



**U.S. Department of Health and Human Services
Office of Inspector General**

HRSA Helped Health Centers With Elevated Risks and Can Continue To Take Additional Steps

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HRSA Helped Health Centers With Elevated Risks and Can Continue To Take Additional Steps

What **OIG** Found

Twenty-five percent of the health centers to which the Health Resources and Services Administration (HRSA) awarded Service Area Competition grants in FY 2014 had elevated programmatic or financial risks. Included among these health centers were two that did not meet HRSA's funding criteria.

HRSA took steps to help health centers improve, and many were able to do so. However, HRSA missed some opportunities to further minimize risk. HRSA did not always limit project periods, restrict funding, or conduct site visits when it should have, exposing Federal funds to potential negative effects. In addition, HRSA was not always able to help health centers, particularly those with financial problems, to improve before awarding them additional years of funding.

What **OIG** Recommends and How the Agency Responded

During this study, the Office of Inspector General (OIG) provided technical assistance to HRSA as it improved its oversight and worked to update its risk management process to implement new guidance from the Department of Health and Human Services. According to HRSA, it made changes in its risk management process based on this early information from OIG. This report provides two additional recommendations to help HRSA in its ongoing efforts to strengthen oversight of the Health Center Program. Specifically, we recommend that HRSA (1) use risk management interventions in accordance with its policies to help health centers reduce elevated risks and (2) explore additional steps it could take to help health centers reduce elevated risks.

HRSA did not concur or nonconcur with our recommendations, but it noted actions it has taken that are responsive to them.

Key Takeaway

HRSA intervened in multiple ways and was helpful in reducing health centers' risk. However, HRSA missed opportunities to further assist, particularly for centers with financial problems.

Why **OIG** Did This Review

Health centers are organizations that provide primary care to medically underserved populations. In FY 2018, Federal support for health centers totaled \$5.4 billion. HRSA administers Federal grants that help health centers serve 1 in 12 people in the United States. These grants, called Service Area Competition grants, are typically awarded to health centers serving communities with limited access to affordable health care services.

To maximize access to health care, HRSA sometimes funds health centers that are out of compliance with multiple program requirements or are not financially stable—i.e., health centers with elevated programmatic or financial risks. When funding grantees with unknown risks, effective oversight is needed to ensure that patients receive quality care and Federal grant funds are protected.

Effective oversight is particularly important as Federal investment in the Health Center Program expands. Federal support for health centers has more than doubled from \$2.2 billion in FY 2010 to \$5.4 billion in FY 2018.

How **OIG** Did This Review

We analyzed HRSA data from 2013 through 2015 related to the 309 health centers that received Service Area Competition grants for FY 2014. We used HRSA's risk assessments to identify health centers with elevated risk. For these health centers, we reviewed nearly 2.5 years of HRSA actions to help the health centers improve.

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BACKGROUND

Objective

Our review examined the Health Resources and Services Administration’s (HRSA’s) oversight of programmatic and financial risks in the Health Center Program. We determined the extent to which HRSA (1) awarded FY 2014 Service Area Competition (SAC) grants to health centers with elevated risks and (2) intervened to help health centers improve.

Rationale

Effective oversight is essential to HRSA’s ability to support the crucial roles that health centers play in the U.S. health care system and safeguard health center patients and Federal grant funds. Health centers typically serve communities that have limited access to affordable health care services. Health centers provide health care services to all patients regardless of their ability to pay. Additionally, health centers are increasingly involved in addressing national health priorities like responding to the opioid crisis. The Federal funding that supports health center operations has increased significantly, allowing the number of patients served and the number of health centers to increase nationally. The annual budget for the Health Center Program has increased from \$2.2 billion in FY 2010 to \$5.4 billion in FY 2018. Over this time, the Health Center Program served an additional 6.4 million patients and funded over 2,200 new health center sites.

Health Centers

Health centers are organizations that employ physicians and other healthcare providers to deliver primary care to medically underserved patients. In 2016, nearly 1,400 health centers with more than 11,000 health center sites served nearly 26 million patients—1 in 12 people living in the United States.^{1, 2}

Through the Health Center Program, HRSA administers Federal grants to support health centers’ operations. To be eligible for these funds, health centers must meet statutory Health Center Program requirements (hereinafter referred to as “program requirements.”)³ These requirements are designed to ensure that health centers deliver comprehensive, culturally competent, high-quality services to patients. These requirements cover a variety of concerns, including the needs of the population served; the provision of services to patients; the management and finance of health centers; and the governance of health centers. Key program requirements that directly affect patient care include those that require centers to provide certain health care services, to maintain a qualified staff, and to establish a

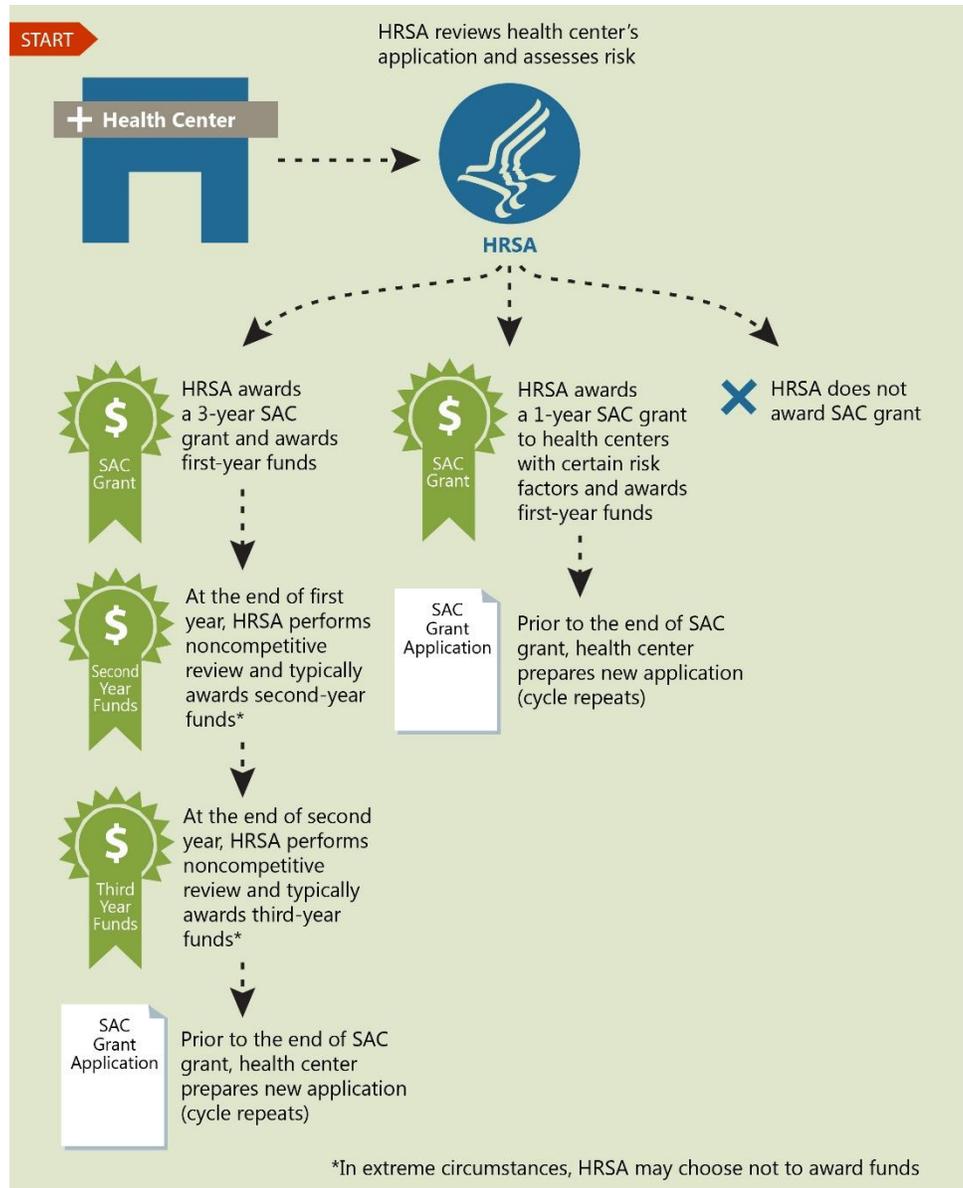
sliding fee-payment scale for low-income patients.⁴ See Appendix A for a description of all 19 program requirements in effect in FY 2014.

Each health center operates one or more sites in a service area.⁵ Service areas are typically communities with geographic, economic, or cultural barriers that limit access to affordable health care services. Typically, a majority of a health center's patients reside in its service area.

