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May 2019

HEALTH CENTERS

Trends in Revenue and Grants Supported by the Community Health Center Fund

GAO-19-496

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GAO Highlights

Highlights of GAO-19-496, a report to the Committee on Finance, U.S. Senate

Why GAO Did This Study

In 2017, nearly 1,400 health centers provided care to more than 27 million people, regardless of their ability to pay. Health centers were established to increase the availability of primary and preventive health services for low-income people living in medically underserved areas. Health centers rely on revenue from a variety of public and private sources, including revenue from CHCF grants. HRSA began awarding grants funded by the CHCF in fiscal year 2011.

GAO was asked to review the sources and amounts of health center revenue. This report describes (1) trends in health centers' revenue and (2) the purposes for which CHCF grants have been awarded.

GAO analyzed HRSA data collected from health centers and compiled in its Uniform Data System to identify the sources and amounts of revenue health centers received from 2010 through 2017, the most recent data at the time of GAO's analysis. GAO also reviewed HRSA grant documentation for grants funded by the CHCF for fiscal years 2011-2017—the most recent data at the time of GAO's analysis—including information on the award amount and purpose of the grant, and reviewed published studies that described the purposes for which CHCF grants have been made. Additionally, GAO interviewed HRSA officials, authors of the published studies, and an association representing health centers.

GAO provided a draft of this report to HHS. HHS provided technical comments, which GAO incorporated as appropriate.

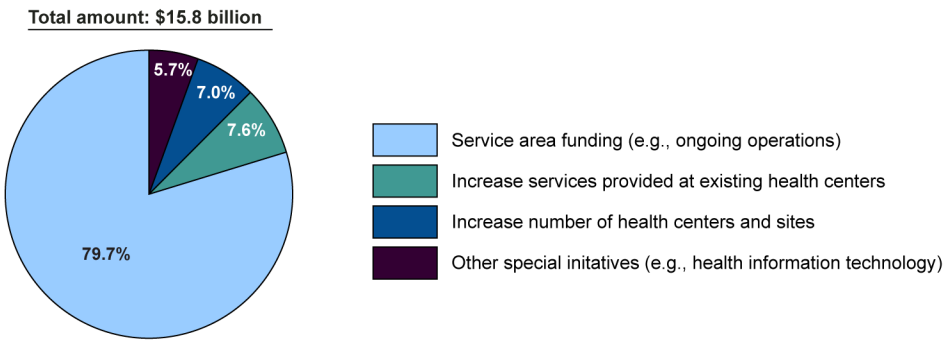
View GAO-19-496. For more information, contact Jessica Farb at (202) 512-7114 or farbj@gao.gov.

What GAO Found

Health centers' revenue more than doubled from calendar years 2010 through 2017, from $12.7 billion to $26.3 billion. Health centers' revenue comes from a variety of sources, including reimbursements from Medicaid, Medicare, private insurance, and federal and state grants. While total health center revenue increased from 2010 through 2017, the share of revenue from each source changed in different ways. In particular, revenue from federal and state grants decreased from 38.0 percent of total revenue in 2010 to about 30.2 percent of total revenue in 2017 while reimbursements from Medicaid, Medicare, and private insurance increased. Over the same time period, the number of health centers increased from 1,124 centers in 2010 to 1,373 centers in 2017. In addition, the number of patients served over the same time period increased by 7.7 million patients, from 19.5 million to 27.2 million.

GAO's analysis of Health Resources and Services Administration (HRSA) data shows that from fiscal years 2011 through 2017, health centers received approximately $15.8 billion in federal grants funded by the Community Health Center Fund (CHCF), which was established by the Patient Protection and Affordable Care Act in 2010. Of this total amount, 79.7 percent—or $12.6 billion—was awarded for the purpose of maintaining operations at existing health centers (see figure). According to HRSA officials, these CHCF grants are used to fill the gap between what it costs to operate a health center and the amount of revenue a health center receives. As such, officials explained, the awards are a primary means through which health centers provide health care services that may be uncompensated, including services for uninsured patients or services not typically reimbursed by other payers, such as adult dental care. The remaining $3.2 billion in CHCF grants were made to increase the amount of services provided at existing health centers; increase the number of health centers and sites; and other special initiatives, such as implementing health information technology.

Total Grant Funding from the Community Health Center Fund, Fiscal Years 2011–2017



Source: GAO review of Health Resources and Services Administration award information. | GAO-19-496

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Abbreviations

CHCF	Community Health Center Fund
HHS	Department of Health and Human Services
HRSA	Health Resources and Services Administration
NAP	New Access Point
PHSA	Public Health Service Act
PPACA	Patient Protection and Affordable Care Act
UDS	Uniform Data System

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
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May 30, 2019

The Honorable Chuck E. Grassley
Chairman
The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate

Health centers were established to increase the availability of primary and preventive health care services for low-income people living in medically underserved areas. These outpatient facilities receive federal funding and serve as an important safety net provider as the majority of their patients are uninsured or enrolled in Medicaid. The majority of health centers serve the general population within a designated area, while other types of health centers provide care to more specific populations, including the homeless, residents of public housing, and migrant and seasonal farmworkers.[1] Regardless of type, health centers are required to provide health care to individuals who are members of the health center's target population or to all individuals located in the health center's service area, regardless of their ability to pay. In some communities, these centers may be the only primary care providers available to certain vulnerable populations. In 2017, nearly 1,400 health centers operated more than 11,000 sites that provided care to more than 27 million people in the United States, including 1 in 9 children; 1 in 5 rural residents; 1 in 3 living in poverty; and more than 355,000 veterans.[2]

Health centers rely on revenue from a variety of public and private sources, including federal, state, and local governments; and payments for services from Medicaid, Medicare, private insurance, and patients. This revenue includes grants awarded by the Health Resources and Services Administration (HRSA) through its Health Center Program. In 2010, the Patient Protection and Affordable Care Act (PPACA) established an additional source of funding for the Health Center

[1]In this report, the term "health centers" refers to all types of health centers unless otherwise indicated.

[2]Most health centers operate facilities at several locations—referred to as sites.

Program's grants: the Community Health Center Fund (CHCF).[3] The CHCF supports a variety of grants to health centers for health care services for low-income populations.

You asked us to review health centers' revenue, including its sources and uses. In this report we describe

1. trends in health centers' revenue from 2010 through 2017; and
2. the purposes for which CHCF grants have been awarded.

To describe trends in health centers' revenue, we analyzed data from HRSA's Uniform Data System for calendar years 2010 through 2017, the most recent data at the time of our analysis.[4] These data include data reported annually by health centers on their patient-related revenue, such as payments from Medicaid and Medicare, as well as other revenue provided from HRSA grants, other federal grants, and non-federal grants or contracts. All revenue data are reported as nominal dollars. We also interviewed HRSA officials about the sources of revenue provided to health centers since 2010, including how those sources may or may not have changed over time.

To describe the purposes for which CHCF grants have been awarded, we reviewed HRSA policy and grant documentation, such as HRSA grant funding announcements that outline the purpose of the grants funded by the CHCF. We also reviewed a list provided by HRSA that includes all 52 awards funded through 28 CHCF grants from fiscal years 2011 through 2017. This list included the award purpose and funding amount.[5] Each

[3]Pub. L. No. 111-148, § 10503, 124 Stat. 119, 1004 (2010), as amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 2303, 124 Stat. 1029, 1083 (2010); Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. No. 114-10, § 221, 129 Stat. 87, 154 (2015); Bipartisan Budget Act of 2018, Pub. L. No. 115-123, § 50901, 132 Stat. 64, 282 (2018) (codified at 42 U.S.C. § 254b-2). The CHCF also supports the National Health Service Corps, a scholarship and loan repayment program that places providers in underserved areas, including at health centers. From fiscal year 2012 through fiscal year 2018, the CHCF was that program's sole funding source.

[4]The Uniform Data System (UDS) includes data reported annually by health center grant awardees. UDS consists of data relating to patients, visits, staffing and utilization, quality of care indicators, health outcomes and disparities, financial costs, and revenue. UDS revenue is the gross receipts on a cash basis for each year collected by health centers, regardless of the period in which the paid for services were rendered. Data are reported in UDS by calendar year, rather than fiscal year.

[5]Some grants were funded in multiple fiscal years.

grant could represent multiple awards to health centers. To corroborate the list of awards provided by HRSA, we reviewed descriptions of the grants contained in the funding opportunity announcements and grant award announcements for a random sample of 10 percent of the 52 awards made, including those for the largest grants. We also analyzed information on health center sites reported by health centers to HRSA—known as Form 5 B Service Site data—to determine the number and location of new health centers from fiscal years 2011 through 2017.[6] These data show the location of each health center site. We reviewed some published studies identified through web searches that describe how the CHCF has been used since fiscal year 2011, such as studies published by the Congressional Research Service and George Washington University's Milken Institute, and we interviewed the studies' authors.[7] Lastly, we interviewed HRSA officials and the National Association of Community Health Centers—an organization representing health centers—about the use of CHCF grant funding.

