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Report to Congressional Requesters

March 2024

HEALTH CENTERS

Revenue, Grant Funding, and Methods for Meeting Certain Access-to-Care Requirements

GAO-24-106815

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Revenue, Grant Funding, and Methods for Meeting Certain Access-to-Care Requirements

GAO Highlights

Highlights of GAO-24-106815, a report to congressional requesters

Why GAO Did This Study

Health centers rely on revenue from a variety of public and private sources, including grants awarded by HRSA through its Health Center Program. Among other things, HRSA requires health centers to have locations and hours that are responsive to patient needs, and to have procedures to handle medical emergencies that arise after hours.

GAO was asked to review health centers' revenue, grant funding, and efforts to meet certain access-to-care requirements. This report describes (1) amounts and sources of health centers' revenue from 2018 through 2022; (2) purposes of HRSA grants awarded from fiscal year 2018 through 2022; and (3) methods used to meet requirements for accessible locations and hours, and coverage of medical emergencies after hours.

GAO analyzed health center revenue data from HRSA and the Department of Health and Human Services for 2018 through 2022, the most recent data available. GAO also reviewed documentation for HRSA grants awarded from fiscal years 2018 through 2022 to determine grant amounts and purposes.

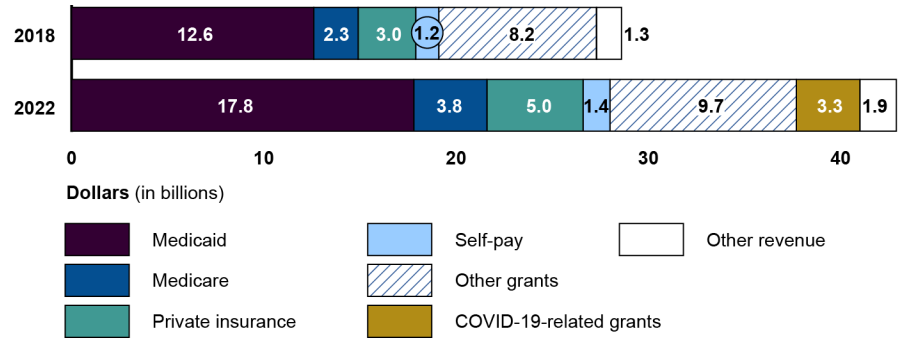
Additionally, GAO reviewed results of health center site visits HRSA conducted from 2018 through 2022 that assessed compliance with certain access-to-care requirements. GAO also interviewed officials from five primary care associations, selected to achieve variation in geographic distribution and number of health centers in their states.

View GAO-24-106815. For more information, contact Michelle B. Rosenberg at (202) 512-7114 or rosenbergm@gao.gov.

What GAO Found

In 2022, nearly 1,400 health centers provided primary and preventive health services to more than 30 million people, regardless of their ability to pay. Health centers' total revenue rose from about $28.7 billion in 2018 to $42.9 billion in 2022—an increase of more than $14 billion. The largest single source of revenue was Medicaid, accounting for over one-third of total revenue each year. The second largest revenue source each year was grants, including those provided by the Health Resources and Services Administration (HRSA).

Health Center Revenue Sources and Amounts, 2018 and 2022



Source: GAO analysis of Health Resources and Services Administration and Department of Health and Human Services data. | GAO-24-106815

Note: For more details, see figure 2 in GAO-24-106815.

HRSA awarded about $34 billion in grant funding to health centers through its Health Center Program in fiscal years 2018 through 2022. About two-thirds of that funding—$23.5 billion—was awarded for service area funding, which supports ongoing operations and services, including existing and recently expanded services, at health centers. The second largest category of funding was provided for the purpose of assisting health centers with preventing, mitigating, and responding to COVID-19. The remaining grant funding supported special initiatives, such as cancer screening; increasing services at existing health centers; and increasing the number of health centers and sites.

