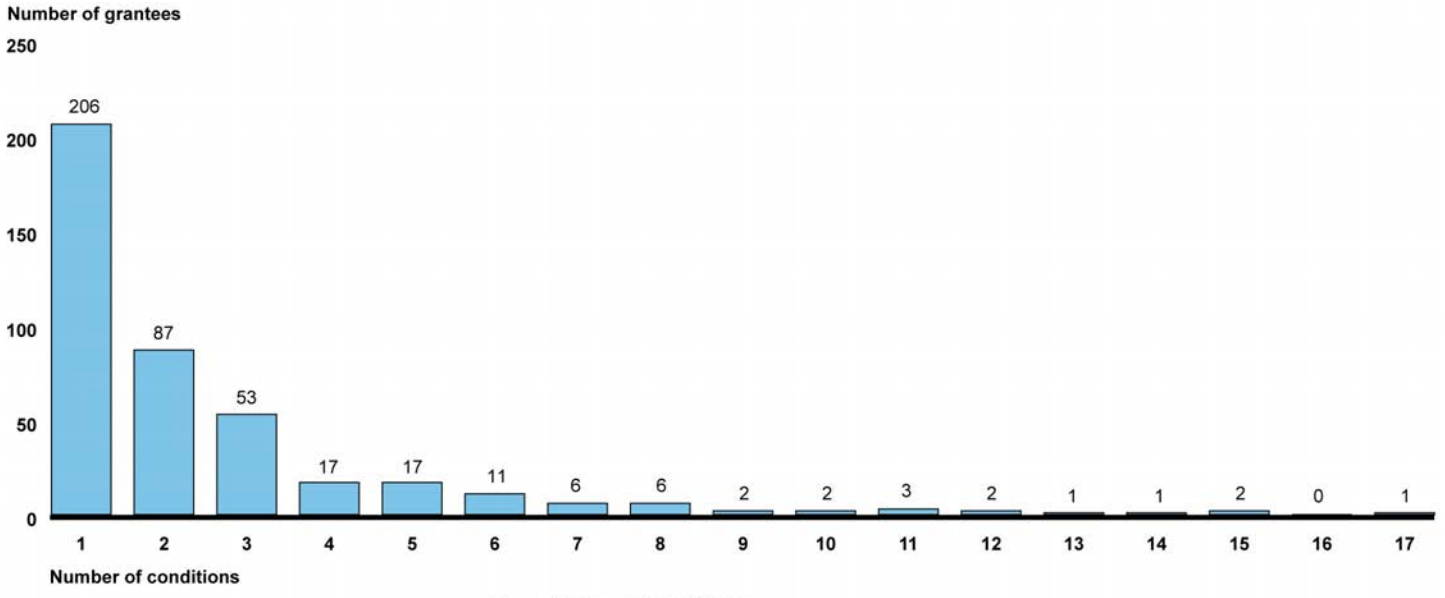
Source: GAO analysis of information from HRSA.

[a]Indicates whether the grantee had at least one documented compliance issue as of July 11, 2011, which was still unresolved more than 90 days after HRSA notified the grantee about the area of noncompliance.