We assessed the reliability of the Uniform Data System and Form 5 B Service Site data used in this report by reviewing relevant documentation and interviewing officials knowledgeable about the data. Based on these steps, we found the data were sufficiently reliable for the purpose of our reporting objectives.

We conducted this performance audit from November 2018 to May 2019 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[6]We analyzed HRSA's Federal Office of Rural Health Policy eligible zip code data files to determine whether the location of a new site was in a rural area. For more information see https://www.hrsa.gov/rural-health/about-us/definition/datafiles.html. We assessed the reliability of this data and determined they were sufficiently reliable for the purpose of our reporting objectives.

[7]See for example, Congressional Research Service, *The Community Health Center Fund: In Brief* (Washington, D.C., July 5, 2018); Congressional Research Service, *Federal Health Centers: An Overview* (Washington, D.C., May 19, 2017); and P. Shin, J. Sharac, R. Gunsalus, and S. Rosenbaum, *Policy Research Brief #49: What are the Possible Effects of Failing to Extend the Community Health Center Fund?"* September 21, 2017.

Background

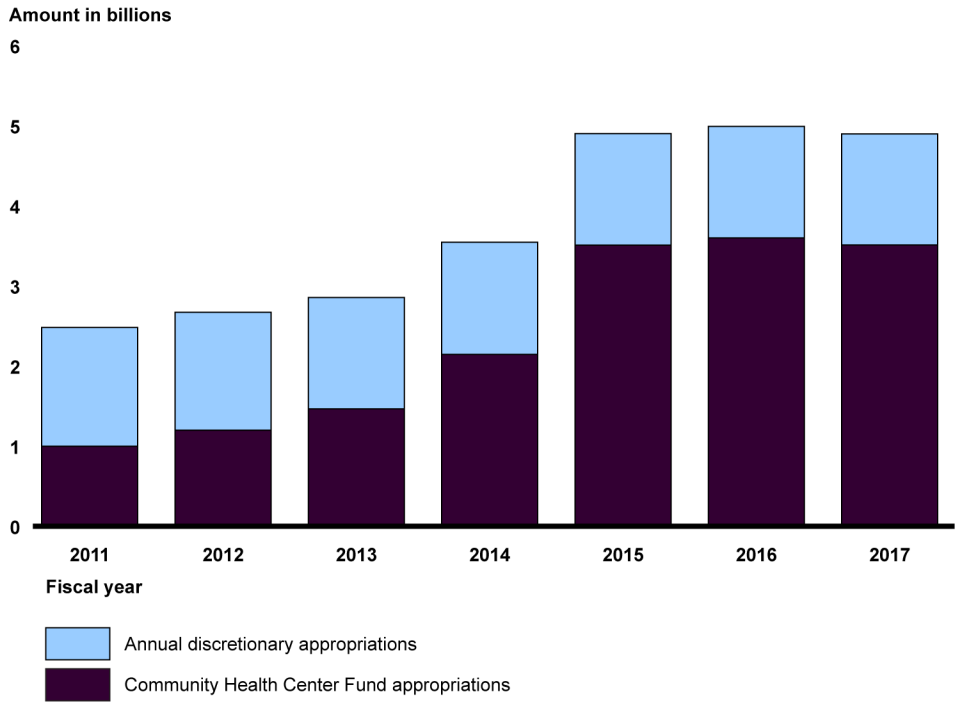
The federal Health Center Program was established in the mid-1960s in an effort to help low-income individuals gain access to health care services. The Health Center Program, authorized in Section 330 of the Public Health Service Act, is administered by HRSA's Bureau of Primary Health Care and makes grants—known as Section 330 grants—to four types of health centers that primarily serve low-income populations:

1. *Community health centers.* These health centers serve the general population with limited access to health care. They are required to provide primary health services to all residents who reside in the center's service area. More than three-quarters of health centers are community health centers.
2. *Health centers for the homeless.* These health centers provide primary care services to individuals who lack permanent housing or live in temporary facilities or transitional housing. These centers are required to provide substance abuse services and supportive services targeted to the homeless population.
3. *Health centers for residents of public housing.* These health centers provide primary health care services to residents of public housing and individuals living in areas immediately accessible to public housing.
4. *Migrant health centers.* These health centers provide primary care to migratory agricultural workers (individuals whose principal employment is in agriculture and who establish temporary residences for work purposes) and seasonal agricultural workers (individuals whose principal employment is in agriculture on a seasonal basis but do not migrate for the work).

HRSA's Section 330 grants are funded by a combination of discretionary appropriations and, since 2011, mandatory appropriations provided from the CHCF.[8] From fiscal years 2010 through 2017, total funding appropriated for Section 330 grants—which includes funding from discretionary appropriations and the CHCF—increased from about $2.1 billion to $4.9 billion (see fig. 1).

[8]Discretionary appropriations are generally made through the annual appropriations process. Mandatory appropriations are generally created and funded in the same law in a multiyear or permanent basis and not through the annual appropriations process. Although created in 2010 under PPACA, the first year of CHCF funding was fiscal year 2011.

Figure 1: Appropriations for Section 330 Federal Grants, Fiscal Years 2011–2017



Source: GAO review of Health Resources and Services Administration budget justifications. | GAO-19-496

According to HRSA data, approximately 70 percent of appropriations for Section 330 awards in fiscal year 2017—or about $3.5 billion—were funded by the CHCF. HRSA officials also told us that the total amount of CHCF appropriations may differ from the total amount of awards funded because, for example, appropriations may be (1) used for administrative costs, (2) reduced because of sequestration, or (3) carried over between fiscal years.

Health centers are required to provide comprehensive primary health services, including preventive, diagnostic, treatment, and emergency health services. (See table 1.) All services that health centers provide must be available to patients at the center regardless of patient payment source or ability to pay and must be available (either directly or under a referral arrangement) to patients at all health center service sites. Services are provided by clinical staff—including physicians, nurses, dentists, and mental health and substance abuse professionals—or through contracts or cooperative arrangements with other providers.

Table 1: Selected Primary Health and Supplemental Services Provided at Health Centers

Category	Examples of services provided
Primary health services	Primary health services include basic health services including those related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology.
Preventive health services	Required preventive services include • Well-child care • Prenatal and perinatal care • Immunizations • Voluntary family planning • Preventive dental care
Emergency medical services	Required services that are provided through defined arrangements with outside providers for medical emergencies during and after centers regularly scheduled hours.
Enabling services	Required services include, but are not limited to • Translation services • Health education • Transportation for individuals residing in a center's service area who have difficulty accessing the center
Supplemental services	Additional services that are not primary health services but are appropriate to meet the health needs of the service population, such as behavioral health and environmental health services.[a] Health centers are not required to provide these services.

Source: Public Health Service Act. | GAO-19-496

[a]Mental health services include the services of psychiatrists, psychologists, and other appropriate mental health professionals. Environmental services can include the detection and alleviation of unhealthful conditions associated with water supply and lead exposure, among other things.

In addition to the services they provide, health centers are also required to document the unmet health needs of the residents in their service area and to periodically review their service areas to determine whether the services provided are available and accessible to area residents promptly and as appropriate. Health centers also must have a sliding fee scale based on a patient's ability to pay and to be governed by a community board of which at least 51 percent of the members are patients of the health center.[9] HRSA determines whether health center grantees meet

[9]HRSA may waive the patient majority board composition governance requirement for certain centers, such as health centers for the homeless, upon a showing of good cause.

these and other health center program requirements when making award determinations.[10]

While Health Centers' Revenue Doubled from 2010 through 2017, the Share of Revenue from Grants Decreased

