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HEALTH CARE ACCESS

Programs for Underserved Populations Could Be Improved

Statement of Janet Heinrich, Associate Director
Health Financing and Public Health Issues
Health, Education, and Human Services Division

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Health Care Access: Programs for Underserved Populations Could Be Improved

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today as you discuss federal safety-net programs intended to improve access to medically underserved populations. As you know, many Americans face barriers to obtaining primary health care. These Americans may live in isolated rural areas or inner-city neighborhoods and lack access to health services or a sufficient number of health care providers. In addition, an increasing number of people lack health insurance. Research shows that people in these situations use less care, often forego seeking care when ill, or travel long distances to get care.

My statement today will focus on two safety-net programs administered by the Department of Health and Human Services' (HHS) Health Resources and Services Administration (HRSA): the Community and Migrant Health Center program and the National Health Service Corps (Corps). Community and Migrant Health Centers (health centers) were authorized about 35 years ago to increase the availability of primary and preventive health care services for low-income people living in medically underserved areas. In some communities, these centers may be the only primary care provider available to vulnerable populations, such as minorities and uninsured families. Health centers rely on public and private funding sources, including federal, state, and local governments; foundation grants; and payments for services from Medicaid, Medicare, private insurance, and patients. Fiscal year 2000 appropriations for the Consolidated Health Centers program[1] totaled over $1 billion. The National Health Service Corps provides some of the health professionals who work in the centers and other sites in communities where there is a shortage of providers. The Corps offers scholarships and educational loan repayments for health care professionals who, in turn, agree to serve for specific periods in communities that have a shortage of health professionals. Since its establishment in 1970, the Corps has placed thousands of health care providers, including physicians, nurses, and dentists, in such communities. The information presented today is based on our report on health centers,[2] being issued today at the request of you and Senator Jeffords, and on several reports we have issued since 1995 related to Corps operations and other efforts to improve access to care.

[1]The Health Centers Consolidation Act of 1996 (P.L. 104-299, 110 Stat. 3626) combined programs for community health centers, migrant health centers, health care for the homeless, and primary care for residents of public housing into one.

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

We conducted follow-up work to update the findings and recommendations contained in the earlier reports.[3]

In brief, we found that both the health centers and the Corps are important safety-net providers to our nation's vulnerable populations, but we believe certain improvements would enhance the effectiveness of these programs. Most health centers continue to be able to serve vulnerable populations, even though a number of significant changes have occurred in the health care environment. HRSA has helped centers respond to developments such as the growing number of uninsured and Medicaid's increased use of managed care by encouraging centers to form networks and participate in managed care. HRSA could increase its effectiveness, however, by establishing a systematic "best practices" program to allow centers to learn from one another and by improving the completeness and accuracy of its data—especially financial—that are used to monitor centers. The Health Care Financing Administration (HCFA), which administers the Medicaid program, could help ensure health centers' continued ability to serve Medicaid beneficiaries and the uninsured by monitoring state Medicaid programs' compliance with federal requirements for reimbursing centers.

Since its reauthorization in 1990, the National Health Service Corps has expanded and now provides thousands of health care providers to underserved areas. However, it, too, could be more effective. For example, a shift of resources could help to provide more loan repayments. Also needed are an improved system to identify and measure areas' need for Corps providers, a better placement process, and coordination with other federal and state efforts to place providers in areas that need them.

Health Centers Have Been a Relatively Stable Source of Care for Underserved People in Urban and Rural Areas

Since they were established in the mid-1960s, community and migrant health centers have offered primary and preventive health services provided by clinical staff—including physicians, nurses, dentists, and mental health and substance abuse professionals—or through arrangements with other providers. A distinguishing feature of centers is that they provide "enabling services" that help patients gain access to health care, such as outreach, translation, and transportation. Most health centers operate facilities at several locations. Health centers are typically managed by an executive director, a financial officer, and a clinical director. A health center's community board, with a majority of members

[3]See app. I for a list of these reports.

who are health center patients, provides policy oversight and has the authority to hire and fire the center's executive director.

Most Health Centers Stay in Business,Operating More Sites and Serving More Patients

The number of health centers remained stable from 1996 to 1998, at a little over 600 grantees. During this 3-year period, 44 centers failed to qualify for continued federal grant funding, but a similar number of new centers received funding. The average number of sites each health center operated increased from 4 to 5, and the total number of people served by health centers increased from 7.7 million to 8.3 million. In 1998, approximately 57 percent of health center grantees were located in rural areas,[4] but the number of people served in rural and urban areas was approximately the same.

According to HRSA, about 40 percent of all health centers are doing well, maintaining sufficient staff capacity and serving a growing number of patients. About 50 percent are considered viable but are experiencing some operational problems. The remaining 10 percent are struggling to survive, and they typically have major financial problems, such as a large deficit, vacancies on their management team, or significant losses or turnover of core health providers. Each year, a small proportion of centers—about 2 percent—actually lose federal funding, typically due to poor financial performance. Centers' degree of success is not necessarily constant. Health centers that excel for a few years sometimes develop problems, and some having problems have improved their situation and become more successful.