Appendix II: Summary of Noncompliance Data for the Health Center Program

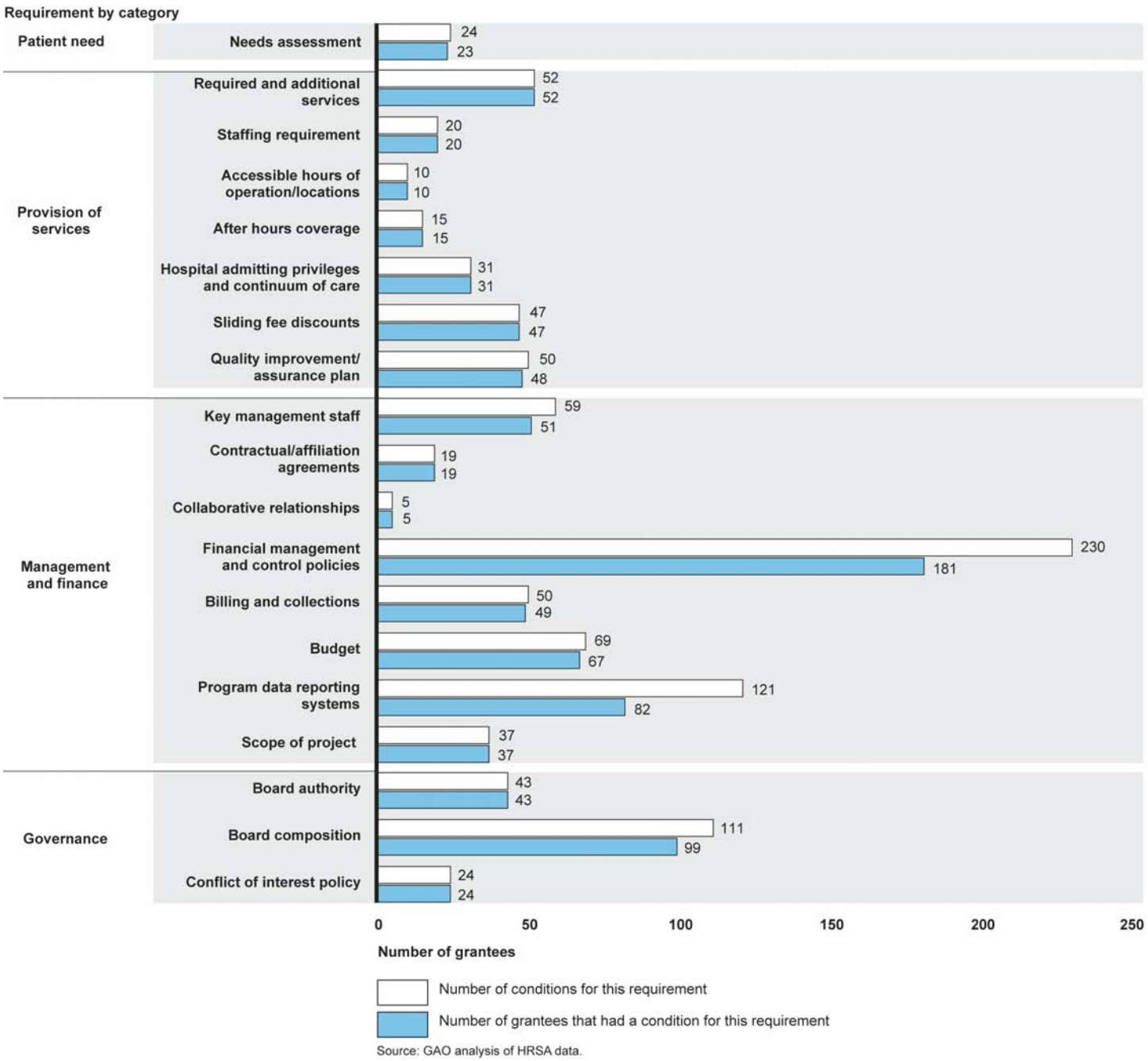
During the first 18 months of HRSA's progressive action process, from April 9, 2010, through October 7, 2011, HRSA issued 1,017 conditions to 417 health center grantees, with some grantees having multiple conditions during this time period. Specifically, the number of conditions HRSA issued to the 417 grantees ranged between 1 and 17 conditions per grantee, with HRSA issuing between 1 and 3 conditions to most of these grantees. (See fig. 2.) HRSA issued conditions for each of the 19 program requirements, with the greatest numbers issued for the financial management and control policies, program and data system reporting, and board composition requirements. (See fig. 3.) Grantees can have multiple and simultaneous conditions associated with the same program requirements, with each condition being related to a different component of the requirement. For example, in fiscal year 2011, there were 3 possible conditions related to the financial management and control policy requirement.

Figure 2: Number of Conditions of Noncompliance HRSA Issued per Grantee, from April 9, 2010, through October 7, 2011



Source: GAO analysis of HRSA data.

Figure 3: Number of Conditions and Number of Grantees That Had a Condition, by Requirement from April 9, 2010, through October 7, 2011



Source: GAO analysis of HRSA data.

Note: Grantees can have multiple and simultaneous conditions associated with the same program requirements, with each condition being related to a different component of the requirement.

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

MAY 10 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: Improved Oversight Needed to Ensure Grantee Compliance with Requirements" (GAO-12-546).

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 REPORT ENTITLED, "HEALTH CENTER PROGRAM: IMPROVED OVERSIGHT NEEDED TO ENSURE GRANTEE COMPLIANCE WITH REQUIREMENTS" (GAO-12-546)

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

For more than 45 years, Health Center Program grantees 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. Today, more than 1,100 health centers operate over 8,500 service delivery sites that provide care to approximately 20 million patients in every State, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin.