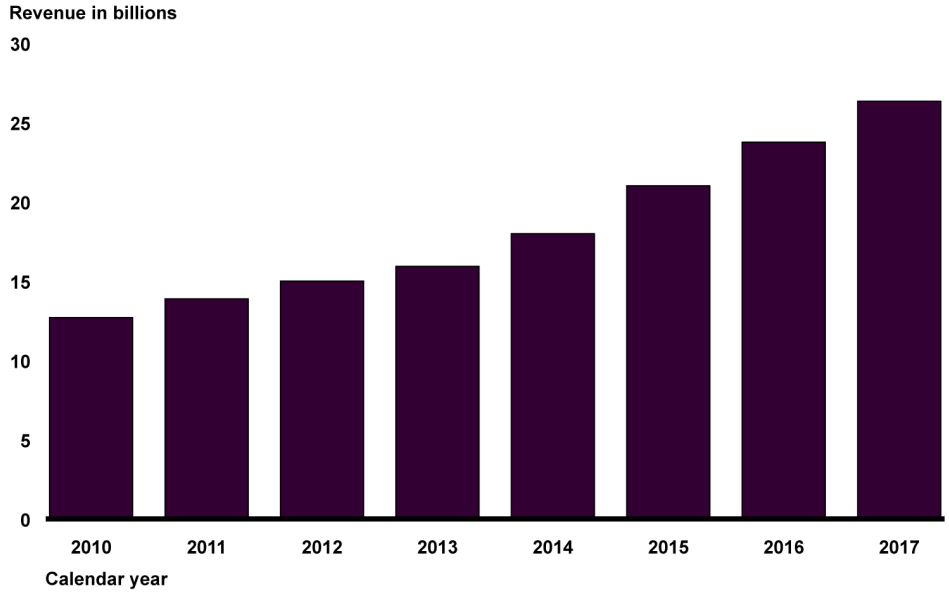
Our analysis shows that total revenue received by health centers nationwide more than doubled from calendar years 2010 through 2017—from about $12.7 billion to $26.3 billion (see fig. 2).[11] Over the same time period, both the number of health centers and the number of patients served also increased. The number of health centers increased from 1,124 centers in 2010—operating 6,949 sites—to 1,373 centers in 2017—operating 11,056 sites.[12] In addition, the total number of patients served at health centers over the same time period increased by 7.7 million patients, from 19.5 million to 27.2 million. See appendix I for additional information.

[10]In 2017 HRSA issued the Health Center Program Compliance Manual which outlines 18 program requirements. The Health Center Program Compliance Manual is the consolidated resource to assist in understanding and demonstrating compliance with the Health Center Program requirements found in the Health Center Program's authorizing legislation and implementing regulations, as well as certain applicable grants regulations. For information on the Health Center Program Compliance Manual see https://bphc.hrsa.gov/programrequirements/compliancemanual/index.html..

[11]In real terms, the growth in revenue is less. Specifically, the inflation-adjusted increase was about 85 percent instead of 107 percent.

[12]In addition to these totals, some organizations choose not to apply for funding under the Health Center Program, but seek to be recognized by HRSA as health center look-alikes. With this recognition, they may become eligible to receive other federal benefits, such as enhanced Medicare and Medicaid payment rates and reduced drug pricing. In 2017, there were 56 look-alikes that served 721,922 patients, a decrease from 93 look-alikes that served 951,242 patients in 2012. For more information on Health Center Program look-alikes, see https://bphc.hrsa.gov/uds/lookalikes.aspx?year=2017.

Figure 2: Health Centers' Revenue, Calendar Years 2010–2017



Source: GAO analysis of Health Resources and Services Administration data. | GAO-19-496

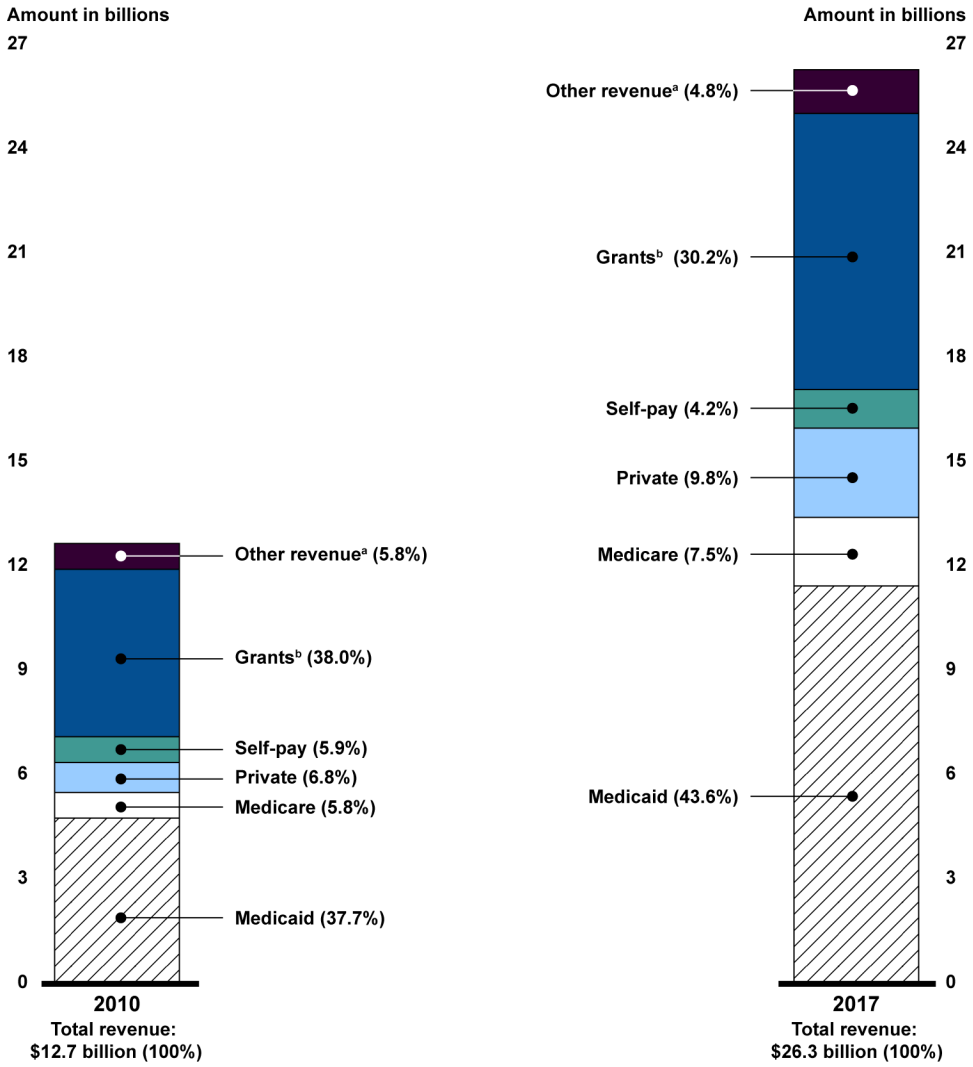
Notes: Revenue in the Uniform Data System is defined as the gross receipts on a cash basis for each year collected by health centers, regardless of the period in which the paid for services were rendered. Dollars are nominal.

While the total revenue received by health centers more than doubled from 2010 through 2017, the share of revenue received from grants—including Section 330 grants and other federal and non-federal grants—decreased, from 38.0 percent of total revenue in 2010 to about 30.2 percent in 2017.[13] During the same time period, the share of revenue health centers received from Medicaid, Medicare, and private health

[13]Grants in HRSA's Uniform Data System include three categories of revenue: (1) Section 330 grants, such as Health Center Program grants; (2) other federal grants, such as Medicare and Medicaid Electronic Health Record Incentive grants; and (3) non-federal grants or contracts, such as amounts from contracts that are not tied to the delivery of services and amounts received from state and local indigent care programs. The federal grants health centers receive are awarded in part to support services provided to the uninsured. The decrease in the share of health center revenue from grants corresponds to a decrease in health centers' uninsured patient population. By 2017, about 23 percent of the overall patient population of health centers were uninsured—a decrease from about 38 percent in 2010. See table 3 in appendix I.

insurance increased (see fig. 3).[14] (See app. II for more information on health centers' revenue from 2010 through 2017.)

Figure 3: Health Center Revenue Sources and Amounts In Calendar Years 2010 and 2017



Source: GAO analysis of Health Resources and Services Administration (HRSA) Uniform Data System data. | GAO-19-496

[14]In 2017, the amount of revenue health centers received from Medicaid generally aligned with the size of the Medicaid patient population. While revenue from Medicaid made up about 44 percent of health centers' revenue, about 49 percent of the patients served by health centers were covered by Medicaid. See table 3 in appendix I.