Service Area Competition Grants

Grants that HRSA administers to support health center operations are called Service Area Competition (SAC) grants. HRSA opens SAC grants for competition when an existing health center completes the terms of its previous SAC grant—generally every 3 years—or is otherwise unable to continue operating in the service area. Health centers compete for SAC grants on a rolling basis, with approximately one-third of health centers eligible for new SAC grants each year. See Exhibit 1 for a representation of the SAC grant lifecycle.

Exhibit 1: HRSA can award SAC grants for 1 or 3 years.



Source: OIG summary of HRSA policy documents, 2017.

HRSA typically awards SAC grants for 3 years. Health centers that are awarded 3-year grants receive first-year funds and then receive noncompetitive continuation grants in their second and third years. Typically, the amounts that a health center receives in the second and third years of its grant are similar to or slightly higher than the amount the center received in the first year.

Alternatively, HRSA can limit the duration of a SAC grant to just 1 year, requiring health centers that receive such grants to compete for new grants after 1 year of funding. A 1-year grant typically indicates that the health center has a history of noncompliance with program requirements and HRSA considers it to be of higher risk.

HRSA's Risk Management Process

In FY 2014, HRSA awarded \$522 million to support the first year of new SAC grants. HRSA staff reported that the average first year of a FY 2014 SAC grant was slightly more than \$1 million. HRSA awarded additional funding to support health centers that had been given SAC grants in previous years and to fund the establishment of new health center sites.

Federal regulations require HRSA to assess the risks posed by each grant applicant before HRSA awards Federal funds.⁶ These regulations generally do not preclude HRSA from awarding funds to health centers with problems. HRSA may choose to award SAC grants to such health centers to maximize patients' access to health services and to ensure continuity of care. This is particularly true if a given service area has no other organizations that are competing for the SAC grant.

According to guidance from the Department of Health and Human Services (HHS), HRSA is required to help grantees reduce their risks.⁷ This guidance does not specify how HRSA should help its grantees. To comply with these regulations and requirements, HRSA developed a risk management process to assess health center applicants and to intervene to help health centers improve.

Assessing Risks

Prior to awarding grants, HRSA conducts assessments to determine the degree to which health center applicants pose risks to the Health Center Program's mission—to serve patients—or to Federal funds. We refer to these two types of risks as "programmatic risks" and "financial risks," respectively. A health center with programmatic risks may not meet multiple Health Center Program requirements, and a health center with financial risks may show signs of financial instability, such as having financial problems that may warrant declaring bankruptcy.

HRSA uses the results of its assessments as one of the factors to help determine whether health center applicants should receive SAC grants. When two or more health center applicants were competing for the same FY 2014 SAC grant, HRSA considered the results of these assessments when selecting which applicant would receive the grant. Additionally, according to HRSA's FY 2014 funding criteria, health centers should not have received SAC grants if they (1) would be limited to a third consecutive 1-year grant or (2) had not met relevant deadlines for compliance with program requirements.

HRSA also uses the results of its assessments to determine the length of the SAC grants it awards to health centers. In FY 2014, HRSA's policy stated that it should limit SAC grants to 1 year for health centers that were out of compliance with five or more program requirements, had failed to come

into compliance with a program requirement after two attempts, or were in jeopardy of bankruptcy.

Programmatic Risks. To assess programmatic risks, HRSA evaluates each health center's compliance with program requirements. According to HRSA, when it determines that a health center is not compliant with a program requirement, it places what it calls a "program condition" on the health center's grant award. A program condition lists the specific requirement with which the health center is not compliant, allows HRSA to track the health center's progress toward compliance, and sets a deadline after which the health center may lose its grant if the condition remains unresolved. A health center may have several program conditions on its grant simultaneously. HRSA assesses health center compliance with program requirements at least annually, including during SAC application reviews and prior to awarding additional years of funding.

Financial Risks. To assess financial risks, HRSA conducts an initial financial assessment to evaluate the financial stability of each health center and documents the results. According to HRSA, it reviews each health center's financial statements, tax records, independent audit findings, and other records. On the basis of the assessment's results, HRSA assigns each health center to a category describing the amount of risk posed to Federal funds: minimal, moderate, high, or extreme.

Intervening to Reduce Risks

HRSA can intervene in a variety of ways to help health centers reduce their risks. HRSA can track the status of existing risks, identify new risks that may develop after receiving SAC grants, and help health centers limit the potential effects of their risks. (We refer to these ways in which HRSA can intervene as "interventions.")

For some interventions, HRSA's policies describe when it should use those interventions to help health centers reduce their risks. See Exhibit 2 for a description of the interventions with criteria governing their use. (See Appendix B for an expanded version of this table that includes additional interventions.)

Exhibit 2: HRSA policy prescribes numerous interventions, with different purposes and criteria for use.

Intervention	Purpose	FY 2014 criteria for when HRSA should use intervention
Annual financial status review	To monitor health centers' financial status, review updated or new information, and determine whether the risk category on the health center's financial assessment should change.	Conduct at least annually for all health centers.
1-year grant restriction	To limit the number of years health centers will receive noncompetitive SAC grant funding and ensure less time passes between operational site visits and grant application reviews.	Assign to health centers with bankruptcy concerns, five or more program conditions, or at least one long-term program condition.
Drawdown restriction	To monitor health centers' use of grant funds by requiring health centers to obtain HRSA approval before accessing funds.	Assign to all health centers with 1-year grants as well as health centers that exhibit a variety of characteristics, including financial viability issues, inadequate financial management systems, and documented allegations of wrongdoing.
Operational site visit	To monitor health centers' performance and compliance.	Conduct at least once during the grant (regardless of whether it is a 3-year or 1-year grant), preferably at the midpoint.
Program condition resolution process	To assign a series of deadlines by which health centers must report progress in correcting program conditions. Failure to correct conditions by final deadline results in forfeiture of grants.	Assign to health centers for each program condition.

Source: OIG summary of HRSA policy documents, 2017.

Previous Reviews of HRSA's Grants Management Process

Both the Government Accountability Office (GAO) and OIG have evaluated aspects of HRSA's grants management process, and HRSA has changed this process in response to the GAO and OIG recommendations.^{8, 9, 10, 11} For example, prior to reviewing FY 2014 SAC grants, HRSA established formal training requirements for its staff and developed guidance documents to ensure that its staff accurately and consistently assessed grantees' compliance with Health Center Program requirements. To communicate compliance expectations to grantees, HRSA also created a publicly available Health Center Program compliance manual and guide for conducting site visits.

Updates to Risk Management Policies

In December 2015, HHS issued the *Grants Policy Administration Manual* (GPAM), which updated its Department-wide policies for grants management to more strongly emphasize risk management. The GPAM

requires HRSA and other HHS grantmaking agencies to exchange information with each other about higher risk grantees in ways that have not previously been required.

HRSA uses the results of its financial assessments to comply with these new requirements. According to HRSA, it shares information with other HHS agencies about health centers that it assesses as having a high level of financial risk. HRSA also reported that its policy on how frequently it updates financial assessments for high-risk health centers was changed from annually to every 6 months.

Methodology

In this evaluation we included the 309 health centers to which HRSA awarded FY 2014 SAC grants. These health centers represent approximately one-quarter of all health centers that received Federal funds in FY 2014. The remaining health centers were in the midst of multiyear grants and received noncompetitive continuation grants in FY 2014. See Appendix C for a full discussion of our methodology.

We analyzed a variety of data related to HRSA's identification of and response to health center risks. Data included the program conditions that HRSA placed on health centers' grants to indicate program noncompliance, the financial assessments that HRSA conducted for the health centers, and the ways in which HRSA intervened to help health centers. These data spanned nearly 2.5 years, from the SAC grant applications in late 2013 through the end of 2015. HRSA stored these data in its Electronic Handbook, which is an electronic repository for data related to HRSA's funding and management of health centers.

Using HRSA's data, we assigned each health center to one of four risk categories that we developed:

1. nominal risks,
2. elevated programmatic risks only,
3. elevated financial risks only, or
4. both elevated programmatic and financial risks.

Our categorization of risk was informed by HRSA's guidance. We classified a health center as having elevated programmatic risk if it met HRSA's programmatic criteria for a restricted grant period. We classified a health center as having elevated financial risk if HRSA's financial assessment categorized the health center's level of financial risk as moderate, high, or extreme.

To determine the extent to which HRSA took steps to help health centers reduce their risks, we identified the ways in which HRSA intervened following the award of FY 2014 SAC grants. We also reviewed situations in

which HRSA did not intervene in accordance with its regulations and policies.

To determine whether a health center was able to reduce its risks before it was awarded an additional year of funding, we compared its risk levels at the start of its FY 2014 funding to its risk levels at the start of its FY 2015 funding. We considered a health center to have reduced its risks if it went from elevated to nominal risks in that time.