This network of 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. The health center model also 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.

A programmatic emphasis on quality improvement, as well as community-responsive and culturally appropriate care, has also translated into impressive reductions in health disparities for health center patients. Calendar Year 2010 Health Center Program data demonstrate that centers continue to provide high quality care and improve patient outcomes, while reducing disparities, despite serving a population that is often sicker and more at risk than seen nationally:

- Between 2008 and 2010 health centers saw improved birth outcomes with the percent of low birthweight babies born to health center patients decreasing from 7.6 percent in 2008 to 7.4 percent in 2010, which is lower than the 2010 national low birthweight rate of nearly 8.2 percent. In addition, the rate of entry into prenatal care in the first trimester for health center patients increased from 65 percent to 69 percent between 2008 and 2010.

- 74 percent of health center children received all appropriate immunizations by their second birthday - up from 69 percent in 2009.

- 71 percent of health center patients demonstrated control over their diabetes with a hemoglobin A1c (HbA1c) level less than or equal to 9.

- 63.2 percent of hypertensive health center patients have their blood pressure under control.

1

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "HEALTH CENTER PROGRAM: IMPROVED OVERSIGHT NEEDED TO ENSURE GRANTEE COMPLIANCE WITH REQUIREMENTS" (GAO-12-546)

Health centers also reduce costs for health systems and contribute to economic growth in their communities. The health center model of care has also been shown to reduce the use of emergency departments and hospitals and serve as a critical source of economic development and growth.

- Health centers continue to deliver high quality care efficiently and effectively at a total annual cost of $630 per (total) patient.

- In addition, in 2010, health centers injected operating expenditures directly into their local economies generating over 131,660 full-time jobs.

HRSA's program oversight has contributed directly to these program accomplishments and HRSA remains committed to ensuring the appropriate and effective use of Federal funds while achieving the Health Center Program's mission of providing comprehensive, culturally competent, quality primary health care services to medically underserved communities and vulnerable populations. Within the past several years, HRSA has significantly strengthened its program oversight policies, systems, and processes. These enhancements include but are not limited to the following:

Clarification of Program Requirements

Beginning in 2007, HRSA consolidated and clarified the list of Health Center Program Requirements based on the program's statutory and regulatory language as well as applicable grants regulations. These 19 Key Health Center Program Requirements (see http://www.bphc.hrsa.gov/about/requirements/index.html) serve as the criteria for determining compliance with program requirements and the foundation for all Health Center Program monitoring and related oversight activities, including documents and tools such as competing continuation funding guidances, annual progress report instructions, the annual internal review tool used to assess and document grantee progress, performance, and compliance and the health center site visit protocol.

Improved Oversight of Program Requirements

- *Program Analysis and Recommendations Tool*: Building on the clarification of program requirements, HRSA created the Program Analysis and Recommendations (PAR) Review Tool. The PAR was designed to draw on a variety of information and data sources but provide a consistent format for HRSA's Project Officers to annually assess and monitor program compliance and performance improvement for all health center grantees. The PAR was developed in 2007 and has been used by HRSA's Project Officers since 2008 to electronically document and track grantee compliance with statutory and regulatory program requirements in alignment with the 19 Key Health Center Program Requirements.

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "HEALTH CENTER PROGRAM: IMPROVED OVERSIGHT NEEDED TO ENSURE GRANTEE COMPLIANCE WITH REQUIREMENTS" (GAO-12-546)

- *Site Visit Protocol:* In 2008, HRSA developed and implemented a new, in-depth site visit protocol, the HRSA Health Center Site Visit Guide, to support on-site assessments of grantee compliance with program requirements and identification of clinical and financial performance improvement. The HRSA Health Center Site Visit Guide also serves as a review instrument that grantees can use for self-assessment. The HRSA Health Center Site Visit Guide and corresponding standard report templates (used to document findings from site visits) are aligned with and structured to correspond to the 19 Key Health Center Program Requirements. The Health Center Site Visit Guide is available at: http://bphc.hrsa.gov/policiesregulations/centerguide.html.