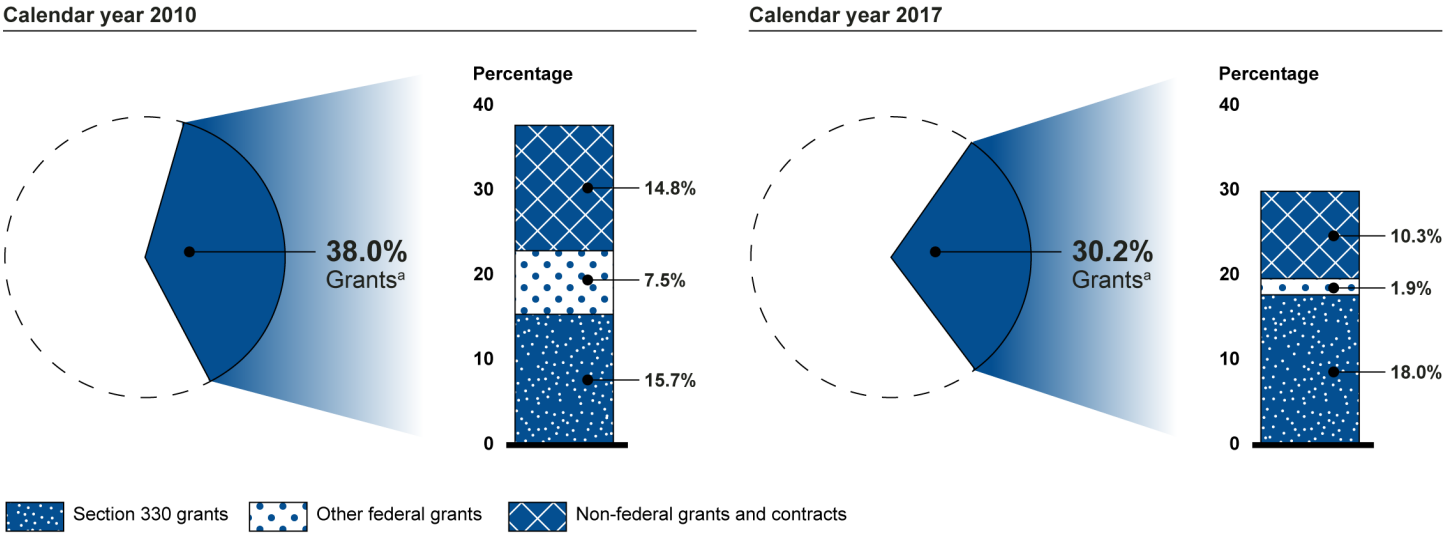
Notes: Revenue in the Uniform Data System is defined as the gross receipts on a cash basis for each year collected by health centers, regardless of the period in which the paid for services were rendered. Dollars are nominal. Percentages may not add to 100 due to rounding.

[a]Other revenue includes two categories in the Uniform Data System: (1) other public insurance and (2) non-patient related revenue not reported elsewhere, such as revenue from fund-raising, rent from tenants, medical record fees, and vending machines.

[b]Grants in HRSA's Uniform Data System include three categories of revenue: (1) Section 330 grants, such as Health Center Program grants; (2) other federal grants, such as Medicare and Medicaid Electronic Health Record Incentive grants; and (3) non-federal grants or contracts, such as amounts from contracts that are not tied to the delivery of services and amounts received from state and local indigent care programs.

While the share of health centers' total revenue coming from all grants decreased from 2010 to 2017, the share of revenue from one type of grant—Section 330 grants—increased. Specifically, the share of revenue health centers received from Section 330 grants—a portion of which are funded by the CHCF—increased from 15.7 percent of health centers' total revenue in 2010 to 18.0 percent in 2017 (see figure 4).

Figure 4: Percentage of Health Center Revenue from Grants, Calendar Years 2010 and 2017



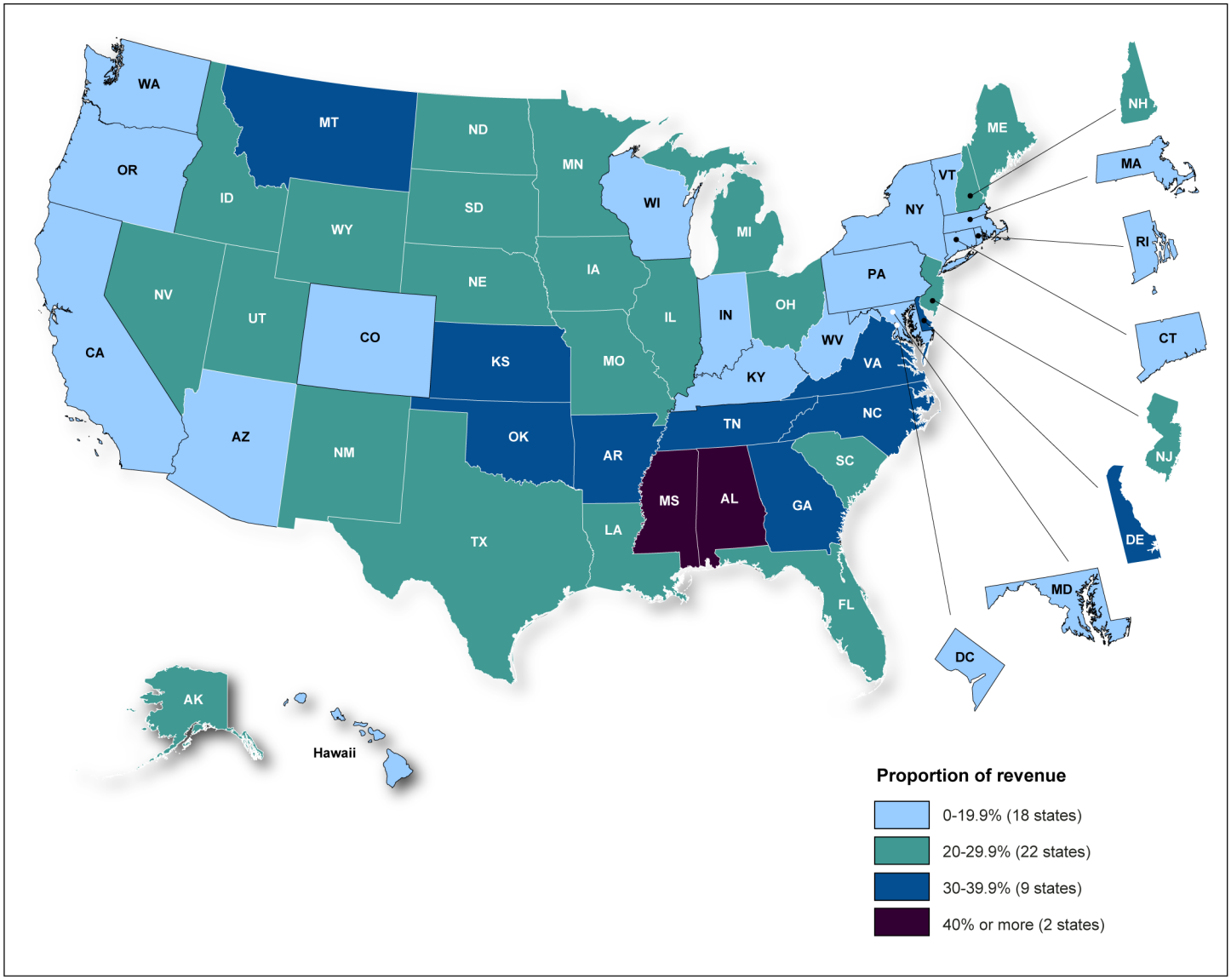
Source: GAO analysis of Health Resources and Services Administration (HRSA) Uniform Data System data. | GAO-19-496

Notes: Total revenue for health centers in 2010 was about $12.7 billion and in 2017 was about $26.3 billion. Dollars are nominal.

[a]Grants in HRSA's Uniform Data System include three categories of revenue: (1) Section 330 grants, such as Health Center Program grants; (2) other federal grants, such as Medicare and Medicaid Electronic Health Record Incentive grants; and (3) non-federal grants or contracts, such as amounts from contracts that are not tied to the delivery of services and amounts received from state and local indigent care programs.

Our analysis also shows that the share of revenue health centers receive from Section 330 grants varies by state. As figure 5 below shows, in 2017, health centers in 2 states received more than 40 percent of their total revenue from Section 330 grants, while health centers in 18 states received less than 20 percent of total revenue from these grants.

Figure 5: Share of Health Center Revenue from Section 330 Grants, by State, Calendar Year 2017

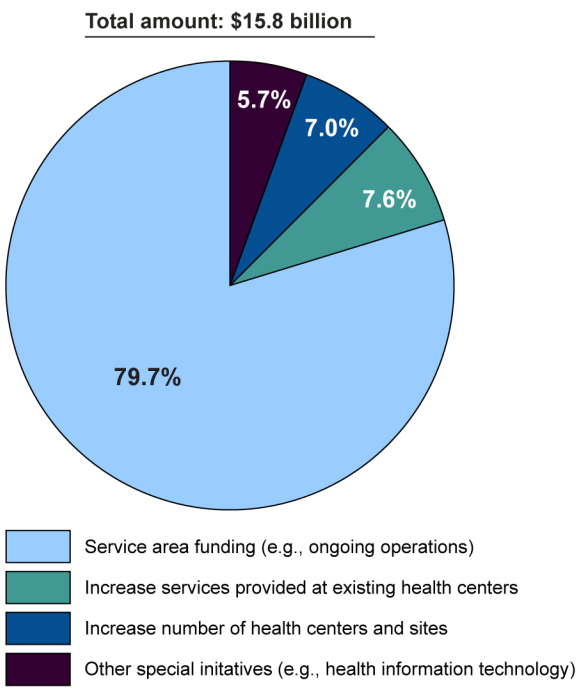


Sources: GAO analysis of Health Resources and Services Administration Uniform Data System (data); Map resources (map). | GAO-19-496

HRSA Awarded CHCF Grants Primarily to Support Ongoing Operations and Services at Health Centers

Our analysis of HRSA data shows that for the 7-year period from fiscal years 2011 through 2017, HRSA provided health centers with about $15.8 billion in Section 330 grants funded by the CHCF.[15] Most of this funding—$12.6 billion, or nearly 80 percent of all grants awarded through the CHCF during this period—was awarded for the purpose of service area funding, which supports ongoing operations and services across the nearly 1,400 health centers nationwide (see fig. 6). The remaining $3.2 billion in CHCF grants were awarded to increase the amount of services provided at existing health centers; to increase the number of health centers and sites; and for other special initiatives, such as initiatives to support health information technology.