Health centers used various methods to meet requirements that they provide care at accessible locations and hours, and coverage for medical emergencies after regularly scheduled hours. According to officials from five primary care associations—organizations that provide technical assistance to health centers—most health centers in their states have at least one site that regularly offers extended hours, such as evenings or weekends, to accommodate patient needs. Officials said health centers have varied arrangements to ensure patients are evaluated after hours by a clinician and referred to emergency care or local urgent care as appropriate. GAO's analysis of HRSA's site visit findings from 2018 through 2022 found that over 93 percent of the 1,391 health centers that had a site visit complied with both of these access-to-care requirements. Health centers not in compliance took corrective actions, such as expanding clinic hours to include weekend hours and contracting with nurse triage services to clinically evaluate patients who called with symptoms after regular hours.

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Abbreviations

CHCF	Community Health Center Fund
HRSA	Health Resources and Services Administration

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
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Washington, DC 20548

March 7, 2024

The Honorable Bill Cassidy, M.D.
Ranking Member
Committee on Health, Education, Labor, and Pensions
United States Senate

The Honorable Cathy McMorris Rodgers
Chair
Committee on Energy and Commerce
House of Representatives

Health centers serve as an important safety-net provider for low-income people living in medically underserved areas. These outpatient facilities are intended to increase the availability of primary and preventive health care services for the patients they serve—the majority of whom are enrolled in Medicaid or are uninsured. Health centers are required to provide health care to individuals who are members of their target population or to all individuals located in their service area, regardless of their ability to pay.[1] In some communities, these centers may be the only source of primary care available to certain vulnerable populations. In 2022, nearly 1,400 health centers operated almost 15,000 sites.[2] These sites provided care to more than 30 million people in the United States in 2022, including more than 9 million rural residents and over 1 million people experiencing homelessness.

Health centers depend on revenue from a variety of public and private sources, including federal, state, and local governments; and payments for services from Medicaid, Medicare, private insurance, and patients.[3]

[1]Most health centers serve the general population within a designated area, while other types of health centers provide care to more specific populations, including people experiencing homelessness, residents of public housing, and migrant and seasonal farmworkers and their families. In this report, the term "health centers" refers to all these types of health centers unless otherwise indicated and does not include organizations that do not receive Health Center Program funding but are recognized by the Health Resources and Services Administration (HRSA) as health center look-alikes.

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

[3]Medicaid is a joint, federal-state program that finances health care coverage for low-income and medically needy individuals. Medicare is the federal program that provides coverage of health care services for individuals aged 65 years and older, certain individuals with disabilities, and individuals with end-stage renal disease.

This revenue includes grants awarded by the Health Resources and Services Administration (HRSA), an agency within the Department of Health and Human Services, through the agency's Health Center Program. HRSA funding for the Health Center Program comes from discretionary appropriations as well as mandatory appropriations through the Community Health Center Fund (CHCF), which was established by the Patient Protection and Affordable Care Act and has subsequently been extended.[4] In 2019, we reported that the CHCF provided approximately $15.8 billion to health centers in fiscal years 2011 through 2017.[5] Since 2020, Congress has also provided additional funding for health centers to prevent, mitigate, and respond to COVID-19.

Health centers are required to provide comprehensive primary health services, including preventive, diagnostic, treatment, and emergency medical services. In addition, HRSA requires health centers to have locations and scheduled hours of operation that are responsive to patient needs and allow patients to schedule appointments and to access the health center's full range of services. Health centers are also required to have procedures to evaluate patients who experience medical emergencies after regularly scheduled hours and, if necessary, refer them for treatment.

You asked us to review health centers' revenue, including COVID-19-related funding, since our previous report. In addition, you asked us to provide information on how health centers meet certain access-to-care requirements. In this report we describe

1. the amounts and sources of health centers' revenue from 2018 through 2022;
2. the purposes for which HRSA awarded grant funding to health centers from 2018 through 2022; and
3. methods health centers used to meet requirements to provide care within accessible locations and hours, and coverage for medical emergencies after regularly scheduled hours.

[4]Discretionary appropriations are generally made through the annual appropriations process. Mandatory appropriations are generally created and funded in the same law on a multiyear or permanent basis and not through the annual appropriations process. The CHCF was initially funded for five years and has since been extended more than once.

[5]See GAO, *Health Centers: Trends in Revenue and Grants Supported by the Community Health Center Fund*, GAO-19-496 (Washington, D.C.: May 30, 2019).