Community and migrant health centers provide mostly primary health care, averaging four encounters per patient per year; they are also required to provide services that enable center users to gain access to care, such as transportation and translation services.[5] We found that the average number of enabling service encounters reported by health centers dropped from 1996 to 1998, and health centers in some states have reported eliminating or reducing transportation, education, and counseling services.

[4]Urban/rural designation is self-reported by health center grantees.

[5]42 U.S.C. 254b(hh)(iv).

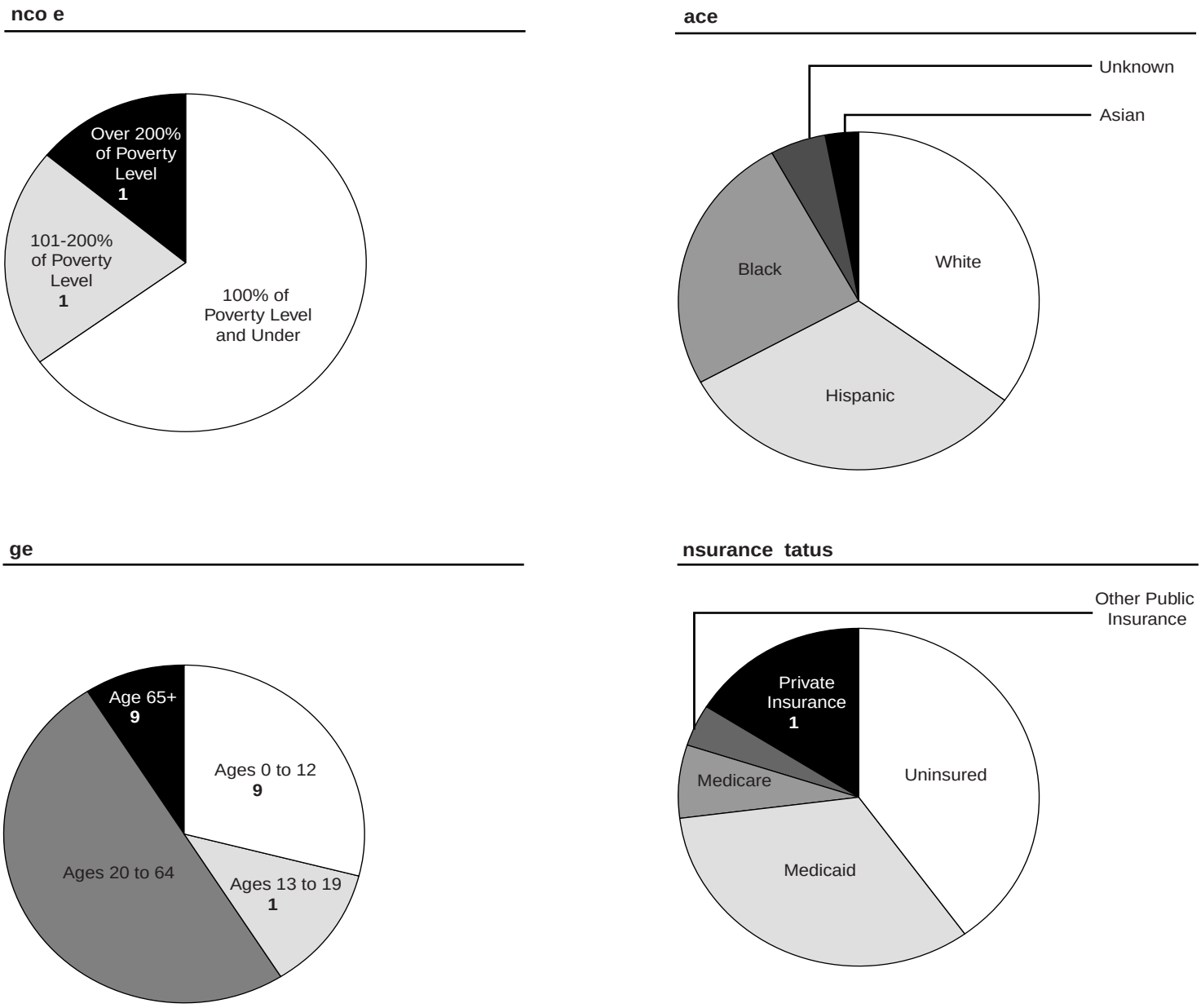
Health Center Patients Are Predominantly From Vulnerable Populations, and Many Lack Health Insurance

A high proportion of health center patients are from vulnerable populations (see fig. 1). Health centers report that overall, their user population is poor or low income, with 65 percent having incomes at or under the federal poverty level. Health centers also serve a disproportionate number of minorities. Almost one-third of health center patients are Hispanic, and one quarter are black. Centers primarily serve children and women of childbearing age. Centers also report that they provide care to migrant and seasonal farmworkers and that almost one in five of their patients need an interpreter to use their services.