Standardization of Performance Improvement Measures

In 2008, HRSA adopted a set of core clinical and financial performance measures, specifically relevant to the Health Center Program and aligned with nationally recognized and standardized quality metrics. These measures reflect HRSA's emphasis on health outcomes and quality of care delivered by health centers. Clinical and financial performance measures are integrated into the annual Health Center Program progress reports and competing continuation applications and provide an additional dimension of monitoring that allows Project Officers to track grantee performance on these measures.

Time-Phased Approach to Address Compliance Issues

In 2010, HRSA introduced the Progressive Action policy and process, which provided a uniform structure and a time-phased approach for notifying grantees of compliance issues through standard conditions of award based on the 19 Program Requirements. The Progressive Action policy and process was implemented through an integrated electronic system that greatly enhanced the ability for both HRSA staff and health center grantees to track, respond to conditions with documented corrective actions, and assess responses to these conditions.

Frequency of Operational Site Visits

In 2012, HRSA expanded its Technical Assistance (TA) efforts to include regularly scheduled Operational Site Visits to all health center grantees. HRSA recently increased the number of site visits provided through their current nationwide contract and plans to conduct approximately 240 Operational Site Visits annually. Beginning in 2012, all Health Center Program grantees will receive an Operational Site Visit at least once every five years. These visits are designed to provide a full operational assessment of all 19 Program Requirements as well as focus on areas for clinical and financial performance improvement.

Building on these significant achievements, HRSA will continue to focus on advancing accountability in all aspects of the program's development to ensure the appropriate and effective use of Federal funds and to achieve the Health Center Program's mission of providing

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "HEALTH CENTER PROGRAM: IMPROVED OVERSIGHT NEEDED TO ENSURE GRANTEE COMPLIANCE WITH REQUIREMENTS" (GAO-12-546)

comprehensive, culturally competent, quality primary health care services to medically underserved communities, and vulnerable populations.

Response to the Report's Findings

While HHS considers the report's findings to be helpful in informing ongoing efforts to improve oversight of the Health Center Program, HHS does not concur with the following central conclusions drawn for the report's findings:

Now page 20.

Page 17: HRSA's Process for Identifying Noncompliance is insufficient because annual compliance reviews do not identify all instances of non-compliance. HRSA project officers monitor grantees throughout the year to identify potential issues, including non-compliance with program requirements and areas where technical assistance might be necessary. Contrary to GAO's conclusion, this active monitoring is not limited to the project officer's annual Program Analysis and Recommendations (PAR) review, but is accomplished through a variety of available resources including, but not limited to, the review of grantee data reports, independent annual audit reports, quarterly conference calls, site visits, correspondence from the grant recipient, and other information available as shared with GAO during the study and as described within the report itself. Project officers utilize all of these resources to determine if conditions are warranted at any point during the year. In fact, the site visits examined during the GAO review period were conducted because HRSA determined that these organizations presented a higher level of risk for non-compliance and/or performance concerns. Therefore, HHS does not concur with GAO's conclusion that because site visits identified additional areas of non-compliance beyond what was identified in the annual PAR review, HRSA's process for identifying non-compliance was insufficient.

Now page 23.

Page 19: The lack of documentation [in the annual PAR review] is not consistent with internal control standards for the federal government [found in Standards for Internal Control in the Federal Government (GAO/AIMD-00-21.3.1)]. The stated purpose of the Standards for Internal Control in the Federal Government is to "provide the overall framework for establishing and maintaining internal control and for identifying and addressing major performance and management challenges and areas at greatest risk of fraud, waste, abuse, and mismanagement" (GAO/AIMD-00-21.3.1, Page 1). The PAR review utilizes a risk-based approach for identifying major performance and management challenges and areas at greatest risk of fraud, waste, abuse, and mismanagement. Specifically, HRSA established its PAR review to record documented findings of non-compliance and utilizes a standard progressive action process to resolve these areas consistent with its overall internal control procedures. Therefore, HHS does not concur with GAO's conclusion that HRSA's annual PAR review does not meet the internal control standards for identifying and addressing major performance and management challenges and areas of greatest risk.

Now page 26.