Limitations

We were not able to determine whether HRSA's interventions had a direct impact on health centers' ability to improve because it was not possible to isolate HRSA's interventions from other explanatory variables. For example, we could not separate the impact of HRSA's interventions from the impact of actions that health centers took.

We did not review all documents that may have included HRSA's justifications for awarding SAC grants to health centers, as some of these documents were outside the scope of this review.

In assessing whether HRSA used risk management interventions when it should have, we were not able to assess its use of five of its nine interventions because HRSA either did not have data available or did not have criteria governing the interventions' use. As a result, we may have underreported the number of times that HRSA did not intervene when it should have.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

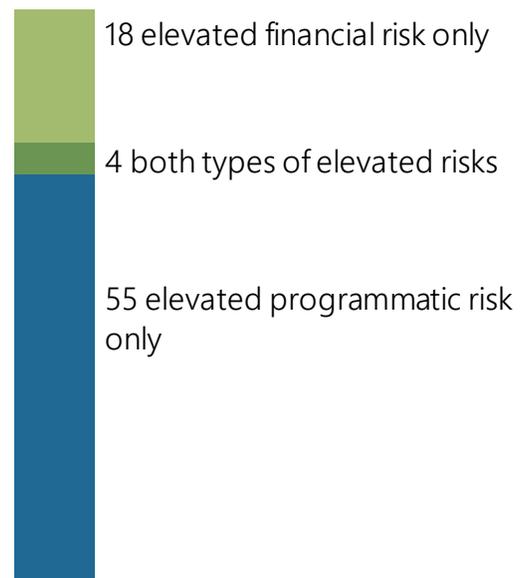
Twenty-five percent of the health centers to which HRSA awarded SAC grants in FY 2014 had elevated risks

HRSA awarded FY 2014 SAC grants to 309 health centers that served 4.8 million patients in 2014. HRSA identified 232 of these health centers as having only nominal risks. HRSA identified the remaining 77 health centers as having elevated programmatic or financial risks. These health centers represented 25 percent of health centers that were awarded FY 2014 SAC grants. They received \$102 million in SAC grant funding and served almost 819,000 patients in 2014. See Exhibit 3 for the extent to which the 77 health centers had one or both types of problems.

Health centers with elevated programmatic risks had a range of problems that potentially could have harmed health center patients. These health centers were most frequently out of compliance with program requirements directly related to patient care, including providing certain types of services and ensuring appropriately credentialed staff. Patients who sought care at these health centers may have been treated by uncredentialed staff or may not have been able to receive all of the care they needed. These health centers were less frequently out of compliance with program requirements related to their management, such as maintaining a fully staffed management team. See Appendices D and E for further details on health centers with programmatic problems.

Health centers with elevated financial risks also had a range of issues that may have negatively affected their abilities to appropriately use Federal funds. Some of these health centers experienced more concerning problems such as overbilling for services provided, using funds for unallowable expenditures, and staff theft. Other health centers had less concerning problems, like being unable to provide HRSA with results from

Exhibit 3: While most health centers with elevated risks had only a financial or programmatic risk, some had both.



Source: OIG analysis of health centers to which HRSA awarded FY 2014 SAC grants, 2017.

independent audits or having minor problems identified through their independent audits. See Appendix E for further details on health centers with financial problems.

HRSA renewed a grant to one health center with elevated financial risks. This center had more than \$500,000 in unallowable expenditures at the time of the grant renewal.

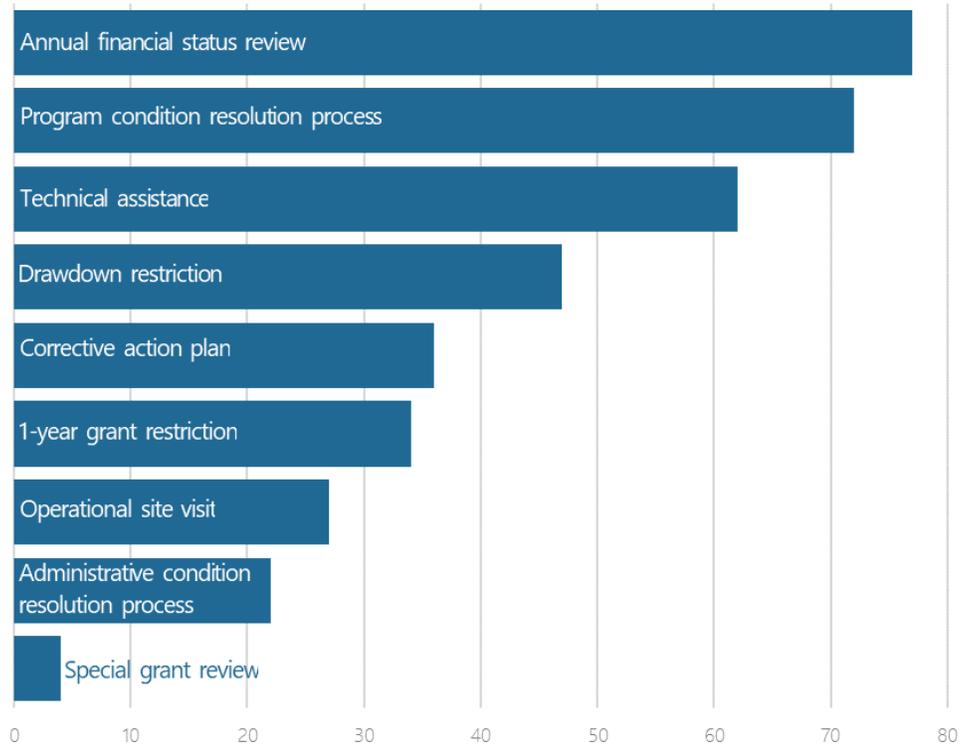
Two of the health centers with problems should not have received SAC grants according to HRSA's funding criteria. HRSA awarded each of these health centers a 1-year grant in FY 2014, as it had done for each of the health centers in each of the previous 2 years. HRSA's policy states that it should not fund health centers that meet the criteria for being limited to 1-year grants 3 years in a row, as this indicates unsatisfactory performance and demonstrates that the health center cannot meet all of the Health Center Program requirements. According to HRSA, it sometimes funds health centers with problems to ensure access to health care for patients in the areas served by these health centers.

HRSA took steps to help health centers reduce their risks but could have done more

HRSA intervened in multiple ways to help health centers reduce their risks, and most health centers were able to do so

HRSA helped 77 health centers, and ultimately 59 of these health centers improved before receiving additional years of funds. For many health centers with programmatic problems, HRSA provided technical assistance to improve their compliance and regularly monitored their progress toward compliance. For some health centers with financial problems, HRSA awarded 1-year grants and assigned drawdown restrictions to protect Federal funding while providing technical assistance to help health centers resolve their financial issues. See Exhibit 4 for the number of health centers for which HRSA used each intervention.

Exhibit 4: HRSA most frequently used annual financial status reviews, the program condition resolution process, and technical assistance to help health centers with elevated risks.*



Source: OIG analysis, 2017.

* This exhibit is based on our analysis of 77 health centers with problems. The total number of health centers for which HRSA used these interventions sums to more than 77 because HRSA intervened in multiple ways for each health center.

HRSA most frequently used annual financial status reviews, the program condition resolution process, and technical assistance to help health centers with problems. HRSA conducted annual financial status reviews for all of these health centers to monitor known issues and to identify new ones. Similarly, for any of the health centers that were out of compliance with one or more program conditions, HRSA tracked their progress toward compliance through the program condition resolution process. Finally, HRSA provided technical assistance to many of these health centers on an as-needed basis to help them improve.

HRSA used its remaining interventions less frequently. Some of these interventions are intended to help health centers deal with less common issues. For example, HRSA requires health centers to develop corrective action plans only if their independent audits have findings. Other interventions, such as special grant reviews, are resource-intensive and are reserved for health centers with serious problems.

HRSA missed opportunities to further help health centers reduce risks

For some health centers with problems, HRSA did not use all of its interventions as intended. While most health centers were able to improve, HRSA missed opportunities to provide additional help.

HRSA did not always use three of its interventions—1-year grants, drawdown restrictions, and operational site visits—for 47 of the 77 health centers with problems that met the criteria for one or more of these

HRSA did not conduct the operational site visits that it should have for the two health centers that did not meet its funding criteria.

interventions. Most frequently, HRSA did not assign 1-year grants when it should have, failing to assign these grants to half of the health centers that met the criteria. Two of these health centers were out of compliance with more than 10 program requirements. For more information on the rates at which HRSA did not use its interventions as required, see Appendix F.