Figure 6: Total Health Resources and Services Administration (HRSA) Section 330 Grants Funded by the Community Health Center Fund (CHCF), Fiscal Years 2011–2017



Source: GAO review of Health Resources and Services Administration award information. | GAO-19-496

[15]As previously noted, Section 330 grants funded by the CHCF are a subset of all Section 330 grants. For fiscal years 2011 through 2017, Congress appropriated about $16.4 billion for the CHCF. HRSA officials told us that the amount of Section 330 grants health centers received may be less than the total amount appropriated for the CHCF because of factors such as administrative costs, sequestration, or monetary carryover between fiscal years.

Notes: Section 330 grants funded by the CHCF are a subset of all Section 330 grants. Percentages may not add to 100 due to rounding. Dollars across fiscal years are nominal.

Service area funding. From fiscal years 2011 through 2017, HRSA used the CHCF to provide health centers with approximately $12.6 billion in grants for service area funding, which supports ongoing operations and service delivery.[16] HRSA officials told us that these CHCF grants are used to fill the gap between what it costs to operate a health center and the amount of revenue a health center receives. As such, the awards are a primary means through which health centers provide health care services that may be uncompensated, including services for patients who are uninsured or services not typically reimbursed by other payers, such as adult dental care, or other services such as transportation and nutritional education. These awards can cover uncompensated care costs for patients with incomes low enough to qualify for sliding fee assistance, which reduces or waives the cost of services for patients based on their ability to pay. In addition, these awards can cover patients who have private insurance but face substantial deductibles and cost-sharing. Officials we interviewed from the Congressional Research Service, George Washington University's Milken Institute, and the National Association of Community Health Centers similarly noted that CHCF grants support services not typically covered by public health insurance, such as adult dental care services not generally covered by Medicare or Medicaid.

Increasing services at existing health centers. From fiscal years 2011 through 2017, HRSA used the CHCF to provide health centers with about $1.2 billion in grants to help increase the amount of services offered at existing health centers that chose to apply for an award. This amount included funding to increase the availability of specific health care services, such as dental care, as well as funding to support health centers' efforts to extend service hours or increase the number of available providers. Specifically, these grants were awarded for the following:

- *Behavioral and mental health, substance abuse*. Three grants totaling about $400.8 million were awarded to expand access to behavioral health, mental health, and substance abuse services. These awards focused primarily on integrating primary care and behavioral health

[16]These grants are known as service area competitions and yearly budget period renewals.

care services and expanding substance use services at existing health centers, such as medication-assisted treatment for opioid-use disorder.[17]

- *Oral health.* A grant for about $155.9 million was awarded to increase access to oral health services and improve oral health outcomes by funding new onsite providers and supporting the purchase and installation of dental equipment.
- *Expanding Services.* Two grants—one in fiscal year 2014 for $295.6 million and another in fiscal year 2015 for about $349.6 million—were made to increase access to comprehensive primary health care in various ways, at the discretion of individual health centers. At existing sites, health centers may have chosen to expand service hours, increase the number of health care providers, or expand services such as oral health, behavioral health, pharmacy, and vision services.

Increasing the number of health centers and sites. From fiscal years 2011 through 2017, HRSA awarded about $1.1 billion—or about 7 percent of total CHCF funds—to organizations to help establish new health centers or new sites at existing health centers. Specifically, HRSA awarded grants for the following purposes:

- *New Access Point (NAP) Awards.* Most of the funding to increase access to health centers—about $648.5 million of the $1.1 billion—was provided through what are called NAP awards. According to HRSA officials, there are two primary ways these funds can be used—either to allow a new organization to become a health center (about 30 percent of grant applicants) or for an existing health center to add one or more service sites (about 70 percent of grant applicants).[18] HRSA officials told us that they funded 1,059 NAP awards to new and existing health centers from fiscal year 2011 through 2017 for a combined total of 1,609 proposed new health centers or sites.[19] These awards included 295 awards to new organizations and 764 awards to existing health centers adding one or more service sites. (See table 2 below for more information on the

[17]Medication-assisted treatment is an approach that combines behavioral therapy and the use of certain medications, such as methadone and buprenorphine. See GAO-16-833, *Opioid Addiction: Laws, Regulations, and Other Factors Can Affect Medication-Assisted Treatment Access* (Washington, D.C.: Sept. 27, 2016).

[18]Grant recipients could apply to establish a single site or multiple sites as part of one grant.

[19]HRSA did not make NAP awards in fiscal year 2016.

increase in health centers resulting from NAP awards.) Among the 1,609 total proposed new health centers or sites, 686 were in rural areas, including 191 new health centers and 495 additional sites at existing centers.

- *Construction Grants.* HRSA awarded construction grants totaling about $411.3 million through the Health Infrastructure Investment Program to help existing health centers alter, renovate, expand, or construct a facility.[20] According to HRSA officials, construction grants may increase the number of health center sites or may result in the consolidation of sites while still expanding access to care.
- *Health Center Planning Grants.* HRSA awarded a Health Center Planning grant in fiscal year 2011 for about $10.3 million to support planning and development of comprehensive primary care health centers.

Table 2: Community Health Center Fund New Access Point (NAP) Awards

Fiscal year	Total number of NAP awards[a]	Number of new centers or sites proposed by grantee[b]	Total NAP award funding ($ million)
2011	67	125	28.8
2012	219	344	128.6
2013	32	49	19.6
2014	236	367	150.7
2015	430	632	269.8
2017	75	92	51
Total	**1,059**	**1,609**	**648.5**

Source: Health Resources and Services Administration (HRSA). | GAO-19-496

Note: HRSA did not make NAP awards in fiscal year 2016.

[a]These awards include those for new health centers or new sites at existing health centers.

[b]Grantee proposals may include establishing multiple sites using one grant. These figures reflect the number of sites HRSA approved upon review of grant applications. According to HRSA officials, this number is subject to change.

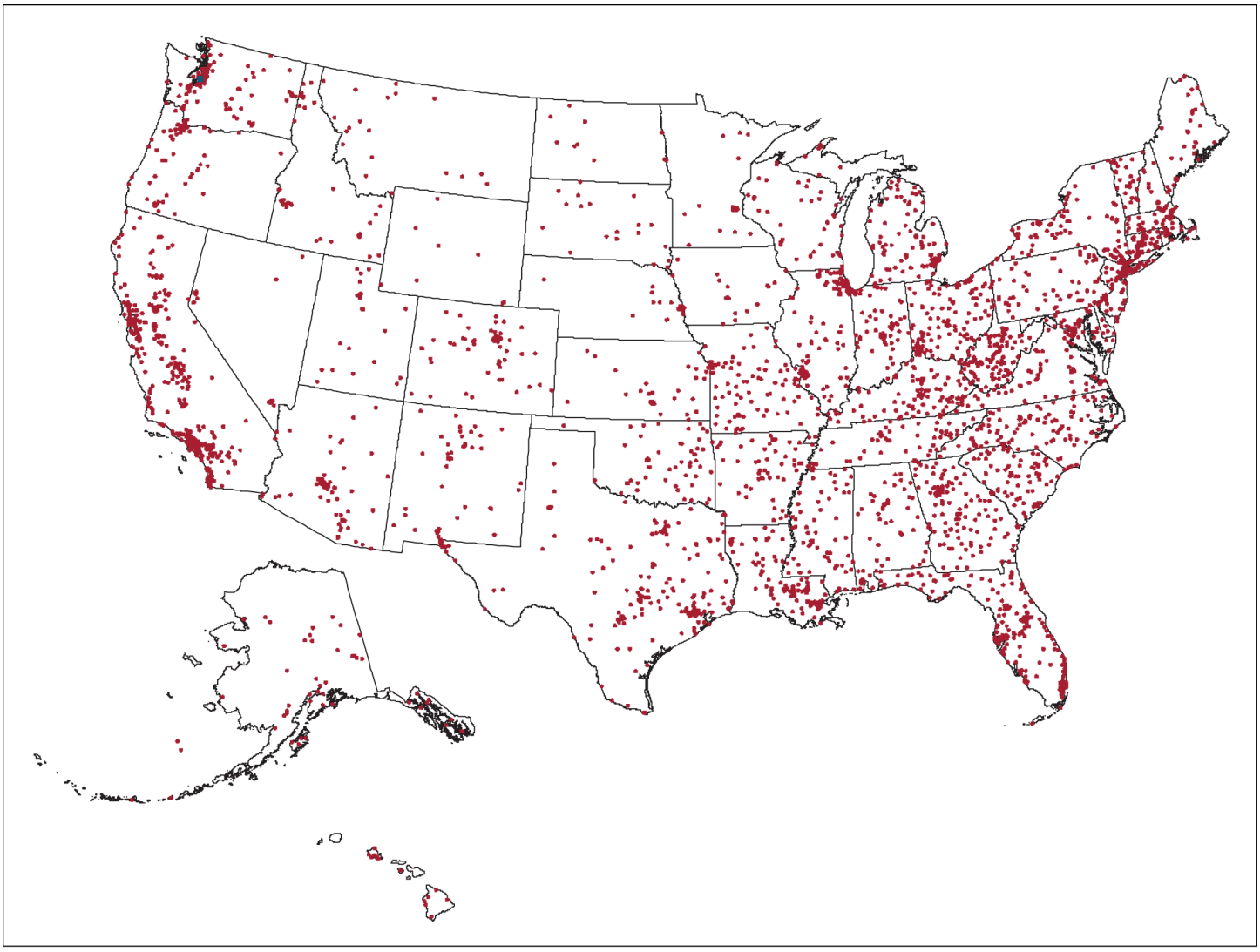
[20]These construction grants are separate from the $1.5 billion appropriated by PPACA to fund construction associated with health centers.