Reflecting the national growth in the uninsured, the number of uninsured people receiving care at health centers increased 10 percent between 1996 and 1998,[6] with the share of center patients lacking health insurance reaching 40 percent. The proportion of Medicaid patients declined slightly. Medicaid was, however, the largest source of coverage for health center users with health insurance; about one-third of health center users in 1998 were Medicaid beneficiaries.

[6]Uninsured users pay a fee for services, based on a sliding-fee schedule that takes into account their income level.

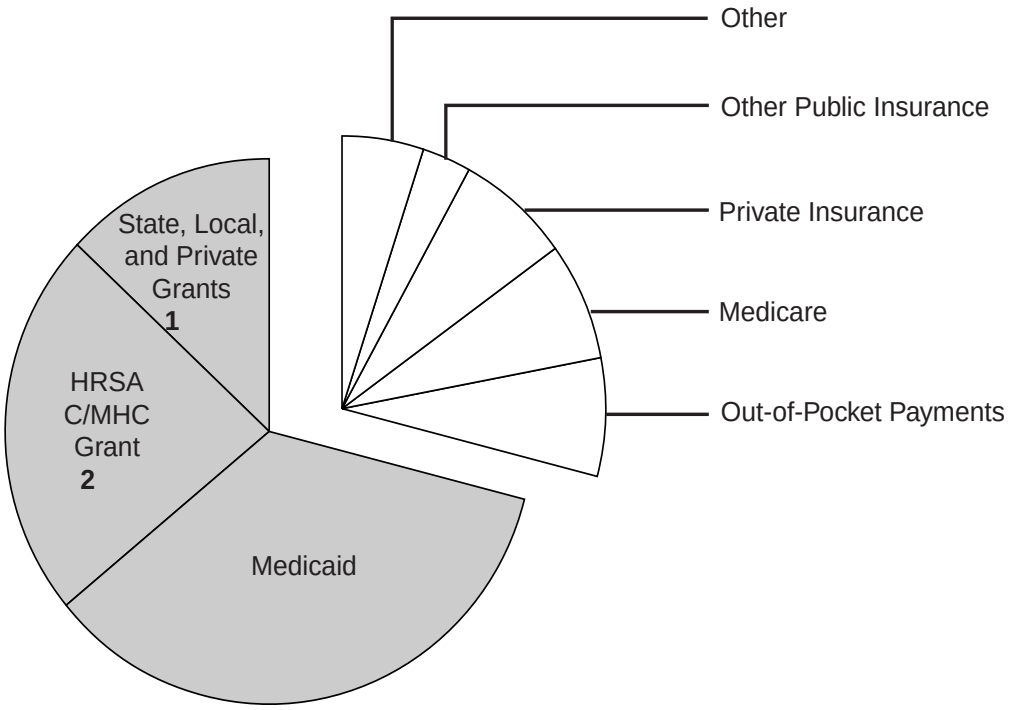
Figure 1: Health Center Patient Population Characteristics, 1998



Medicaid Has Become the Largest Source of Health Center Revenue

In 1998, health centers reported revenues of almost $3 billion. Medicaid was the largest funding source, representing about 35 percent of the total. HRSA's health center grants were the second largest source, representing 23 percent of the total. (See fig. 2.) The proportion of revenue that comes from Medicaid has increased gradually, while the proportion of health center revenue that comes from federal grant funding has steadily declined.

Figure 2: Health Center Revenue by Source, 1998



In response to the increase in the uninsured and other challenges facing health centers, the Congress passed legislation to substantially increase the health center program budget for the last 2 fiscal years. Federal funding for health centers increased by $100 million in fiscal year 1999 and

another $99 million in fiscal year 2000.[7] Over 80 percent of the existing health centers received an increase in funding in 1999, and HRSA also allocated funds for 19 new community and migrant health centers and gave existing centers funds to open 27 new sites.

Growth of Medicaid Managed Care and Changes in Payment Policies Can Affect Health Centers

The increase in Medicaid's use of managed care and changes in Medicaid payment requirements can affect the number of Medicaid beneficiaries health centers treat and centers' Medicaid revenues. While our analysis of health center data shows that, nationally, the average number of health center Medicaid patients has increased over the past several years, the number of Medicaid patients has declined at health centers in 20 states and territories. Our analysis also indicates that the effect of Medicaid managed care on health center revenue varies by state and individual center, reflecting differences in payment practices among states and managed care organizations. According to directors of primary care associations in several states with Medicaid managed care programs, the implementation of managed care has resulted in the loss of Medicaid revenues at some health centers.

Almost all state and territorial Medicaid programs serve at least some beneficiaries through managed care plans. Moreover, between 1991 and 1998, the proportion of Medicaid beneficiaries enrolled in managed care increased from 9.5 percent to 54 percent. Under waiver authority of section 1115 or 1915(b) of the Social Security Act, states may require people eligible for Medicaid to enroll in a managed care plan.[8] In addition, section 4701 of the Balanced Budget Act of 1997 (BBA) gave states the ability to implement mandatory managed care programs without obtaining a special waiver from HCFA if they meet certain requirements.[9] In these programs, states typically pay managed care organizations a fixed monthly capitation fee to provide all covered services needed by enrolled beneficiaries. Therefore, to serve Medicaid beneficiaries in managed care, health centers must either contract with a managed care organization to

[7]The fiscal year 2000 amount was later subject to a $5 million rescission.