By not using these interventions as required, HRSA did not do all that it could to safeguard patients and Federal funds. By not limiting grant periods to 1 year or assigning drawdown restrictions to every health center that met the respective criteria, HRSA did not limit health centers' access to funds and thus may have increased the amount of Federal funds exposed to unnecessary risk. Additionally, by not conducting operational site visits for every health center that met the criteria, HRSA may have missed opportunities to collect comprehensive information about health centers' performance and compliance, monitor existing risks, and identify new risks to patients and Federal funds at health centers.

Some health centers, particularly those with elevated financial risks, were not able to reduce their risks despite HRSA's help

Despite HRSA's help, half of all health centers with financial problems did not improve before HRSA awarded them additional years of funding. In comparison, just 14 percent of health centers with programmatic problems were not able to improve before HRSA awarded them additional years of funding.¹²

Health centers may not have addressed their financial problems even with HRSA's help because the contributing issues are not always fully within health centers' control. For example, one health center that had been flagged for multiple years as potentially considering bankruptcy did indeed file for bankruptcy in 2015, citing issues related to untimely reimbursements from payers. This health center closed 2 of its service sites and served 1,480 fewer patients in 2015 than in 2014. The patients who regularly visited

these now-closed service sites may have had difficulty finding other health care providers.

In some cases, health centers with financial problems developed more serious problems after receiving a first year of funding. For example, to remain operational, one health center required not only the typical second year of funding, but also emergency supplemental funding. This health center was not able to repay the emergency funding as expected. Another health center had significant negative assets, zero working capital, a steady decline in revenue and patients served, and more than \$500,000 in unallowable expenditures. HRSA chose to continue funding this health center while simultaneously requiring it to repay the unallowable expenses.

In contrast, health centers may have reduced their programmatic problems more frequently because the contributing issues are typically within their control. Most programmatic problems are directly related to health centers' operation and management.

CONCLUSION AND RECOMMENDATIONS

Approximately one-quarter of the health centers to which HRSA awarded SAC grants in FY 2014 had elevated risks, including two that did not meet HRSA's funding criteria. HRSA took steps to help health centers improve, and most health centers did so. However, HRSA could have done more at the time to help health centers and to limit the potential negative effects on health center patients and Federal funds. Additionally, some health centers, particularly those with financial problems, were not able to improve despite HRSA's help.

HRSA's ability to provide comprehensive oversight is a key element in its mission to ensure that medically underserved patients are able to access health care. To ensure access for these patients, HRSA may choose to fund health centers with problems. However, after awarding grants to these health centers, HRSA must ensure that it uses interventions to limit potential negative effects on health center patients and Federal funds.

During this study, OIG provided technical assistance to HRSA as it undertook improvements to its oversight and worked to update its risk management process to implement new HHS guidance. According to HRSA, it has already made changes to this process based on this early information. As HRSA continues these efforts, we recommend that it:

Ensure that it uses its risk management interventions as intended

HRSA should ensure that it uses its interventions for all health centers that meet the respective criteria. Specifically, HRSA should ensure that it:

- awards grants of only 1 year and assigns drawdown restrictions to all health centers that meet the criteria for these interventions, and
- conducts operational site visits within a year for all health centers awarded 1-year grants.

Each of these interventions is an important component of HRSA's risk management process. One-year grants and drawdown restrictions allow HRSA to limit health centers' access to Federal funds, thereby limiting the potential for health centers to misuse those funds. Operational site visits are an important way for HRSA to collect comprehensive information about health centers' performance and compliance.

There are several steps that HRSA could take to help ensure that it is following its policies. For example, it could develop automated mechanisms in its Electronic Handbook (an electronic repository for data related to its funding and management of health centers) that (1) alert staff when health centers meet the criteria for 1-year grants and drawdown restrictions and (2) send reminders to relevant staff when health centers should have

operational site visits conducted, if such mechanisms are not already in place. Alternatively, HRSA could audit how consistently it limits SAC grants to 1 year and assigns drawdown restrictions for health centers that meet the respective criteria for those interventions, and HRSA could audit the timeliness with which it conducts operational site visits. HRSA could then evaluate the results of these audits for process improvements.

Explore additional steps it could take to help health centers reduce their elevated financial risks

HRSA should take additional steps to help health centers with financial problems. Compared to health centers with programmatic problems, health centers with significant financial problems were less frequently able to improve before being awarded additional Federal funds. Although some financial issues may be beyond the control of HRSA and/or health centers, HRSA could expand its use of existing interventions or develop new interventions to help health centers. For example, HRSA could facilitate sharing of best practices among health centers that are able to reduce financial problems. Additionally, HRSA could focus more of its efforts on health centers with the most serious risk. HRSA may need to revise existing or draft new internal policies to take these additional steps.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

HRSA did not express whether it concurred or did not concur with our recommendations. However, HRSA outlined actions it took that are consistent with OIG's recommendations. Specifically, HRSA described adding new interventions to assess and mitigate risk, as well as developing new processes across the grants management lifecycle that HRSA believes are fully responsive to the recommendations in OIG's report. OIG commends HRSA for its efforts and believes that these actions represent improvements to the program. During a more detailed review of further evidence, we may find that HRSA's actions justify closing these recommendations.

HRSA also expressed concern about some findings from OIG's report. First, HRSA stated that OIG's findings do not account for justifications for HRSA's funding decisions. OIG focused on reporting the number of health centers with elevated risks that received Federal funds and the steps that HRSA took to safeguard those funds. We do note in the report that HRSA may choose to fund health centers with problems to ensure access to health care for patients.

Second, HRSA expressed concern that OIG's report overstates the risk to patients associated with a HRSA finding of noncompliance with credentialing and privileging requirements. HRSA states that its findings of noncompliance may represent a weakness in recordkeeping rather than a determination that providers were unlicensed or not credentialed. However, because the documentation was found to be problematic, we cannot know for certain whether all providers are appropriately licensed and credentialed. OIG maintains HRSA's findings could in fact represent providers that were unlicensed or not credentialed, and OIG continues to believe that treatment of patients by unlicensed or uncredentialed providers does pose a risk to patients.

OIG reviewed all materials provided by HRSA and updated the findings and recommendations as appropriate based on the scope and objective of the report. OIG has maintained the recommendations that remain relevant, especially for grantees that pose the greatest risk to Federal funds.

APPENDIX A: Health Center Program Requirements

Need

1. Needs Assessment: Health center demonstrates and documents the needs of its target population, updating its service area, when appropriate. (Section 330(k)(2) and Section 330(k)(3)(J) of the PHS Act)

Services

2. Required and Additional Services: Health center provides all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established written arrangements and referrals. (Section 330(a) of the PHS Act)

Note: Health centers requesting funding to serve homeless individuals and their families must provide substance abuse services among their required services. (Section 330(h)(2) of the PHS Act)

3. Staffing Requirement: Health center maintains a core staff as necessary to carry out all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established arrangements and referrals. Staff must be appropriately licensed, credentialed, and privileged. (Section 330(a)(1), (b)(1)-(2), (k)(3)(C), and (k)(3)(I) of the PHS Act and 42 CFR Part 51c.102 and 51c.303(n))

4. Accessible Hours of Operation/Locations: Health center provides services at times and locations that assure accessibility and meet the needs of the population to be served. (Section 330(k)(3)(A) of the PHS Act)

5. After Hours Coverage: Health center provides professional coverage for medical emergencies during hours when the center is closed. (Section 330(k)(3)(A) of the PHS Act and 42 CFR Part 51c.102(h)(4))

6. Hospital Admitting Privileges and Continuum of Care: Health center physicians have admitting privileges at one or more referral hospitals, or other such arrangement to ensure continuity of care. In cases where hospital arrangements (including admitting privileges and membership) are not possible, health center must firmly establish arrangements for hospitalization, discharge planning, and patient tracking. (Section 330(k)(3)(L) of the PHS Act)

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Appendix A: Health Center Program Requirements (Continued)

7. Sliding Fee Discounts: Health center has a system in place to determine eligibility for patient discounts adjusted on the basis of the patient's ability to pay.

- This system must provide a full discount to individuals and families with annual incomes at or below 100% of the Federal poverty guidelines (only nominal fees may be charged) and for those with incomes between 100% and 200% of poverty, fees must be charged in accordance with a sliding discount policy based on family size and income.*
- No discounts may be provided to patients with incomes over 200% of the Federal poverty guidelines.*
- No patient will be denied health care services due to an individual's inability to pay for such services by the health center, assuring that any fees or payments required by the center for such services will be reduced or waived.