Collectively, a total of 5,536 new health center sites were added in the United States from fiscal year 2011 through 2017.[21] Of these new sites, 3,838 were in urban locations and 1,698 were in rural locations.[22] While many of these new health center sites were from NAP awards, as previously described, other grants either funded by the CHCF or by discretionary appropriations may have contributed to the establishment of new health center sites. For example, HRSA officials told us that health center sites may be added through a change of scope to their service area competition award or through other types of grants funded by the CHCF, such as grants to increase adult dental services. However, according to HRSA officials, the data do not allow for directly associating the number of new sites with those grants, as the grants may be used for multiple purposes. Figure 7 below shows the locations of health center sites added during this time period that are active as of February 2019.

[21]This number reflects new health center sites in the 50 states and the District of Columbia that were still active as of February 2019. In addition to these sites, 67 new health center sites were added in other areas.

[22]The number of new sites reported (5,536) here differs from the number of sites reported elsewhere in this report, including in figure 9 in appendix I. According to HRSA officials, differences are the result of the two methodologies used to generate these numbers. Specifically, the number of new sites reported here reflect new sites added to scope in fiscal year 2011 through fiscal year 2017, excluding sites added prior to fiscal year 2011 and sites terminated during this time period. Data reported elsewhere represent the net increase in total active sites as of the end of calendar year 2017.

Figure 7: Locations of New Health Center Sites, Fiscal Years 2011–2017



Source: GAO analysis of Health Resources and Services Administration Form 5 B Service Site data. | GAO-19-496

Note: Each dot represents a zip code where one or more health centers are located.

Other special initiatives. From fiscal years 2011 through 2017, HRSA awarded about $898.9 million of CHCF funds for grants to health centers to support other special initiatives and to address identified priorities or emerging health care needs. Specifically, HRSA awarded grants to those health centers that chose to apply for the following purposes:

- *Health information technology.* Three grants totaling about $243.4 million were awarded to advance the adoption and implementation of health information technology. For example, the purpose of one grant—the Health Center Controlled Networks—was to advance the adoption, implementation, and optimization of health information technology. Another grant provided supplemental funding to improve the electronic reporting capabilities of health centers in Beacon Communities.[23]
- *HIV.* Two grants totaling about $23.8 million were awarded with the goal to increase access to HIV care and services. One specifically targeted prevention and treatment services in those communities most affected by HIV.
- *Outreach and enrollment.* $222.0 million in grant funding was awarded to support health centers in raising awareness of affordable insurance options and providing eligibility and enrollment assistance to uninsured patients of health centers and residents in their approved service areas.
- *Patient-Centered Medical Home.* About $84.6 million in grant funding was awarded to support HRSA efforts to expand the number of patient-centered medical homes with a particular focus of improving quality of care, access to services, and reimbursement opportunities.[24]
- *Quality improvement.* Approximately $305.1 million in grant funding was awarded to support health centers that displayed high quality performance so they can continue to strengthen quality improvement efforts. Specifically, the funds were to support health centers to further improve the quality, efficiency, and effectiveness of health care delivered to the communities served.
- *Training and technical assistance.* Two grants totaling about $14.3 million were awarded to support training and technical assistance for health centers in order to support programmatic, clinical, and financial operations. One grant focused on the delivery of training and technical

[23]The Beacon Community Agreement Program is a cooperative agreement program administered by HHS's Office of the National Coordinator for Health Information Technology. The program provides funding to 17 selected communities throughout the United States with strong health information technology infrastructure, including high rates of electronic health record adoption.

[24]A patient-centered medical home is an approach to provide comprehensive primary care by facilitating partnerships between individual patients, their physicians, and when appropriate, the patient's family.

assistance by national organizations and the other grant was based on statewide and regional needs.

- *Zika.* A grant for about $5.7 million was awarded to health centers that chose to apply to expand their existing activities to strengthen the response to the Zika virus in Puerto Rico, the U.S. Virgin Islands, and American Samoa. These activities included outreach, patient education, screening, voluntary family planning services, and/or treatment services.

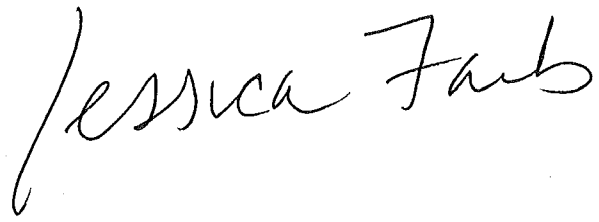
See appendix III for a complete list of all grants awarded through CHCF by category.

Agency Comments

We provided a draft of this report to HHS. HHS provided technical comments, which we incorporated as appropriate.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further action until 30 days from the report date. At that time, we will send copies of this report to the Secretary of Health and Human Services and other interested parties. In addition, the report will be available at no charge on GAO's 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 at farbj@gao.gov. Contact points for our Office of Congressional Relations and Office of Public Affairs can be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix IV.