[8]42 U.S.C. 1315 and 1396n(b).

[9]Under section 1932(a) of the Social Security Act, states may establish Medicaid managed care programs simply by amending their state Medicaid plans.

provide services to its enrollees or form their own managed care organization.[10]

Health center revenue may also be affected by states' implementation of statutory Medicaid requirements for reimbursing community and migrant health centers and other federally qualified health centers, as well as waivers of those requirements given to states. Beginning in 1989, Medicaid was required to reimburse federally qualified health centers at 100 percent of their reasonable costs.[11] In September 1999, 15 states had been exempted, under their section 1115 waivers, from the requirement to provide 100-percent cost-based reimbursement for these centers. The terms and conditions of a majority of such waivers included a provision that centers be reimbursed on a cost-related or risk-adjusted basis. Section 4712(a) of BBA allowed all states to gradually reduce their reimbursement levels for health centers through fiscal year 2004; section 603 of the Medicare, Medicaid and State Children's Health Insurance Program Balanced Budget Refinement Act of 1999 modified these provisions, slowing the phase-down.[12]

Few states have made long-term decisions about how to pay health centers that provide services to Medicaid patients in light of the changes in the federal requirement for cost-based reimbursement. Five states have passed legislation ensuring 100-percent payment, 25 other states will continue 100-percent reimbursement for at least fiscal year 2000, but most have not made any decisions about what payment method they will use in the long term. Seven states have already reduced their reimbursement to the BBA floor of 95 percent of costs.

If a managed care organization payment for a Medicaid service is insufficient to meet a health center's costs, states are required under section 4712(b) of BBA to make up a portion of the difference with a

[10]Many states' Medicaid managed care programs also use a primary care case management model, in which primary care providers receive per capita management fees for coordinating patients' care and fee-for-service payments for each of the health services a patient receives. In this arrangement, health centers can serve as case managers or provide services approved by the case manager.

[11]Section 6404 of the Omnibus Budget Reconciliation Act (OBRA) of 1989 (P.L. 101-239, 103 Stat. 2258, 2264) established the Federally Qualified Health Centers program in Medicaid and Medicare. The law recognized these providers as a unique type of Medicaid and Medicare provider. Section 4704 of OBRA of 1990 (P.L. 101-508, 104 Stat. 1388, 1388-171) defined health center services as mandatory services and required Medicaid and Medicare to reimburse them at 100 percent of their reasonable costs.

[12]Section 603 of H.R. 3426–which was enacted as appendix F to P.L. 106-113, 113 Stat. 1501, 1501A-394–amended the language established by section 4712(a) of BBA to permit states to pay 95 percent of costs in fiscal years 2000, 2001, and 2002; 90 percent in fiscal year 2003, and 85 percent in fiscal year 2004.

supplemental, or "wraparound," payment. The payment amount, when combined with the managed care payment, should equal the statutorily required percentage of costs—for example, 95 percent in fiscal year 2000. Some states with large Medicaid enrollments, including California and Florida, delayed giving health centers the required supplemental payments established by BBA until HCFA intervened or until health centers filed suit.

Timely Responses to Changes in the Health Care Environment Contribute to Centers' Success

Individual health centers face varying degrees of pressure from changes in the health care market, such as increased competition for Medicaid patients. Through our site visits and discussions with HRSA and health center officials, we found that centers that have taken appropriate and timely actions to respond to these changes are more likely to succeed. Successful centers typically have management teams with strong business skills and dedication to carrying out the health center mission, as well as boards that actively perform their policy and oversight roles.

Increasingly, health centers are trying to compete for patients and improve their operations by forming partnerships or networks with other health care providers. Networks can enable centers to share expertise and resources—such as information systems or fiscal operations—control costs, or improve the quality of clinical services. For example, a Florida network consisting of four health centers and one homeless health center integrates administrative, fiscal, information system, clinical, and program planning and development services. Participating centers have improved their efficiency by sharing four major managerial positions and a centralized automated information system.

Effectively addressing the growth of managed care is another factor critical to some health centers' success. While some health centers participate in managed care by contracting with managed care organizations, others have formed their own managed care plans, either individually or in networks with other health centers or other health care providers.[13] As of June 1999, 25 health center managed care plans in 18 states served almost 959,900 members.

HRSA officials and others knowledgeable about health centers believe that the more successful centers know how to attract patients with diverse

[13]The degree to which health centers that form managed care organizations assume financial risk ranges from no risk to full risk for all primary, secondary, and tertiary care; HRSA policy is that health centers should assume risk only for the services they manage.

payment sources, including those with private and public insurance. These centers also pursue a wide variety of revenue sources—such as private donations, foundation grants, or local government funding—to pay for services and facilities. Good billing, collection, and reporting systems help to maximize collections from these various revenue sources.