(Section 330(k)(3)(G) of the PHS Act, 42 CFR Part 51c.303(f), and 42 CFR Part 51c.303(u))

8. Quality Improvement/Assurance Plan: Health center has an ongoing Quality Improvement/Quality Assurance (QI/QA) program that includes clinical services and management, and that maintains the confidentiality of patient records. The QI/QA program must include:

- a clinical director whose focus of responsibility is to support the quality improvement/assurance program and the provision of high quality patient care;*
- periodic assessment of the appropriateness of the utilization of services and the quality of services provided or proposed to be provided to individuals served by the health center; and such assessments shall:
 - be conducted by physicians or by other licensed health professionals under the supervision of physicians;*
 - be based on the systematic collection and evaluation of patient records;* and
 - identify and document the necessity for change in the provision of services by the health center and result in the institution of such change, where indicated.*

(Section 330(k)(3)(C) of the PHS Act and 42 CFR Part 51c.303(c)(1-2))

Management and Finance

9. Key Management Staff: Health center maintains a fully staffed health center management team as appropriate for the size and needs of the center. Prior approval by HRSA of a change in the Project Director/Executive Director/CEO position is required. (Section 330(k)(3)(l) of the PHS Act, 42 CFR Part 51c.303(p), and 45 CFR Part 74.25(c)(2),(3))

10. Contractual/Affiliation Agreements: Health center exercises appropriate oversight and authority over all contracted services, including assuring that any subrecipient(s) meets Health Center program requirements. (Section 330(k)(3)(l)(ii), 42 CFR Part 51c.303(n), (t)), Section 1861(aa)(4) and Section 1905(l)(2)(B) of the Social Security Act, and 45 CFR Part 74.1(a)(2))

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Appendix A: Health Center Program Requirements (Continued)

11. Collaborative Relationships: Health center makes effort to establish and maintain collaborative relationships with other health care providers, including other health centers, in the service area of the center. The health center secures letter(s) of support from existing health centers (section 330 grantees and FQHC Look-Alikes) in the service area or provides an explanation for why such letter(s) of support cannot be obtained. (Section 330(k)(3)(B) of the PHS Act, 42 CFR Part 51c.303(n), and HRSA, *Health Center Program Compliance Manual*, accessed at <https://bphc.hrsa.gov/programrequirements/pdf/healthcentercompliancemanual.pdf>)

12. Financial Management and Control Policies: Health center maintains accounting and internal control systems appropriate to the size and complexity of the organization reflecting Generally Accepted Accounting Principles (GAAP) and separates functions appropriate to organizational size to safeguard assets and maintain financial stability. Health center assures an annual independent financial audit is performed in accordance with Federal audit requirements, including submission of a corrective action plan addressing all findings, questioned costs, reportable conditions, and material weaknesses cited in the Audit Report. (Section 330(k)(3)(D), Section 330(q) of the PHS Act and 45 CFR Parts 74.14, 74.21 and 74.26)

13. Billing and Collections: Health center has systems in place to maximize collections and reimbursement for its costs in providing health services, including written billing, credit and collection policies and procedures. (Section 330(k)(3)(F) and (G) of the PHS Act)

14. Budget: Health center has developed a budget that reflects the costs of operations, expenses, and revenues (including the Federal grant) necessary to accomplish the service delivery plan, including the number of patients to be served. (Section 330(k)(3)(D), Section 330(k)(3)(I)(i), and 45 CFR Part 74.25)

15. Program Data Reporting Systems: Health center has systems which accurately collect and organize data for program reporting and which support management decision making. (Section 330(k)(3)(I)(ii) of the PHS Act and 42 CFR Part 51c.303(j))

16. Scope of Project: Health center maintains its funded scope of project (sites, services, service area, target population and providers), including any increases based on recent grant awards. (42 CFR Part 51c.107(c) and 45 CFR Part 74.25)

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Governance

17. Board Authority: Health center governing board maintains appropriate authority to oversee the operations of the center, including:

- holding monthly meetings;
- approval of the health center grant application and budget;
- selection/dismissal and performance evaluation of the health center CEO;
- selection of services to be provided and the health center hours of operations;
- measuring and evaluating the organization's progress in meeting its annual and long-term programmatic and financial goals and developing plans for the long-range viability of the organization by engaging in strategic planning, ongoing review of the organization's mission and bylaws, evaluating patient satisfaction, and monitoring organizational assets and performance;* and
- establishment of general policies for the health center.

(Section 330(k)(3)(H) of the PHS Act and 42 CFR Part 51c.304)

Note: In the case of public centers (also referred to as public entities) with co-applicant governing boards, the public center is permitted to retain authority for establishing general policies (fiscal and personnel policies) for the health center (Section 330(k)(3)(H) of the PHS Act and 42 CFR 51c.304(d)(3)(iii) and (iv)).

18. Board Composition: The health center governing board is composed of individuals, a majority of whom are being served by the center and, this majority as a group, represent the individuals being served by the center in terms of demographic factors such as race, ethnicity, and sex. Specifically:

- Governing board has at least 9 but no more than 25 members, as appropriate for the complexity of the organization.*
- The remaining non-consumer members of the board shall be representative of the community in which the center's service area is located and shall be selected for their expertise in community affairs, local government, finance and banking, legal affairs, trade unions, and other commercial and industrial concerns, or social service agencies within the community.*
- No more than one half (50%) of the non-consumer board members may derive more than 10% of their annual income from the health care industry.*

Note: Upon a showing of good cause the Secretary may waive, for the length of the project period, the patient majority requirement in the case of a health center that receives a grant pursuant to subsection (g), (h), (i), or (p) of the PHS Act. (Section 330(k)(3)(H) of the PHS Act and 42 CFR Part 51c.304)

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Appendix A: Health Center Program Requirements (Continued)

19. Conflict of Interest Policy: Health center bylaws or written corporate board approved policy include provisions that prohibit conflict of interest by board members, employees, consultants, and those who furnish goods or services to the health center.

- No board member shall be an employee of the health center or an immediate family member of an employee. The Chief Executive may serve only as a non-voting ex-officio member of the board.*

(45 CFR Part 74.42 and 42 CFR Part 51c.304(b))

Source: Health Resources & Services Administration, *Health Center Program Requirements*, 2014.

Note: Portions of program requirements notated by an asterisk (*) indicate regulatory requirements that are recommended but not required for health centers that receive funds solely for Health Care for the Homeless (section 330(h)) and/or the Public Housing Primary Care (section 330(i)) Programs.

APPENDIX B: Risk Management Interventions

Exhibit 5: There are a variety of ways in which HRSA can intervene to help health centers reduce their risks.*

Intervention	Description	Scope
Operational site visit	Gathers comprehensive "on the ground" information on health centers' performance and compliance.	Universal. Conducted at the midway point of health centers' grants.
Annual financial status review	Monitors changes in health centers' financial stability, identifies new risks, documents resolved risks, and updates financial risk categories as appropriate.	Universal. Conducted at least annually for all health centers.
Technical assistance	Communicates with health centers' staff through phone or email.	Universal and targeted. Periodic, routine assistance to all health centers, targeted assistance to select health centers as needed.
Program condition resolution process	Assigns a series of deadlines by which health centers must report progress in correcting program conditions. Failure to correct conditions by final deadline results in forfeiture of grants.	Targeted. Assigned to health centers with one or more program conditions.
1-year grant restriction	Assigns shortened grants to health centers. These shortened grants result in more frequent operational site visits and grant application reviews.	Targeted. Assigned to health centers with bankruptcy concerns, multiple program conditions, or at least one long-term program condition.
Drawdown restriction	Requires health centers to obtain HRSA approval before accessing grant funds.	Targeted. Assigned to all health centers on 1-year grants.
Corrective action plan	Requires health centers to submit plans to address audit findings.	Targeted. Assigned to all health centers with at least one audit finding.
Special grant review	Examines systemic issues at health centers.	Targeted. Conducted for health centers identified by HRSA.
Administrative condition resolution process	Requires health centers to address administrative issues of concern by specified deadlines.	Targeted. Assigned to health centers with one or more administrative conditions (i.e., conditions not related to the program requirements).

Source: OIG summary of HRSA documents, 2017.

* HRSA is not required to use all available interventions on health centers with elevated risk. Most interventions have specific criteria that describe when HRSA should use them.

APPENDIX C: Detailed Methodology

Data Sources and Analysis

This study is based on our analysis of Health Center Program data for FY 2014 SAC grants that we requested from HRSA's Electronic Handbook, an electronic repository for data related to HRSA's funding and management of health centers. This data spanned nearly 2.5 years, from the SAC grant applications in late 2013 through the end of 2015.

FY 2014 SAC grant applicants. To identify health centers that competed for FY 2014 SAC grants, we requested data on SAC grant applicants. The data included health centers' demographic information, the service area(s) for which health centers applied, and HRSA's funding decisions.

In total, we gathered data on 331 health centers that competed for FY 2014 SAC grants, including 309 health centers that were awarded SAC grants and 22 that were not.