To describe the amounts and sources of health centers' revenue, we analyzed patient-related and other revenue data reported by health centers in HRSA's Uniform Data System for calendar years 2018 through 2022.[6] Patient-related revenue includes payments from public insurance such as Medicare and Medicaid, as well as private insurance and payments received directly from patients (self-pay).[7] Other revenue includes Health Center Program grants—referred to as Section 330 grants—from HRSA; other federal, state, and local grants; and funds received from foundations or other private sources.[8]

We also analyzed data on health center revenue related to COVID-19 from the Department of Health and Human Services' Payment Management System, which HRSA officials said was the most accurate data source available for COVID-19-related revenue. We calculated total revenue received by health centers each year by source. All revenue data are reported as nominal dollars. To assess the reliability of data from both HRSA's Uniform Data System and the Department of Health and Human Services' Payment Management System, we reviewed relevant documentation, such as published reports and user reporting manuals. We also interviewed and reviewed written responses from officials knowledgeable about the data. Based on these steps, we found the data were sufficiently reliable for the purpose of our reporting objective.

To describe the purposes for which HRSA awarded grant funding to health centers, we reviewed information for the 21 Section 330 grants

[6]The Uniform Data System is a standardized reporting system that health centers use to annually report data to HRSA. It consists of data relating to patients, visits, staffing and utilization, quality of care indicators, health outcomes and disparities, financial costs, and revenue. Revenue is the gross receipts on a cash basis for each year collected by health centers, regardless of the period in which the payment for services was rendered. Data are reported in the Uniform Data System by calendar year, rather than fiscal year. At the time of our analysis, 2022 data were the most recent available.

[7]Health centers may also generate revenue through their participation in the 340B Drug Discount Program. This program requires drug manufacturers to sell outpatient drugs at a discount to covered entities—including health centers—in order for their drugs to be covered by Medicaid. Participating health centers can purchase covered outpatient drugs at the 340B Program price and may generate revenue by receiving reimbursement from patients' insurance that may exceed the 340B prices paid for the drugs. However, the Uniform Data System does not separately capture and report revenue that health centers receive through their participation in the 340B Program. According to HRSA officials, such revenue would be included in patient-related revenue sources, such as Medicaid, Medicare, and private insurance.

[8]Health Center Program grants are authorized in Section 330 of the Public Health Service Act. 42 U.S.C. § 254b.

awarded during fiscal years 2018 through 2022, including documentation that described the purposes and allowable uses of the funding.[9] Based on these descriptions, we placed the 21 grants into five main categories, with subcategories as appropriate.[10] We also reviewed HRSA information on the funding amount and source for each grant (i.e., HRSA's discretionary funds, CHCF funds, or funds appropriated by COVID-19-related legislation). To assess the reliability of these data, we selected six grants to achieve variation in dollar amounts and purposes. For each grant, we traced individual health center award amounts to the HRSA-provided total to ensure totals reflected the sum of the individual awards. Based on these steps, we found the data were sufficiently reliable for the purpose of our reporting objective. We also interviewed and reviewed written responses from HRSA officials and interviewed officials from the National Association of Community Health Centers—an organization representing health centers—about the purposes of HRSA's grant funding.

To describe the methods health centers used to meet requirements to provide 1) care within accessible locations and hours, and 2) coverage for medical emergencies after regularly scheduled hours, we reviewed HRSA's Health Center Program Compliance Manual and Site Visit Protocol.[11] These documents outline requirements health centers must meet to receive Health Center Program grant funding and how HRSA determines health center compliance. In addition, we analyzed findings of noncompliance regarding these requirements that HRSA identified during operational site visits of health centers conducted in calendar years 2018

[9]When discussing the purposes of HRSA grant funding for health centers in this report, we use the term "grant" to refer to a funding opportunity for which funds have been awarded. Each of the 21 grants provided funding for multiple health centers. For example, HRSA awarded a 2019 oral health grant to 298 health centers. HRSA reports grant data by fiscal year. At the time of our analysis, 2022 was the most recent full year of data available.

[10]The five categories are: Service area funding; COVID-19-related; Special initiatives; Increase services at existing health centers; and Increase number of health centers and sites.