Many health centers are also seeking accreditation through the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), believing this will improve their competitiveness. HRSA is encouraging all centers to take this action. As of August 1999, 124 health centers had received accreditation. Health center directors and HRSA officials believe that preparing for and going through the accreditation process are valuable experiences because they can improve the quality of services and staff commitment to high standards. Some center managers also believe that achieving accreditation gets them recognition from other providers as well as consumers and that it will improve their ability to negotiate favorable contracts and rates with managed care organizations and other providers. However, evidence of whether JCAHO accreditation improves health centers' bargaining position is just beginning to be reported.

Poor Management Has Contributed to Some Health Centers' Problems

We learned that health centers that do not respond appropriately to changes in the health care market are more likely to have serious problems. Some centers have lost market share as the demographics or socioeconomic status of their communities have changed or as competition from other providers has increased. Others have unfavorable contracts with other providers and managed care organizations, leading to lost revenues.

Most of the health centers that we reviewed and that were defunded or identified by HRSA as having serious operational problems had management that demonstrated a lack of understanding of their centers' business operations. In general, the centers operated inefficiently, resulting in expenses that exceeded income. When faced with difficult financial situations, the managers of these centers did not take the necessary actions to control expenditures and restore their center's financial viability. In some cases, the center's board had not provided active oversight, including exercising its responsibility to replace the health center leadership.

Some HRSA Strategies to Help Health Centers Show Promise; Others Need Improvement

The health center program is administered by HRSA's Bureau of Primary Health Care. HRSA provides grants to health centers to support the provision of health care and enabling services. HRSA also provides grants to state and regional primary care associations—private, nonprofit membership organizations of health centers and other providers—and has cooperative agreements with primary care offices, federally supported entities within state health agencies. HRSA coordinates with HCFA, which administers the Medicaid and Medicare programs, on issues concerning health centers.

To help health centers strategically respond to changes in the health care environment, HRSA has provided grants to states' primary care associations to conduct marketplace analyses that help identify areas where new or expanded services would improve access. For example, a marketplace analysis in Colorado found that one area had no doctors accepting Medicaid patients or offering care on a sliding-fee basis. This led to an existing health center grantee using HRSA funding to open a new site in the underserved area in 1999.

To encourage health center participation in managed care, HRSA's Integrated Services Development Initiative gives health centers grants to help them develop comprehensive integrated delivery systems and practice management networks. HRSA also provides training, technical assistance, and financial support to help health centers participate in managed care. As health centers enter into managed care contracts, they need to know their costs, understand their competition, and carefully consider how much financial risk they can assume. While some health center managers have found HRSA's courses on managed care helpful, others told us that HRSA's training on negotiating managed care contracts could have been more timely and provided more specific information to help them negotiate contracts.

In addition, HRSA does not have a systematic mechanism to allow all health centers to share information and learn from one another. Consequently, many centers work on developing solutions to the same problems for which other centers have already devised successful strategies. For example, we learned of two health centers that independently developed a productivity measurement system. Therefore, we recommended in our report, issued today, that HRSA establish a best practices program to facilitate health centers' sharing of information.

HCFA also has responsibilities for helping to ensure that vulnerable populations have access to health care services. One of HCFA's responsibilities is ensuring that state Medicaid programs properly

reimburse health centers. If states do not comply with federal payment provisions, health centers' ability to serve both Medicaid patients and uninsured people can be impaired. Over the years, HCFA has sent state Medicaid agencies instructions on how to implement health center payment changes, such as those established by BBA. HCFA has not routinely reviewed state operations to determine their compliance with the laws affecting health centers; instead, it typically responds to issues brought to its attention. In the report we issued today, we also recommended that HCFA monitor state Medicaid programs' compliance with federal payment requirements and intervene when states do not meet their financial obligations to health centers.

HRSA Monitors Health Center Performance, but Timely Problem Identification and Intervention Are Difficult and Data Collection Needs Improvement

HRSA assesses each health center's financial health, growth in patient population, staffing capacity, and competitiveness in the health care market. It considers several characteristics to be markers of success, such as having growth in the number of patients and a stable, high quality management team. Conversely, it considers to be at risk and more closely monitors centers that have a high budget deficit, spend their HRSA grant too quickly, or have significant management or medical team vacancies.

To understand how health centers are operating and to evaluate their overall performance, HRSA each year collects administrative, demographic, financial, and utilization data from each center through its Uniform Data System (UDS). While UDS gathers some useful information, it also has weaknesses and limitations. Instructions to centers have not always been clear, data editing and cleaning processes have not always worked well, and some centers have failed to report certain data elements or have reported them very late, even though complete and accurate reporting is a condition of receiving a HRSA grant.

UDS also has limitations for monitoring and evaluating performance. The financial data in UDS cannot provide an accurate indication of an individual center's financial status because costs are reported on an accrual basis, while revenues are reported on a cash basis.[14] This makes it difficult to estimate the extent to which centers' revenues cover costs. The required independent financial audit is perhaps the best source of accurate information on a health centers' fiscal health, but there are delays in

[14]Using the cash method of accounting for revenues requires that revenue be recorded when it is received. However, the accrual method of accounting for expenses requires that the costs of goods or services be recorded when received, regardless of whether payment has been made for them.