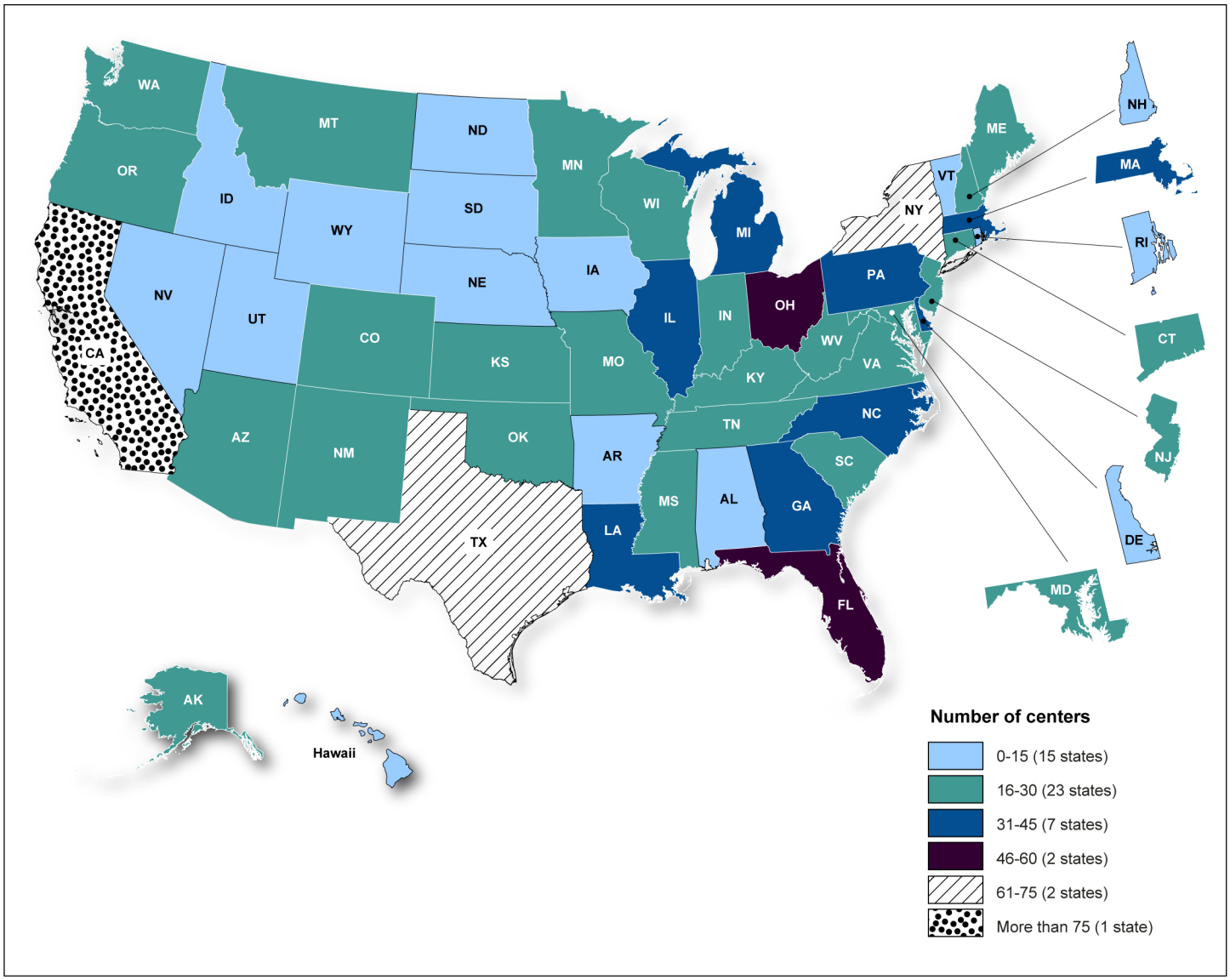
Jessica Farb
Director, Health Care

Appendix I: Information on Health Centers and Patients Served

This appendix provides information on health centers and patients served. Specifically,

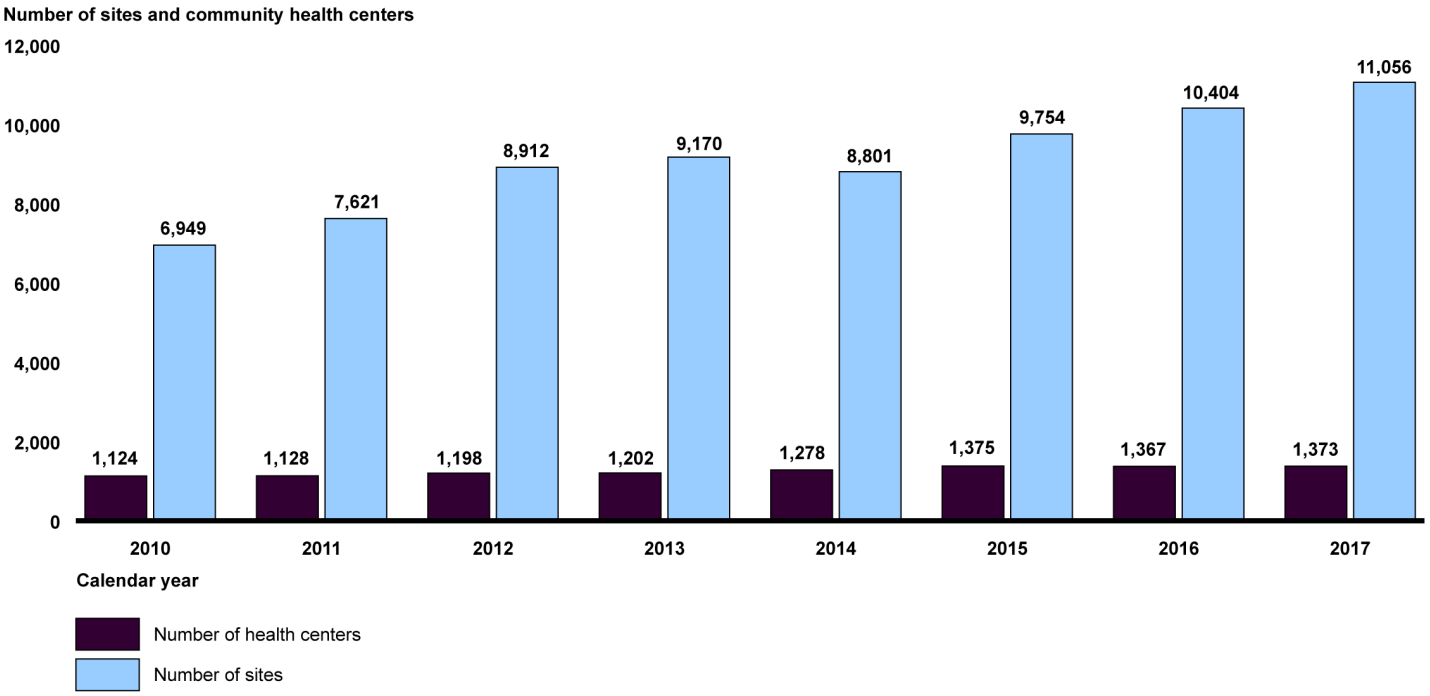
- figure 8 illustrates the number and location of health centers in 2017;
- figure 9 illustrates the growth in health centers and sites since 2010;
- figure 10 illustrates the growth in patients served at health centers since 2010; and
- table 3 provides information on how the payer mix for patients served at health centers has changed since 2010.

Figure 8: Number and Location of Health Centers, Calendar Year 2017



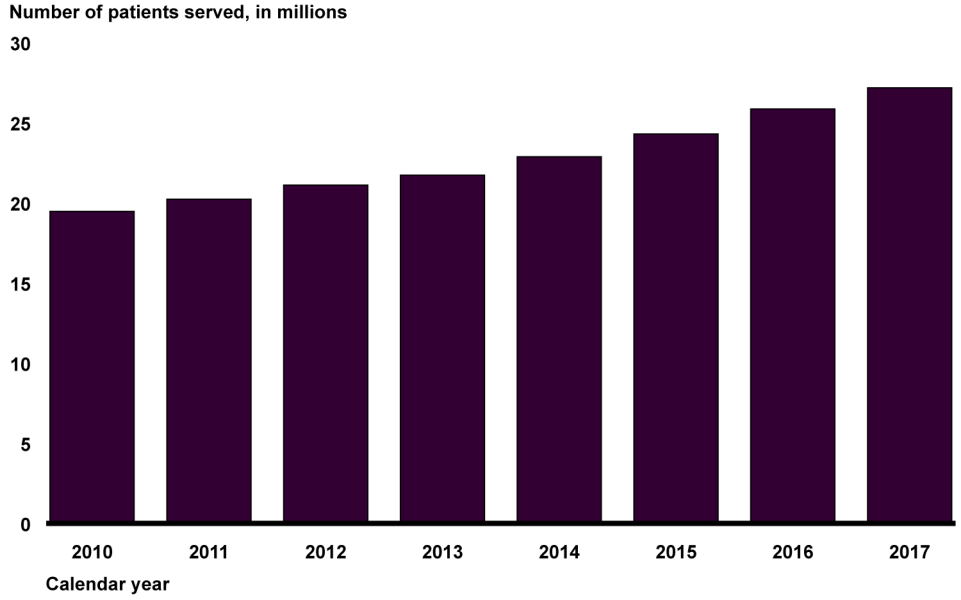
Sources: Health Resources and Services Administration Uniform Data System (data); Map Resources (map). | GAO-19-496

Figure 9: Growth in Health Centers and Sites, 2010–2017



Source: Health Resources and Services Administration Uniform Data System data. | GAO-19-496

Figure 10: Growth in Number of Patients Served at Health Centers, 2010–2017



Source: Health Resources and Services Administration Uniform Data System data. | GAO-19-496

Table 3: Proportion of Health Center Patients Who are Uninsured or Covered by Medicaid, Medicare, or Private Insurance, Calendar Years 2010 through 2017

Year	Percentage covered by Medicaid	Percentage covered by Medicare	Percentage covered by other public insurance[a]	Percentage covered by private insurance	Percentage uninsured
2010	38.5	7.5	2.5	13.9	37.5
2011	39.3	7.8	2.4	14.1	36.4
2012	39.6	8.0	2.3	14.0	36.0
2013	40.6	8.4	2.0	14.1	34.9
2014	46.7	8.6	1.3	15.6	27.9
2015	48.9	8.9	1.0	16.8	24.4
2016	49.2	9.2	1.0	17.2	23.4
2017	49.1	9.4	1.0	17.6	22.9

Source: GAO analysis of Health Resources and Services Administration (HRSA) Uniform Data System data. | GAO-19-496

[a]HRSA's Uniform Data System defines other public insurance as state and/or local government programs, such as Washington's Basic Health Plan or Massachusetts' Commonwealth plan, that provide a broad set of benefits for eligible individuals. It can also include the Children's Health Insurance Program.