[11]In addition to providing coverage for medical emergencies after hours, HRSA requires health centers to address medical emergencies during regular hours. We did not review how health centers addressed medical emergencies during regular hours.

through 2022.[12] We reviewed these data to determine reasons HRSA cited the health centers for noncompliance, and the corrective actions the health centers took to achieve compliance. We then selected 20 health centers for further review and asked HRSA to provide documentation outlining corrective actions these health centers took to achieve compliance.

Specifically, we selected the five health centers that were noncompliant with both requirements, and a random sample of 15 other health centers that were noncompliant with the after-hours coverage for medical emergency requirement. We also analyzed weekly operating hours health centers reported to HRSA as of December 31, 2022.[13] Finally, we interviewed officials from five states' primary care associations to learn about methods health centers in their states use to meet the two requirements.[14] We selected these associations to achieve variation in geographical distribution and number of health centers in their states.

We conducted this performance audit from April 2023 to March 2024 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Health Center Program

The federal Health Center Program was established in the mid-1960s to help low-income individuals gain access to health care services. In 2022, almost 15,000 health center sites were distributed across states and

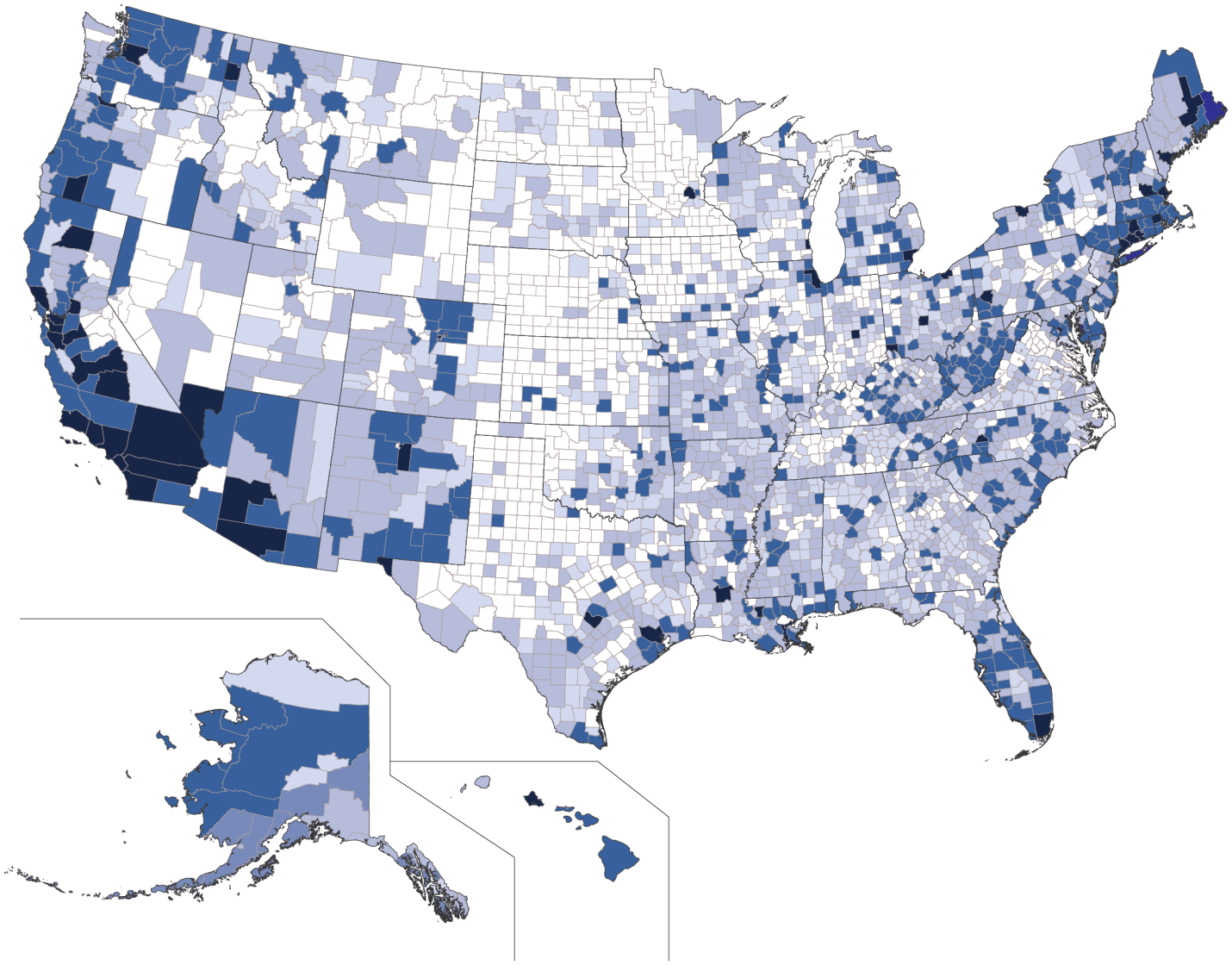
[12]The purpose of an operational site visit is to verify the status of each Health Center Program awardee's compliance with the statutory and regulatory requirements of the Health Center Program. In calendar years 2018 through 2022, HRSA conducted site visits of 1,391 health centers. According to HRSA, due to the COVID-19 pandemic, HRSA suspended all in-person operational site visits in March 2020 and began conducting virtual site visits. Since summer 2022, HRSA has been conducting both in-person and virtual site visits. At the time of our analysis, 2022 data were the most recent available.