HRSA's receipt of the financial audits.[15] HRSA officials have taken steps to improve UDS and the collection of performance information. Our report recommends that HRSA further improve the quality of UDS data, enforce the requirement that every grantee report complete and accurate data, and use more accurate and timely financial data to monitor performance.

Another method HRSA uses to monitor health center performance is its Primary Care Effectiveness Review. These reviews, which include on-site visits, are a mandatory part of the grant renewal process, which occurs every 3 to 5 years. Health centers with identified problems are expected to take corrective actions before receiving additional grant funding. When necessary, HRSA sends consultants to help centers develop a financial recovery or action plan that can help them solve their financial or operational problems. However, sometimes HRSA's interventions have been too late to make a difference. The agency often goes through a lengthy process before deciding whether to continue funding a particular health center or pursue other alternatives for providing primary care services in the area, such as a merger with another grantee.

For centers seeking JCAHO accreditation, HRSA has been able to obtain information from the JCAHO survey to help monitor centers, but the JCAHO process does not provide HRSA with all the information it needs on health centers' fiscal, information system, and other operations. HRSA currently supplements the JCAHO survey with its own fiscal and information system review protocols.

Corps Reauthorization Provides Opportunities for Improvements

At the end of fiscal year 1999, the National Health Service Corps had 2,526 physicians, dentists, nurse practitioners and other providers serving in shortage areas. Since 1990, when the Corps was last reauthorized, funding for its scholarship and loan repayment programs has increased sevenfold, from $11 million in 1990 to $78 million in 1999.[16] Nevertheless, the Corps continues to be challenged to use these dollars as effectively as possible in meeting its mission, as year after year, it receives more requests from communities for health professionals than it can meet.

[15]The financial audit is governed by OMB Circular A-133, which states that the audit shall be completed and reported within 30 days of receiving the auditor's report or 9 months after the end of the audit period.

[16]In addition to funding for scholarship and loan repayment awards, the Corps receives funding for support of Corps providers and operations. In fiscal year 1999, this field budget was about $37 million.

Loan Repayment Program Has Favorable Costs and Benefits

In past work,[17] we have addressed which approach works better—scholarships or loan repayments. Under the scholarship program, students are recruited before or during their health professions training—generally several years before they begin their service obligation. Under the loan repayment program, providers are recruited after they complete their training. The scholarship program provides tuition and other support for each year while in school, while the loan repayment program repays up to $25,000 of student debt for each year of service provided.[18] Under the Public Health Service Act, at least 40 percent of the available funding must be for scholarships.

We found that, for several reasons, the loan repayment program is generally the better approach to provide health care professionals to shortage areas:

- The loan repayment program costs less. On average, a year of service by a physician under the scholarship program costs the federal government over $43,000 compared with less than $25,000 under the loan repayment program.[19] A major reason for this difference is the time value of money—7 or more years can elapse between when a physician receives scholarship assistance and begins to practice in an underserved area. In the loan repayment program, however, the federal government does not pay until after the service has begun.

- Loan repayment recipients are more likely to complete their service obligations. This is not surprising when one considers that scholarship recipients enter into their contracts up to 7 or more years before beginning their service obligation, during which time their professional interests and personal circumstances may change. Twelve percent of scholarship recipients breached their contract to serve between 1980 and 1999,[20]

[17] *National Health Service Corps: Opportunities to Stretch Scarce Dollars and Improve Provider Placement* (GAO/HEHS-96-28, Nov. 24, 1995).

[18] The loan repayment program pays up to $35,000 per year for third and subsequent years of service, if qualified loans are still outstanding.

[19] Amounts are in 1999 dollars. This cost analysis is based on new scholarship and new federal loan repayment awards made in fiscal year 1999. We did not analyze the net cost per year of service for 179 state loan repayment awards made in fiscal year 1999 using grant funding from the Corps. However, our prior work suggests that state loan repayment costs less than federal loan repayment for a year of service.

[20] This includes scholarship recipients who defaulted and paid the default penalty, those who defaulted and subsequently completed or are serving their obligation, and those who defaulted and have not begun service or payment of the default penalty.

compared with about 3 percent of loan repayment recipients since that program began.

- Loan repayment recipients are more likely to continue practicing in the underserved community after completing their obligation. How long providers remain is not clear, because the Corps does not have a tracking system in place. However, we analyzed data for calendar years 1991 through 1993 and found that 48 percent of loan repayment recipients were still at the same site 1 year after fulfilling their obligation, compared to 27 percent for scholarship recipients. Again, this finding is not surprising. Because loan repayment recipients do not commit to service until after they have completed training, they are more likely to know what they want to do and where they want to live or practice at the time they make the commitment.