Risk assessment. To identify how and when HRSA assessed risks at health centers, we used the financial assessments that HRSA completed for each of the 309 health centers to which it awarded a FY 2014 SAC grant. We entered the data from each financial assessment into a database for analysis.

To determine when HRSA should have assessed risks at health centers, we reviewed relevant policy documents, including the Department's *Awarding Agency Grants Administration Manual* and related HRSA policies.

Health centers that should not have received grants. To identify the number of health centers that should not have received FY 2014 SAC grants, we counted the number of health centers that were awarded 1-year grants for 3 years in a row—FYs 2012, 2013, and 2014.

Health center risks. To identify the number of health centers with elevated risks, we assigned each health center to one of our designated risk categories. See Exhibit 6 on the next page for a description of the criteria we used for each category.

Exhibit 6: OIG used HRSA’s criteria to categorize health centers as having nominal risks, elevated programmatic risks, elevated financial risks, or both types of elevated risks.

Nominal Risks	Elevated Programmatic Risks	Elevated Financial Risks
<p>Health centers that HRSA:</p> <ul style="list-style-type: none"> • determined to be out of compliance with fewer than five program requirements, • determined not to have any program conditions that reached the final stage of the program condition resolution process, and • assigned a financial risk category of minimal risk 	<p>Health centers that HRSA determined to:</p> <ul style="list-style-type: none"> • be out of compliance with five or more program requirements, or • have at least one program condition that reached the final stage of the program condition resolution process 	<p>Health centers that HRSA assigned a financial risk category of:</p> <ul style="list-style-type: none"> • moderate risk, • high risk, or • extreme risk

Source: OIG summary of HRSA policy documents, 2017.

To determine the number of health centers with elevated programmatic risks that received FY 2014 SAC grants, we used the data we requested from HRSA related to program conditions. We used this data to identify health centers that—at the time HRSA reviewed their respective SAC grant applications—were either (1) out of compliance with five or more program requirements or (2) had at least one program condition that reached the final stage of the program condition resolution process. We used program conditions as a marker for program noncompliance because HRSA uses them in a similar way in the Electronic Handbook.

We included program conditions in our determination of health centers with elevated programmatic risks if any of the following were applicable:

1. The condition had been placed before the SAC grant application was due to HRSA and had not been removed from the grant before HRSA finished its review of the application.
2. The condition had been placed while HRSA was reviewing the SAC grant application and had not been removed from the grant before HRSA finished its review.
3. The condition had been placed as a result of HRSA’s review of the SAC grant application, typically after HRSA had finished its review of the application.

To determine the number of health centers with elevated financial risks that received FY 2014 SAC grants, we used the information recorded on the financial assessment that HRSA conducted prior to or during the review period for applications for FY 2014 SAC grants. We used this data to identify health centers that HRSA had designated as having a financial risk level above “minimal.” We considered a health center to have elevated financial risks if HRSA had assigned it a financial risk level of moderate, high, or extreme.

We considered a health center to have nominal risks if HRSA had placed fewer than five program conditions on the health center’s grant or assigned it a financial risk level of minimal.

Risk management interventions. To identify the ways in which HRSA intervened to help health centers reduce their elevated risks, we identified each type of intervention that HRSA used from the time of the FY 2014 SAC grant application through the end of 2015. We then counted the number of risk management interventions that HRSA used for these health centers.

To determine when HRSA should have used certain risk management interventions, we reviewed relevant policy documents.

To identify the number of health centers with elevated risks for which HRSA did not use an intervention when it should have, we first identified the health centers that met the criteria for each intervention. For our analysis of whether HRSA limited grants to 1 year when it should have, we identified the number of health centers that had five or more program conditions, had at least one condition in the final stage of the condition resolution process, or were at risk for bankruptcy. We then counted the number of health centers that awarded 3-year grants despite meeting the criteria for being limited to 1-year grants. For our analysis of whether HRSA assigned drawdown restrictions and conducted operational site visits when it should have, we identified health centers to which HRSA had awarded 1-year grants. We then counted the number of these health centers for which HRSA did not use each intervention.

Health centers that reduced their risks. To determine the number of health centers that reduced their elevated programmatic risks before receiving an additional year of funding, we used the number of program conditions placed on each health center’s grant at the start of the health center’s FY 2015 funding. If a health center had fewer than five conditions on its grant at the start of its next year of funding, we classified it as having reduced its programmatic risks.

To determine the number of health centers that reduced their elevated financial risks before receiving an additional year of funding, we used the information recorded on each health center’s most recent financial assessment available at the start of the health center’s FY 2015 funding. We identified the level of financial risk that HRSA had assigned to each health

center on the basis of its annual financial status review. If a health center was assigned to the minimal-risk level, we classified it as having reduced its financial risks.

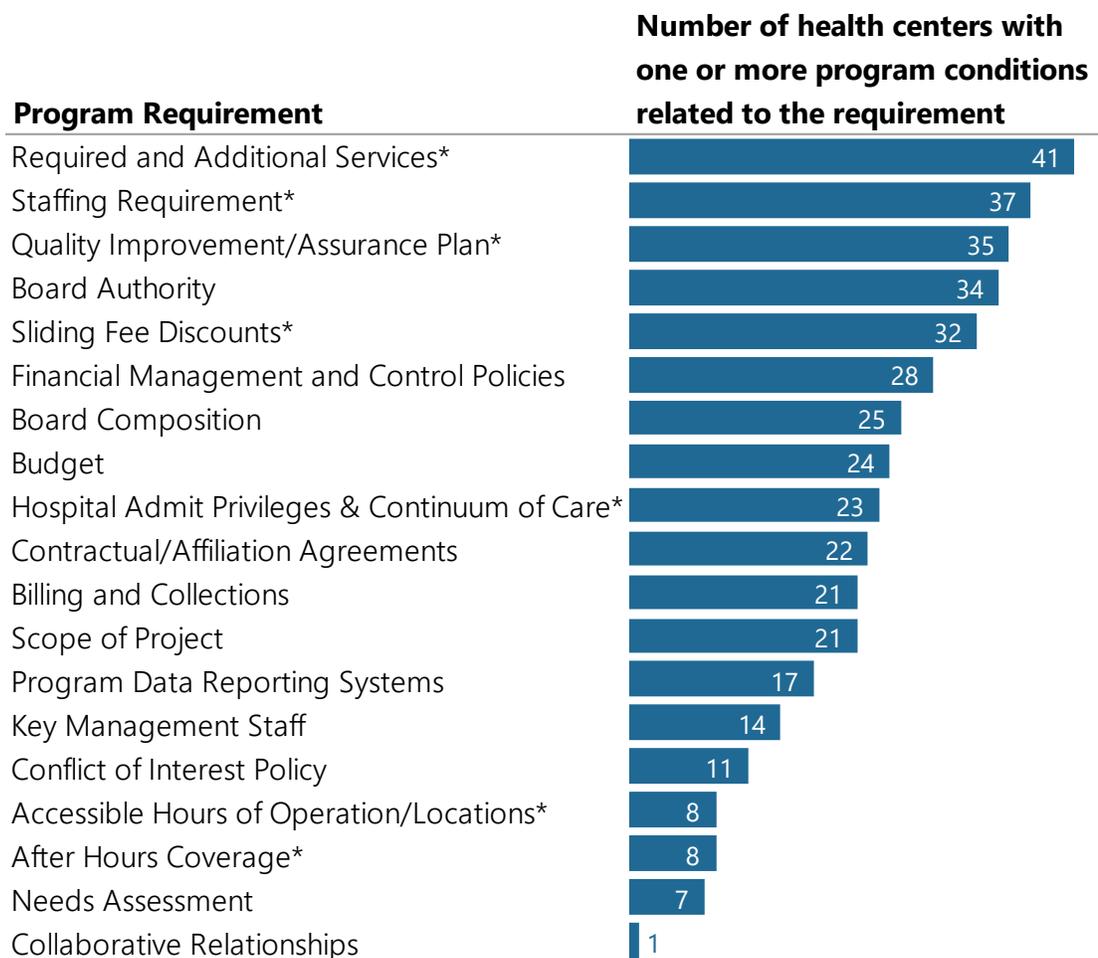
Amounts awarded to health centers. To calculate the amounts awarded to health centers, we summed the FY 2014 SAC grant award amounts recorded in HRSA's Electronic Handbook.

Patients served by health centers. To calculate the number of patients served by health centers, we summed the number of patients recorded for each health center in HRSA's Uniform Data System (UDS). The UDS is a data repository for health center performance data, including number of patients served.

APPENDIX D: Frequency of Noncompliance Among Health Centers With Elevated Programmatic Risks

Exhibit 7: Health centers with elevated programmatic risks were frequently out of compliance with program requirements related to patient care.

We based this exhibit on our analysis of the 59 health centers with elevated programmatic risk. Each of these health centers was out of compliance with at least five program requirements.