Appendix II: Sources and Amounts of Revenue for Health Centers, Calendar Years 2010 through 2017

Table 4: Health Center Revenue Sources by Year, Calendar Years 2010 through 2017

	2010		2011		2012		2013	
Source	**Millions of dollars**	**Percent of total revenue**	**Millions of dollars**	**Percent of total revenue**	**Millions of dollars**	**Percent of total revenue**	**Millions of dollars**	**Percent of total revenue**
Total Medicaid	4,780	37.7	5,288	38.1	5,744	38.3	6,302	39.6
Total Medicare	740.3	5.8	799.6	5.8	897.6	6.0	969.9	6.1
Total other public insurance[a]	339.5	2.7	333.6	2.4	383.4	2.6	355.7	2.2
Total private insurance	864.2	6.8	951.3	6.9	1,086	7.2	1,197	7.5
Self-pay	744.2	5.9	818.2	5.9	912.7	6.1	977.6	6.1
Total federal Section 330 Grants[b]	1,993	15.7	2,295	16.5	2,614	17.4	2,832	17.8
Total other federal Grants[c]	950.3	7.5	1,010	7.3	750.6	5.0	478.5	3.0
Total non-federal grants and contracts[d]	1,880	14.8	1,940	14.0	2,050	13.7	2,164	13.6
Other revenue[e]	399.5	3.1	444.6	3.2	561.5	3.7	647.2	4.1
Total revenue	**12,691**	**100.0**	**13,880**	**100.0**	**15,001**	**100.0**	**15,923**	**100.0**
	2014		**2015**		**2016**		**2017**	
Total Medicaid	7,632	42.4	9,327	44.4	10,289	43.3	11,478	43.6
Total Medicare	1,098	6.1	1,386	6.6	1,692	7.1	1,974	7.5
Total other public insurance[a]	276.3	1.5	257.3	1.2	256.2	1.1	280.7	1.1
Total private insurance	1,467	8.2	1,805	8.6	2,228	9.4	2,569	9.8
Self-pay	942.9	5.2	930.2	4.4	1,005	4.2	1,109	4.2
Total federal Section 330 Grants[b]	3,210	17.8	3,701	17.6	4,422	18.6	4,732	18.0
Total other federal Grants[c]	481.0	2.7	459.1	2.2	457.2	1.9	509.7	1.9
Total non-federal grants and contracts[d]	2,150	12.0	2,305	11.0	2,460	10.4	2,701	10.3
Other revenue[e]	729.8	4.1	831.2	4.0	943.8	4.0	983.2	3.7
Total revenue	**17,987**	**100.0**	**21,001**	**100.0**	**23,753**	**100.0**	**26,337**	**100.0**

Source: Health Resources and Services Administration (HRSA) Uniform Data System data. | GAO-19-496

Notes: Dollars are nominal. Percentages may not equal 100 due to rounding.

[a]HRSA's Uniform Data System defines other public insurance as state and/or local government programs, such as Washington's Basic Health Plan or Massachusetts' Commonwealth plan, that provide a broad set of benefits for eligible individuals.

[b]Total federal Section 330 grants includes Health Center Program grants.

[c]Other federal grants in HRSA's Uniform Data System include Medicare and Medicaid Electronic Health Record Incentive grants.

[d]HRSA's Uniform Data System defines non-federal grants and contracts as revenue from contracts that are not tied to the delivery of services and revenue received from state and local indigent care programs.

[e]HRSA's Uniform Data System defines other revenue as non-patient related revenue not reported elsewhere. Examples include revenue from fund-raising, rent from tenants, medical record fees, and vending machines.

Appendix III: Community Health Center Fund Awards for Health Centers, Fiscal Years 2011 through 2017

Table 5: Community Health Center Fund (CHCF) Awards for Health Centers, Fiscal Years (FY) 2011 through FY 2017

		Amount in millions of dollars						
Name of award	**Purpose of funding**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Service area funding								
Base Adjustment for Continued Operations	Increase health center's annual ongoing base funding	-	-	48.2	110.4	165	-	-
Funding for continued operations (Service area competition or budget period renewal)*	Ensure continued access to primary health care services for communities currently served by the Health Center Program	891.3	960.6	1,200	1,400	2,000	2,700	3,100
Increase services at existing health centers								
Behavioral and Mental Health, Substance Abuse								
Access Increases for Mental Health and Substance Abuse Services (AIMS)	Expand access to mental health and substance abuse services with a focus on treatment, prevention, and awareness of opioid abuse	-	-	-	-	-	-	200.5
Behavioral Health Integration	Increase coordination, collaboration, and integration of primary and behavioral health care services	-	-	-	55.1	51.3	-	-
Substance Abuse Service Expansion	Improve and expand delivery of substance abuse services at existing health centers, including medication-assisted treatment	-	-	-	-	-	93.9	-
Expanding services								
Expanding Services (ES) – FY2014	Increase access to primary care health services[a]	-	-	-	295.6	-	-	-
Expanding Services (ES) – FY2015	Increase access to primary care health services[a]	-	-	-	-	349.6	-	-
Oral health								
Oral Health	Increase access to oral health services and improve oral health outcomes, such as by hiring new providers and purchasing dental equipment	-	-	-	-	-	155.9	-

		Amount in millions of dollars						
Name of award	**Purpose of funding**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Increase the number of health centers and sites								
Construction[b]								
Health Infrastructure Investment Program (HIIP)	Funding for alteration/renovation, expansion, or construction of a facility at existing health centers	-	-	-	-	148.9	262.4	-
Increase number of health centers								
Health Center Planning Grants	Increase in number of health centers (organizations or sites at existing centers)	10.3	-	-	-	-	-	-
New Access Point (NAP)	Increase in number of health centers (organizations or sites at existing centers)	28.8	128.6	19.6	150.7	269.8	-	51
Other special initiatives								
Health information technology								
Beacon Communities	Supplemental funding to improve the quality of care and electronic reporting capabilities of health centers in Beacon Communities	8.5	-	-	-	-	-	
Health Center Controlled Networks (HCCN)	Advance the adoption, implementation and optimization of health information technology	-	-	21.1	21	32.8	36.3	36.3
Delivery System Health Information Investment (DSHII)	Support strategic investments in health information technology to support quality improvement	-	-	-	-	-	87.4	-
HIV								
HIV Supplement[c]	Increase access to HIV care and treatment services	-	5.1	6.3	-	-	-	-
Partnerships for Care*	Expand provision of HIV prevention and care services within communities most impacted by HIV	-	-	-	6.3	3	3.1	-
Outreach and enrollment								
Outreach and enrollment	Expand current outreach and enrollment activities	-	-	150	58.7	6.3	7	-
Patient-Centered Medical Home								
Patient-Centered Medical Home	Improve quality of care, access to services, and reimbursement opportunities	31.6	44.4	-	-	-	8.6	-

		Amount in millions of dollars						
Name of award	**Purpose of funding**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Quality improvement								
Quality Improvement	Support health centers that displayed high levels of quality performance	-	-	-	-	99.6	100.2	105.3
Training and technical assistance								
National Training and Technical Assistance Cooperative Agreements (NCA)*	Support the delivery of training and technical assistance by national organizations to maintain fiscal and operational excellence, engage in effective workforce development activities, and appropriately structure health care services.	2.9	-	-	-	-	-	-
State and Regional Primary Care Association (PCA) Cooperative Agreements*	Provide technical assistance based on statewide and regional needs to help health centers improve programmatic, clinical, and financial performance and operations.	5	-	6.4	-	-	-	-
Zika								
Zika	Expansion of existing activities to strengthen response to Zika in Puerto Rico, the U.S. Virgin Islands, and American Samoa[d]	-	-	-	-	-	5.7	-

Source: GAO analysis of Health Resources and Services Administration (HRSA) documentation. | GAO-19-496

Notes: An "*" indicates that this grant was also funded through discretionary appropriations. Award amounts in the table are only CHCF funds. Dollars are nominal.

[a]Expanding services grants provided supplemental funding to support expanded service hours, increased numbers of medical providers, increased availability of medical services, and, optionally, the provision of services such as oral health, behavioral health, pharmacy, and/or vision service at existing health center sites.

[b]The capital improvement awards included in this table are those funded by the CHCF.

[c]HIV supplement grants were a joint effort by HRSA's HIV/AIDS Bureau and Bureau of Primary Health Care.

[d]Existing activities include outreach, patient education, screening, voluntary family planning services, and/or treatment services.

Appendix IV: GAO Contact and Staff Acknowledgments

GAO Contact

Jessica Farb, (202) 512-7114 or farbj@gao.gov

Staff Acknowledgments

In addition to the contact named above, Kristi Peterson, Assistant Director; Amy Leone, Analyst-in-Charge; Margot Bolon, Krister Friday, Jeff Tamburello, and Eric Wedum made key contributions to this report. Also contributing were Vikki Porter, Rotimi Adebonojo, Giselle Hicks, and Jennifer Whitworth.