For these reasons, we suggest now—as we did in our 1995 report on the Corps—that the Congress consider modifying the current requirement that scholarships receive at least 40 percent of the funding. Besides being generally less costly and having favorable benefits, the loan repayment program allows the Corps to respond more quickly to changing needs. If demand suddenly increases for a certain type of health professional, the Corps can recruit graduates right away through loan repayments. By contrast, giving a scholarship means waiting for years for the person to complete training.

This is not to say that the scholarship program should be eliminated. Because scholarship recipients have fewer choices of where they can fulfill their service obligation, they could be directed to the neediest sites. However, our work indicates this advantage has not worked out in practice. For Corps providers beginning practice in 1993-94, we found no significant difference, on average, between scholarship and loan payment recipients in the priority of their service location. This suggests that the scholarship program should be tightened so that it focuses on those areas with critical needs that cannot be met through loan repayment. In this regard, one way to increase the number of providers in high priority areas might be to reduce the number of sites that scholarship recipients can choose from, so that the focus of scholarships is clearly on the neediest sites.[21] While placing greater restrictions on service locations could potentially reduce interest in the scholarship program, the program

[21]The number of choices available to scholarship recipients is provided for by statute: three vacancies for each scholar, up to a maximum of 500 vacancies. For example, if there are 10 physicians available for service, the Corps would provide a list of 30 eligible vacancies for that group if there were 500 or fewer vacancies in total.

currently has almost seven applicants for every scholarship—suggesting the interest level is high enough to allow for some tightening in the program's conditions. If that should fail, additional incentives to get providers to the neediest areas might need to be explored.

Current System for Identifying Need Could Be Improved

While the Public Health Service Act states that the purpose of the Corps is to eliminate health manpower shortages in health professional shortage areas, measuring the extent of these shortages is problematic. Under current regulations, HHS considers a health professional shortage area (HPSA) generally to be an area, population group, or facility with less than one primary care physician for every 3,500 persons.[22] In December 1999, HHS identified 2,862 primary care HPSAs. To eliminate these HPSA designations, HHS identified a need of over 5,500 full-time physicians.

Over the past 5 years, we have identified and reported on a number of problems with HHS' process for determining whether an area is a HPSA. In addition to problems with the timeliness and quality of the data used, we found that HHS' current approach does not count some providers already working in shortage areas. For example, it does not count nonphysicians providing primary care, such as nurse practitioners, and it does not count Corps providers already practicing in the shortage area. As a result, the current HPSA system tends to overstate the need for more providers, limiting HHS' ability to identify the universe of need and prioritize areas.

Recognizing these flaws, HHS has been working on ways to improve the designation of HPSAs, but the problems have not yet been resolved. After studying the changes needed to improve its HPSA designation system for most of the 1990s, HHS published a proposed rule in the *Federal Register* in September 1998. This proposal included provisions to update the designations regularly and count nonphysician practitioners. The proposed rule generated a large volume of comments and a high level of concern about its potential effect. In particular, people in some areas were concerned that the new criteria would result in their losing their HPSA designations. In June 1999, HHS announced that it would conduct further analyses before proceeding.

The controversy surrounding proposed modifications to the HPSA designation system may be due, in large part, to its use by other programs.

[22] Under certain circumstances, the ratio used to designate a primary care HPSA may be 1 to 3,000. A primary care HPSA can be a distinct geographic areas (such as a county), a specific population group (such as the poor), or a specific public or nonprofit facility (such as a prison). HHS has different criteria for dental and mental health HPSAs.

Originally, the system was only used to identify an area that could request providers from the Corps. Today, many federal and state programs—including efforts unaffiliated with HHS—use the HPSA designation in considering program eligibility. These areas want the HPSA designation in order to be eligible for other programs such as a 10-percent bonus on Medicare payments or cost-based reimbursement under the Rural Health Clinic program.

Current Placement Process Could Be Improved

Related to the need to improve the current system for identifying areas eligible for Corps providers, it is also critical that the Corps implement an effective system for placing providers in those areas. There are not enough Corps providers to fill all of the vacancies approved for them. In fiscal year 1999, for example, HHS determined that 828 primary care HPSAs requesting providers had vacancies meeting the criteria for being listed as a place where a Corps provider could serve. Some of these HPSAs needed multiple providers. That same year, the Corps could fill only a fraction of these vacancies.

One question we have examined is whether providers are being placed in as many needy areas as possible. In analyzing placements for 1993, we found that at least 22 percent of shortage areas receiving Corps providers received more providers than needed to increase their provider-to-population ratio to the point that their HPSA designation could be removed, while 65 percent of shortage areas with Corps-approved vacancies did not receive any providers.[23] Of these latter locations, 143 had unsuccessfully requested a Corps provider for 3 years or more. The Corps has subsequently made improvements in its procedures and has substantially cut the number of HPSAs not receiving providers. However, that number is still above 380, and some HPSAs can still receive more than enough providers to remove their shortage designation.