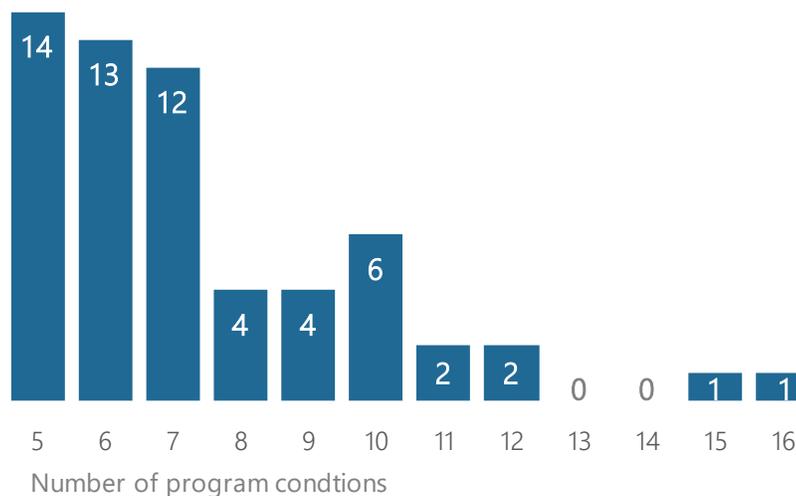


Source: OIG analysis of FY 2014 program conditions data, 2017.

* Program requirement related to patient care.

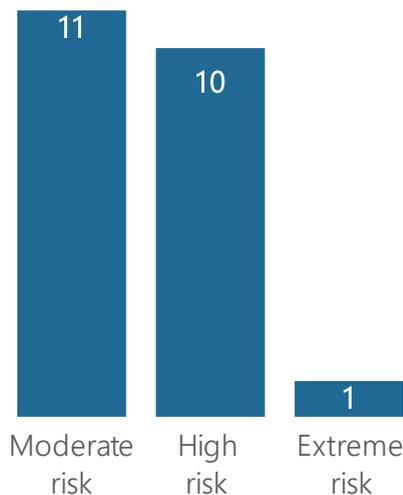
APPENDIX E: Descriptive Information for Health Centers With Elevated Programmatic or Financial Risks

Exhibit 8: Most of the 59 health centers with elevated programmatic risk had 5 program conditions, with the number of health centers declining as the number of program conditions increased.



Source: OIG analysis of health centers with elevated programmatic risks, 2017.

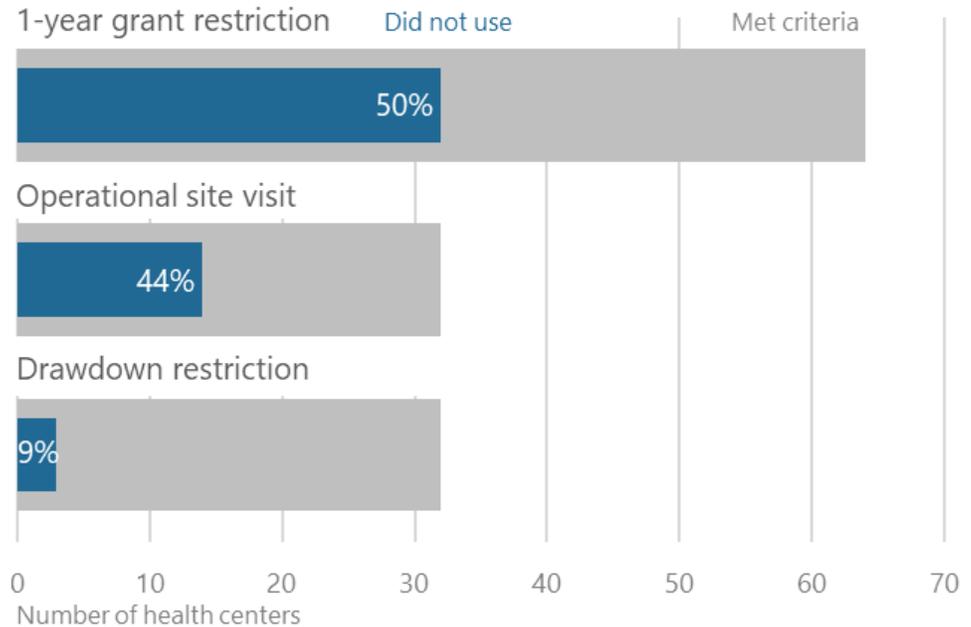
Exhibit 9: One-half of the 22 health centers with elevated financial risk were assessed as either high risk or extreme risk on their financial assessments.



Source: OIG analysis of health centers with elevated financial risks, 2017.

APPENDIX F: Risk Management Interventions HRSA Did Not Use When It Could Have

Exhibit 10: HRSA did not always limit grants to 1 year, use drawdown restrictions, or conduct operational site visits when health centers with elevated risks met the criteria for these interventions.



Source: OIG analysis of health centers with elevated risks, 2017.

HRSA awarded 3-year grants when it should have awarded only 1-year grants for 50 percent of health centers that met the criteria for having their grants limited to 1 year. In FY 2014, 64 health centers met the criteria for having their grants limited to 1 year because they had five or more program conditions, had one or more program conditions in the final phase of the condition resolution process, or were at risk for bankruptcy. However, HRSA limited grants to 1 year for only 32 of these 64 health centers. By not limiting grants to 1-year periods when it should have, HRSA may have increased the amount of Federal funds subject to risk by not limiting the number of years when health centers would have access to funds.

Additionally, after awarding 1-year grants to these 32 health centers, HRSA did not always use 2 other interventions when it should have. HRSA's FY 2014 criteria stated that a health center that is limited to a 1-year grant should receive an operational site visit within that year and be assigned a drawdown restriction. However, HRSA did not conduct operational site visits when it should have for 14 of these 32 health centers or assign

drawdown restrictions to 3 of the 32 health centers. Two of the 32 health centers received neither an operational site visit nor a drawdown restriction.

APPENDIX G: Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Resources and Services
Administration

Rockville, MD 20857

JAN 26 2017

TO: Inspector General Daniel R. Levinson
Inspector General, HHS OIG

FROM: Administrator
Health Resources and Services Administration

DATE:

SUBJECT: Office of Inspector General's (OIG) Draft Report: *HRSA Took Steps to Help Health Centers with Elevated Risks but Could Have Done More* (OEI-05-14-00470)

Thank you for the opportunity to review OIG's draft report. Attached are HRSA's comments. If you have any questions, please contact Rebeca Sanchez-Barrett in HRSA's Office of Planning, Analysis and Evaluation at (301) 443-0324.


George Sigouras, MS, Ph.D.

Attachments

**GENERAL COMMENTS OF THE HEALTH RESOURCES AND SERVICES
ADMINISTRATION ON THE OFFICE OF INSPECTOR GENERAL'S DRAFT
REPORT (OEI-05-14-00470)**

The Health Resources and Services Administration (HRSA) appreciates the opportunity to review and comment on this draft report. Since early fiscal year (FY) 2014 when the Office of the Inspector General (OIG) initiated this study, HRSA has significantly enhanced and continues to improve its risk management practices and has already substantially addressed the OIG's recommendations. HRSA has added new risk assessment and mitigation interventions and developed new processes across the grants management lifecycle that are fully responsive to the recommendations in the OIG's draft report. HRSA thanks the OIG for a productive relationship over the course of this 4-year review. However, HRSA has concerns regarding several of the conclusions currently stated in the draft report.

OIG's draft report does not sufficiently reflect the study's methodological limitations regarding HRSA decisions to award Health Center Program Service Area Competition (SAC) grants. The draft report briefly acknowledges (on page 7) that the study had limitations. The OIG states that it did not review all documents that may have formed the basis for HRSA's decisions, including HRSA's justification for awarding SAC grants to health centers and the associated determinations of project period lengths. By foregoing a review of HRSA's complete grant file records (i.e., Program Analysis and Recommendations (PARs) and Notices of Awards), OIG's conclusions do not account for instances where HRSA documented justification for its decision making consistent with its standard operating procedures (SOPs) for application reviews. This included instances in which HRSA made funding and/or project period length determinations based on the most current and complete programmatic risk information available, which the OIG did not review. HRSA offers the case of health centers that met the criteria for a 1-year project period according to the point-in-time data reviewed by the OIG. Given that HRSA works continuously to help health centers resolve their findings, those health centers may well have subsequently qualified for a full 3-year project period versus a 1-year project period based on existing guidance.

The OIG draft report overstates the risk to patients based on a finding of noncompliance with Health Center Program credentialing and privileging requirements. HRSA identifies non-compliance based on weaknesses identified in the health center's procedures or recordkeeping related to credentialing and privileging of clinical staff, which is not equivalent to a determination that providers were unlicensed, not credentialed, or otherwise not competent to provide care.