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "HEALTH CENTER PROGRAM: IMPROVED OVERSIGHT NEEDED TO ENSURE GRANTEE COMPLIANCE WITH REQUIREMENTS" (GAO-12-546)

Pages 22-23: HRSA's Process for Identifying Noncompliance Is Insufficient because HRSA's Project Officers do not consistently identify and document grantee non-compliance. When documented non-compliance issues are identified, Project Officers are expected to follow the Progressive Action policy and process and notify grantees of the area of non-compliance via a condition of award, provide guidance on the corrective actions necessary to meet compliance, and provide technical assistance as needed. GAO concluded that HRSA's process for identifying non-compliance is insufficient because HRSA's project officers do not consistently identify and document grantee non-compliance in cases where non-compliance cannot be definitively determined. In these cases, HRSA's standard operating procedures require project officers to record these areas of uncertainty in the PAR review for follow-up action, including conference calls, grantee site visits and/or additional documentation to verify compliance. Based on the results of these follow-up actions, HRSA places conditions on the grant award, as appropriate. Therefore, HHS does not concur with GAO's conclusion that HRSA's process for identifying non-compliance is insufficient in cases where non-compliance cannot be definitively determined.

Given the significant improvements made by HRSA in creating a core foundation to support and strengthen overall program monitoring and oversight capacity of the Health Center Program, coupled with a commitment to continually assess and improve on this foundation, HHS concurs with all six Recommendations for Executive Action. While resource availability may impact the extent of certain actions, HRSA is already in the process of planning and implementing many of these recommendations:

1. ***Develop and implement a mechanism for recording, tracking and following-up on instances where project officers are unable to determine compliance during the annual compliance review process.***

   Added electronic functionality to the PAR is under development as part of the HRSA Electronic Handbook Project Management Module (PMM) to support Project Officers in their overall, ongoing monitoring of grantees throughout the year, including instances where program compliance is uncertain.

2. ***Require that, when completing annual compliance reviews, project officers clearly document their basis for determining that grantees are in compliance with program requirements.***

   HRSA plans to update the structure of the FY 2013 PAR to require a justification that cites the source document when a Project Officer marks "Yes, organization demonstrates compliance."

5

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "HEALTH CENTER PROGRAM: IMPROVED OVERSIGHT NEEDED TO ENSURE GRANTEE COMPLIANCE WITH REQUIREMENTS" (GAO-12-546)

3. ***Clarify agency guidance and provide training, as needed, to better ensure that project officers are accurately and consistently assessing grantees' compliance with program requirements.***

   HRSA is working to publicly issue several policies that clarify program requirements, including sliding fee discount programs, quality improvement/assurance programs and governance, for both grantees as well as HRSA staff. HRSA will continue to provide staff training on the Health Center Program requirements as well as specific trainings on any forthcoming policies once released. HRSA will also continue to offer extensive internal support to assist Project Officers and Branch Chiefs in making compliance review decisions.

4. ***Ensure that site visit data contained in HRSA's electronic system are complete, reliable and accurate to better target the use of available resources and help ensure that all grantees have compliance-related site visits at regular and timely intervals.***

   HRSA is updating its Onsite Technical Assistance Module to improve the quality, accuracy, and completeness of data captured in the module, including improvements identified by GAO in this study. As noted above, HRSA has communicated to stakeholders that beginning in 2012, all Health Center Program grantees will receive an Operational Site Visit at least once every five years. HRSA has also created operating guidance for the development of an annual site visit plan and has obligated additional resources accordingly.

5. ***Develop and implement procedures to ensure that instances of noncompliance with program requirements consistently result in the placement of a condition on a health center's grant.***

   HRSA has developed a Standard Operating Procedure (SOP) for determining appropriate and consistent placement of conditions at times and for reasons outside of the annual application PAR review process (referred to as "Off-Cycle" conditions).

6. ***Periodically assess whether its new progressive action process for addressing grantee noncompliance, including the timeframes allotted for grantees to respond, is working as intended and make any needed improvements to the process.***

   HRSA has and will continue to monitor its Progressive Action process and make identified improvements, as necessary. HRSA established a Progressive Action Enhancements Workgroup to:

   - Identify issues and key areas of improvement for the Progressive Action process;
   - Identify and prioritize proposed solutions that align with the Progressive Action policy and related grants regulations and policies;
   - Define critical tasks and task leads needed to implement proposed solutions; and
   - Provide related training on the Progressive Action policy and process for HRSA staff.

Appendix IV: Contacts and Staff Acknowledgments

GAO Contact

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

Staff Acknowledgments

In addition to the contact named above, key contributors to this report were Michelle B. Rosenberg, Assistant Director; Krister P. Friday; David Lichtenfeld; Lillian Shields; and Jennifer M. Whitworth.