[13]At the time of our analysis, 2022 data were the most recent available.

[14]Primary care associations are state and regional nonprofit entities that work with health centers, including providing technical assistance, to help them best meet the needs of communities they serve.

territories (see fig. 1). These sites served a total of about 30.5 million patients in 2022. See appendix I for additional information on the number of health centers and sites, the patients they served, and characteristics of those patients from 2018 through 2022.

Figure 1: Number of Health Center Sites, 2022



Number of health center sites by county

- 0 health center sites
- 1 health center site
- 2 to 5 health center sites
- 6 to 10 health center sites
- 11 to 30 health center sites
- More than 30 health center sites

Source: GAO analysis of Health Resources and Services Administration data (data); GAO (map). | GAO-24-106815

Note: Map shows the number of health center sites located in each county. It does not necessarily reflect all the counties that may be served by health centers. In addition to health center sites reflected in this map, in 2022 there were 117 organizations that did not receive grant funding under the Health Center Program but were recognized by the Health Resources and Services Administration as health center look-alikes.

Authorized in Section 330 of the Public Health Service Act, the Health Center Program is administered by HRSA's Bureau of Primary Health Care, which makes grants—known as Section 330 grants—to four types of health centers that primarily serve low-income populations:

1. **Community health centers**. These health centers serve the general population that has limited access to health care. They are required to provide primary health services to all residents who reside in the center's service area, regardless of their ability to pay. According to HRSA officials, most health centers are community health centers.[15]
2. **Health centers for the homeless**. These health centers provide primary care services to individuals who lack permanent housing or live in temporary facilities or transitional housing. These centers are also required to provide substance use disorder services and supportive services targeted to people experiencing homelessness.
3. **Health centers for residents of public housing**. These health centers provide primary health care services to residents of public housing and individuals living in areas immediately accessible to public housing.
4. **Migrant health centers**. These health centers provide primary care to migratory agricultural workers (individuals whose principal employment is in agriculture and who establish temporary residences for work purposes) and seasonal agricultural workers (individuals whose principal employment is in agriculture on a seasonal basis but do not migrate for the work). Families of migratory and seasonal agricultural workers are also eligible for care at these sites.

HRSA's Section 330 grants are funded by a combination of discretionary appropriations and, since 2011, mandatory appropriations provided from the CHCF. From fiscal year 2018 through 2022, total funding appropriated for Section 330 grants, excluding COVID-19-related funding, remained relatively steady, ranging from about $5.3 billion to about $5.6 billion. A little over 70 percent of these funds were provided by the CHCF each year. For example, approximately 71 percent of appropriations for non-COVID-19-related Section 330 awards in fiscal year 2022—or about $3.9 billion—were funded by the CHCF.