HHS officials have said that in making placements, they need to weigh—in addition to assisting as many shortage areas as possible—the viability of the site and the chance that a provider might stay beyond the period of obligated service. However, because the sites that are on the vacancy list have to meet Corps requirements for infrastructure and salary, viability

[23]To calculate oversupply, we counted physicians as one full-time provider and nonphysicians (nurse practitioners, nurse midwives, or physician assistants) as one-half of a full-time provider. If only physician placements are counted, 6 percent of these shortage areas would still be identified as oversupplied. We consider these estimates of oversupply to be conservative because our analysis did not include (1) NHSC placements in shortage areas with dedesignation thresholds of 0 or no assigned value, and (2) NHSC providers placed in prior years that were still in service during vacancy year 1993.

should not be an issue for those locations. And while we agree that retention is a laudable goal, the effect of the Corps' current practice is unknown because the Corps does not track long-term retention. We suggest that the Congress consider clarifying the extent to which the program should try to meet the minimum needs of as many shortage areas as possible and the extent to which additional placements should be allowed to try to encourage provider retention.

Placement Efforts Need Better Coordination With Waivers for J-1 Visa Physicians

Underserved communities are frequently turning to another method of obtaining physicians—attracting non-U.S. citizens who have just completed their graduate medical education in the United States. These physicians generally enter the United States under an exchange visitor program, and their visas, called J-1 visas, require them to leave the country when their medical training is done. However, the requirement to leave can be waived if a federal agency or state requests it. A waiver is usually accompanied by a requirement that the physician practice for a specified period in an underserved area. In fiscal year 1999, nearly 40 states requested such waivers. They have been joined by several federal agencies—particularly the Department of Agriculture, which has requested waivers for physicians to practice in rural areas, and the Appalachian Regional Commission, which has requested waivers to fill physician needs in Appalachia.

Waiver placements have become so numerous that they now surpass Corps physicians. In September 1999, over 2,000 physicians had waivers and were practicing in or contracted to practice in underserved areas, compared with 1,356 Corps physicians.[24] The number of waiver physicians is now large enough to total over one-third of the full-time primary care physicians needed to eliminate HPSA designations nationwide.

Although coordinating Corps placements and waiver placements has the obvious advantage of addressing the needs of as many underserved locations as possible, it is not occurring. As a result, some areas have ended up with more than enough physicians to remove their shortage designations, while needs in other areas have gone unfilled. There are two main reasons for the problem:

- HHS does not support the waiver approach as a sound way to address underservice needs in the United States. The agency's position is that

[24]This includes Corps physicians, such as federal employees and state loan repayment recipients, who did not receive scholarships or federal loan repayment.

physicians should return home after completing their medical training to make their knowledge and skills available to their home countries. As a result, although the states and other federal agencies are using waivers to address underservice, HHS does not have a system to take these placements into account in determining where to put Corps physicians.

- This sizeable domestic placement effort is rudderless. Even among those states and agencies using the waiver approach, no agency has responsibility for ensuring that placement efforts are coordinated. While some informal coordination may occur, it remains a fragmented effort with no overall program accountability.

As the Congress considers reauthorizing the Corps, it has the opportunity to address these issues. As we previously reported, we believe that the prospects for coordination could be enhanced by action in two areas. First, clarify how the use of waivers for these physicians fits into the overall federal government strategy for addressing underservice. This should include determining the size of the J-1 visa waiver program and establishing how it should be coordinated with other federal programs. Second, designate leadership responsibility for managing the J-1 visa activity for physicians as a distinct program.

Concluding Observations

Our work has shown that while the Community and Migrant Health Center program and the National Health Service Corps programs have provided valuable services to vulnerable populations, steps could be taken to make them more effective. At the same time, we would like to point out an overarching issue that our work has consistently identified: HHS' systems for identifying underservice need immediate attention. While HHS has been studying these issues for years, the systems are currently of little help in accurately identifying who is underserved and why and in measuring the extent to which a program, once instituted, is alleviating access problems. We believe HHS needs to gather more consistent and reliable information on the changing needs for services in underserved communities. Until then, determining whether federal resources are appropriately targeted to communities of greatest need and measuring their impact will remain problematic.

Mr. Chairman, this concludes my prepared statement. I would be happy to respond to any questions you or other members of the Subcommittee may have.

GAO Contacts and Acknowledgments

For future contacts regarding this testimony, please call Janet Heinrich, Associate Director, Health Financing and Public Health Issues, at (202) 512-7119 or Helene Toiv, Assistant Director, Health Financing and Public Health Issues, at (202) 512-7162. Other individuals who made key contributions include Renalyn Cuadro, Anne Dievler, Brenda James, Frank Pasquier, and Kim Yamane.

Related GAO Reports

Community Health Centers: Adapting to Changing Health Care Environment Key to Continued Success, (GAO/HEHS-00-39, Mar. 10, 2000)

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Health Care Access: Opportunities to Target Program and Improve Accountability (GAO/T-HEHS-97-204, Sept. 11, 1997)

Foreign Physicians: Exchange Visitor Program Becoming Major Route to Practicing in U.S. Underserved Areas, (GAO/HEHS-97-26, Dec. 30, 1996)

National Health Service Corps: Opportunities to Stretch Scarce Dollars and Improve Provider Placement, (GAO/HEHS-96-28, Nov. 24, 1995)

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