Response to Recommendations

OIG Recommendation: HRSA should ensure that it uses its risk mitigation interventions as intended.

HRSA has addressed this recommendation by incorporating a risk-based grants management approach into its electronic infrastructure, agency-wide guidance, SOPs, and staff training to ensure that risk-mitigation interventions are applied as intended. With the goal of supporting each health center's success in reducing identified risks, HRSA also uses a team-based approach in conducting its oversight and monitoring. HRSA's grants management staff meet with

**GENERAL COMMENTS OF THE HEALTH RESOURCES AND SERVICES
ADMINISTRATION ON THE OFFICE OF INSPECTOR GENERAL'S DRAFT
REPORT (OEI-05-14-00470)**

HRSA's program staff, including those who oversee the Health Center Program, prior to funding any high-risk applicant to discuss identified risks and mitigation strategies. These staff also meet on a quarterly basis to monitor the status of high-risk recipients.

HRSA has also implemented several system upgrades resulting in a more robust electronic infrastructure for grants management. These improvements include automatic transfer of conditions; real-time refreshing of grants condition information; automatic term language for drawdown restriction; notifications and dashboards; and an electronic site visit module. The automatic transfer of active conditions between award periods and real-time refreshing of the status of conditions within the SAC application review (i.e., PAR) ensures that the most current information is readily available to staff processing PARs. HRSA notes that it provided related documentation to the OIG in 2016 and again in response to the initial draft report evidencing the design and implementation of this risk mitigation intervention. In addition, HRSA has instituted automatic placement of term language on a health center's Notice of Award in cases where HRSA's SAC application review results in a recommendation for drawdown restriction (DDR). HRSA has also developed and made enhancements to notifications and dashboards that alert project officers (PO) when conditions are about to progress to the next stage of Progressive Action. HRSA notes that it provided OIG with documentation of HRSA's PO training about these notifications, which reflect HRSA's efforts to ensure timely resolution of conditions. Finally, HRSA established an electronic site visit module to better ensure that PO's scheduled site visits in accordance with HRSA's policy—at least once every three years/once per project period.

OIG recommendation: Take additional steps to help health centers with elevated financial risks reduce their risks.

HRSA has addressed this recommendation as the agency has implemented a number of additional steps since the period under review by the OIG. In response to the Grants Policy Administration Manual's 2015 directive to cultivate an HHS culture of risk management, HRSA established and leads quarterly High Risk Grantee meetings with participation across HHS operating divisions (OPDIVs). As a forum for proactive communication, OPDIVs share and discuss best practices for conducting risk assessments; challenges regarding high risk grantees funded by multiple OPDIVs; and collaborative efforts to address systemic issues that are applicable to all grant awards. HRSA notes it provided OIG with documentation of agendas and slides for these meetings. HRSA will continue to explore additional approaches with other HHS operating divisions and federal agencies.

In 2017, HRSA began providing fiscal technical assistance in the form of on-site review of health center policies and procedures and financial management systems. These visits are targeted to grantees at high or moderate risk. HRSA also uses financial ratio analysis and reviews of 3-year trends to help identify recipients that are trending downward financially to identify health centers that may be candidates for fiscal technical assistance. HRSA notes it provided OIG with the FY 2017 HRSA Technical Assistance Protocol for this effort.

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In 2017, HRSA began performing Financial Management Reviews (FMRs) to review policies and procedures and financial management systems of grantees that are under the threshold for single audit coverage. Targeted FMRs may also be performed for recipients who are experiencing financial challenges.

Finally, HRSA has expanded the range of technical assistance resources made available to all grantees. For example, in August 2016, HRSA facilitated [a webinar](#) to help health centers avoid unallowable costs and establish effective financial management systems. HRSA also enhanced its website to include a section, "[Manage Your Grant](#)" with relevant information for grantees including legislative mandates, policy bulletins, financial management requirements, and HRSA's quarterly grants management calls. HRSA notes it provided OIG with links to these resources.

GLOSSARY

1-year grant: a grant with a shortened term; results in more frequent operational site visits and grant application reviews.

Administrative condition resolution process: a process by which health centers address administrative issues of concern by specified deadlines.

Corrective action plan: requires health centers to address audit findings.

Drawdown restriction: requires health centers to obtain HRSA approval before accessing grant funds.

Financial assessment: a document in which HRSA summarizes the financial stability of each health center after reviewing financial statements, tax records, independent audit findings, and other records annually.

Financial risk level: describes the level of risk posed to Federal funds by a health center (i.e., minimal, moderate, high, or extreme), as determined by HRSA's financial assessment of the health center.

Health centers with elevated risks: health centers that had elevated programmatic risks, elevated financial risks, or both types of elevated risks.

Elevated financial risk: describes the situation when a health center poses more than a minimal risk to Federal funds.

Elevated programmatic risk: describes the situation when a health center has five or more program conditions or at least one condition approaching the final deadline of the program condition resolution process.

Noncompetitive continuation grant: a grant for the second or third year of a 3-year grant; a health center with a 3-year grant typically receives a noncompetitive continuation grant, presuming a satisfactory noncompetitive review by HRSA.

Noncompliance: when a health center is unable to meet the conditions of a program requirement.

Operational site visit: gathers comprehensive "on the ground" information on a health center's performance and compliance.

Program condition: serves as an official notification to a health center that it is not compliant with a program requirement and states the terms the health center must meet to remain eligible for its SAC grant; most health centers have at least one program condition.

Program condition resolution process (i.e., HRSA's Progressive Action Process): assigns a series of deadlines by which a health center must report its progress in correcting program conditions; failure to correct conditions by final deadline results in forfeiture of grants.

Service area: an area in which a health center provides health services; typically a geographic area, but can also be demographic groups such as individuals experiencing homelessness, migratory and seasonal agricultural workers, or residents of public housing.

Service Area Competition (SAC) grants: grants that support the operation of health centers; open for competition in a service area when the existing health center completes the terms of its previous SAC grant or is otherwise unable to continue operating in the service area.

Special grant review: examines systemic issues at a health center.

Technical assistance: communication between HRSA and health centers' staff through phone or email; can include both general and targeted information.

ACKNOWLEDGMENTS

Lisa Minich served as the team leader for this study, and Hilary Slover served as the lead analyst. Others in the Office of Evaluation and Inspections who conducted the study include Keisha Keith, Kayla Phelps, Megan Shade, and Liz Weiner. Office of Evaluation and Inspections staff who provided support include Althea Hosein, Seta Hovagimian, Christine Moritz, Jodi Nudelman, and Melicia Seay.

This report was prepared under the direction of Thomas Komaniecki, Regional Inspector General for Evaluation and Inspections in the Chicago regional office, and Kelly Waldhoff and Laura Kordish, Deputy Regional Inspectors General.

For additional information concerning this report or to obtain copies, contact the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

ABOUT THE OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

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The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

ENDNOTES

¹ HRSA, *2016 Health Center Program Grantee Data, Uniform Data System*. Accessed at <https://bphc.hrsa.gov/uds/datacenter.aspx> on August 15, 2017.

² HRSA, *Health Center Program Fact Sheet*. Accessed at <https://www.bphc.hrsa.gov/about/healthcenterfactsheet.pdf> on August 15, 2017.

³ 42 U.S.C. § 254b, 42 CFR § 51c, 45 CFR Part 75.

⁴ 42 U.S.C. § 254b, 42 CFR § 51c, 42 CFR §§ 56.201–56.604, and 45 CFR Part 75.

⁵ 42 U.S.C. § 254b, 42 CFR § 51c; HRSA, *Program Information Notice 2008-01: Defining Scope of Project and Policy for Requesting Changes*, December 2007.

⁶ 45 CFR § 74.14; see also 45 CFR § 75.205 (effective December 26, 2014).

⁷ *Awarding Agency Grants Administration Manual (AAGAM)*, ch. 2.01.101-3.

⁸ GAO, *Improved Oversight Needed to Ensure Grantee Compliance with Requirements* (GAO-12-546), May 2012.

⁹ GAO, *Action Taken to Train and Oversee Grantee Monitoring Staff, but Certain Guidance Could Be Improved* (GAO-14-800), September 2014.

¹⁰ OIG, *Use of the Departmental Alert List by HRSA* (OEI-02-03-00011), May 2006.

¹¹ OIG, *HHS Oversight of Grantees Could Be Improved Through Better Information-Sharing* (OEI-07-12-00110), September 2015.

¹² Eleven of the 22 health centers with financial problems and 8 of the 59 health centers with programmatic problems were not able to reduce their problems before HRSA awarded them additional years of funding. One of these health centers had both types of problems and was not able to reduce either type.