[15]According to HRSA officials, health centers can receive more than one type of funding. Specifically, the officials said that 65 percent of health centers receive only community health center funding, while 30 percent receive both community health center funding and funding to serve one or more special populations, such as people experiencing homelessness. The remaining 5 percent receive funding to serve special populations only.

In 2020 and 2021, Congress appropriated additional funding for health centers to support their ability to respond to the COVID-19 pandemic. Four COVID-19 relief laws enacted in 2020 and 2021 contained funding for the Health Center Program (see table 1).[16] Grant funds were awarded to health centers based on formulas that considered the size of each center's patient population.[17] Broadly, these one-time awards were intended to help health centers to maintain or expand their capacity to serve patients and to provide COVID-19-related services, such as vaccines, testing, and treatment.

Table 1: COVID-19 Relief Laws that Appropriated Funding for the Health Resources and Services Administration's (HRSA) Health Center Program, 2020-2021

Legislation	Date enacted	Amount appropriated, in millions of dollars	Amount awarded per health center
Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020[a]	March 6, 2020	$100	$50,464, plus: $0.50 per patient reported in the 2018 Uniform Data System, plus: $2.50 per uninsured patient reported in the 2018 Uniform Data System.
CARES Act[b]	March 27, 2020	1,320	$503,000, plus: $15.00 per patient reported in the 2018 Uniform Data System, plus: $30.00 per uninsured patient reported in the 2018 Uniform Data System.
Paycheck Protection Program and Health Care Enhancement Act[c]	April 24, 2020	600	$98,329, plus: $15.00 per patient reported in the 2019 Uniform Data System.
American Rescue Plan Act of 2021[d]	March 11, 2021	7,600	$500,000, plus: $125.00 per patient reported in the 2019 Uniform Data System, plus: $250.00 per uninsured patient reported in the 2019 Uniform Data System.

Source: GAO analysis of legislation and HRSA guidance. | GAO-24-106815

Note: The Uniform Data System is a standardized reporting system that health centers use to annually report data to HRSA on, among other things, patients, visits, staffing, and revenue.

[a]Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020, Pub. L. No. 116-123, div. A, tit. III, 134 Stat, 146, 149.

[16]Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020, Pub. L. No. 116-123, div. A, tit. III, 134 Stat. 146, 149; CARES Act, Pub. L. No. 116-136, § 3211, 134 Stat. 281, 368 (2020); Paycheck Protection Program and Health Care Enhancement Act, Pub. L. No. 116-139, div. B, tit. I, 134 Stat. 620, 626 (2020); American Rescue Plan Act of 2021, Pub. L. No. 117-2, § 2601, 135 Stat. 4, 43.

[17]In this report, we refer to these grants as COVID-19-related Section 330 grants.

[b]CARES Act, Pub. L. No. 116-136, § 3211, 134 Stat. 281, 368 (2020).

[c]Paycheck Protection Program and Health Care Enhancement Act, Pub. L. No. 116-139, div. B, tit. I, 134 Stat. 620, 626 (2020). Amount awarded per health center reflects the formula used to distribute the majority of the funding. In addition to the amount specifically appropriated for health centers, HRSA allocated $350 million for a health center grant that supported COVID-19 vaccination efforts.

[d]American Rescue Plan Act of 2021, Pub. L. No. 117-2, § 2601, 135 Stat. 4, 43. Amount awarded per health center reflects the formula used to distribute the majority of the funding. In addition to the amount specifically appropriated for health centers, HRSA allocated $81.1 million for a health center grant that supported COVID-19 vaccination, testing, and treatment efforts.

Health Center Requirements and Compliance

Health centers are required to provide a comprehensive range of services, including enabling services, which are nonclinical services that aim to increase patients' access to care. Health centers may also choose to provide additional services that are not required primary health services but are appropriate to meet the health needs of the service population, such as behavioral health services (see table 2).[18] All services that health centers provide must be available to all residents of the service area, either directly or under a referral arrangement, regardless of patient payment source or ability to pay. Health care services are provided by clinical staff—including physicians, nurses, dentists, and mental health and substance use professionals—or through contracts or cooperative arrangements with other providers.

Table 2: Selected Primary Health and Additional Services Provided at Health Centers

Category	Examples of services provided
Primary health services	Primary health services include basic health services including those related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology.
Preventive health services	Required preventive services include: • Well-child care • Prenatal and perinatal care • Immunizations • Voluntary family planning • Preventive dental care
Case management services	Required case management services include referral services and assistance with establishing eligibility for, or accessing, programs that provide or pay for medical, social, and other services.

[18]Behavioral health services address mental health conditions and substance use disorders and may include psychosocial therapies, such as counseling, and medical services, such as the prescribing of medications.

Category	Examples of services provided
Emergency medical services	Required services that are provided through defined arrangements with outside providers for medical emergencies during and after centers' regularly scheduled hours.
Enabling services	Required services include, but are not limited to: • Translation services • Health education • Transportation for individuals residing in a center's service area who have difficulty accessing the center
Additional services	Additional services that are not required primary health services but are appropriate to meet the health needs of the service population, such as behavioral health and environmental health services.[a] Health centers are not required to provide these services.

Source: Public Health Services Act. | GAO-24-106815

[a]Behavioral health services address mental health conditions and substance use disorders and may include psychosocial therapies, such as counseling, and medical services, such as the prescribing of medications. Environmental health services can include the detection and alleviation of unhealthful conditions associated with water supply and lead exposure, among other things.

To continue receiving Health Center Program funds, health center grantees must comply with requirements found in the Health Center Program's authorizing legislation and implementing regulations, as well as certain applicable uniform grant regulations.[19] HRSA outlines these requirements in its Health Center Program Compliance Manual.[20] According to HRSA, the Compliance Manual provides a consolidated resource to assist health centers in understanding and demonstrating compliance with Health Center Program requirements.

Among these requirements are two that specifically relate to health centers providing accessible services to their patients:

- **Accessible locations and hours**. Required primary health services must be available and accessible in the service area of the health center promptly, as appropriate, and in a manner that ensures continuity of service to the residents of the health center's service area.
- **Coverage of medical emergencies during and after hours**. Health centers must be able to respond to medical emergencies during

[19]42 U.S.C. § 254b; 42 C.F.R. Parts 51c, 56; 45 C.F.R. Part 75.

[20]For information on the Health Center Program Compliance Manual see https://bphc.hrsa.gov/programrequirements/compliancemanual/index.html, accessed October 11, 2023.

regularly scheduled hours, and have clearly defined arrangements for promptly responding to patient medical emergencies after the health center's regularly scheduled hours.

A key tool that HRSA uses to assess health centers' compliance with these requirements is an operational site visit. HRSA's policy is generally to conduct an operational site visit for each health center at least once every 3 years.[21] HRSA uses its Health Center Program Site Visit Protocol, which is based on the Compliance Manual, to assess compliance with Health Center Program requirements during these operational site visits.

According to HRSA's Site Visit Protocol, requirements have several subelements that HRSA individually assesses during an operational site visit. For example, to assess compliance with the accessible locations and hours requirement, HRSA checks whether health centers have both accessible sites and accessible hours of operation. HRSA reviews key health center documents, such as needs assessments or related studies, and interviews health center management to learn how the health center considers patient access when selecting site locations and determining operating hours. For the medical emergencies after-hours coverage requirement, HRSA assesses whether a health center has procedures for after-hours coverage, and documentation of after-hours' calls and follow-up to ensure continuity of care. HRSA reviews key documents, such as health centers' after-hours coverage procedures, written agreements with non-health center providers, and samples of after-hours clinical advice documentation in patient records. HRSA also interviews health center management on how they address barriers that patients may face in accessing after-hours coverage.

HRSA documents its findings in a site visit report that it provides to each health center under review. In circumstances where HRSA determines that a health center has failed to demonstrate compliance with one or more Health Center Program requirements, HRSA will place one or more conditions on the health center's award. Program conditions on a health center's award describe the nature of the finding, the reason why the condition was issued, and the actions needed to remove the condition, among other things. The health center must then take corrective actions

[21]HRSA conducts operational site visits for each health center once during a grant's project period, and according to HRSA officials, health centers typically operate under three-year project periods.

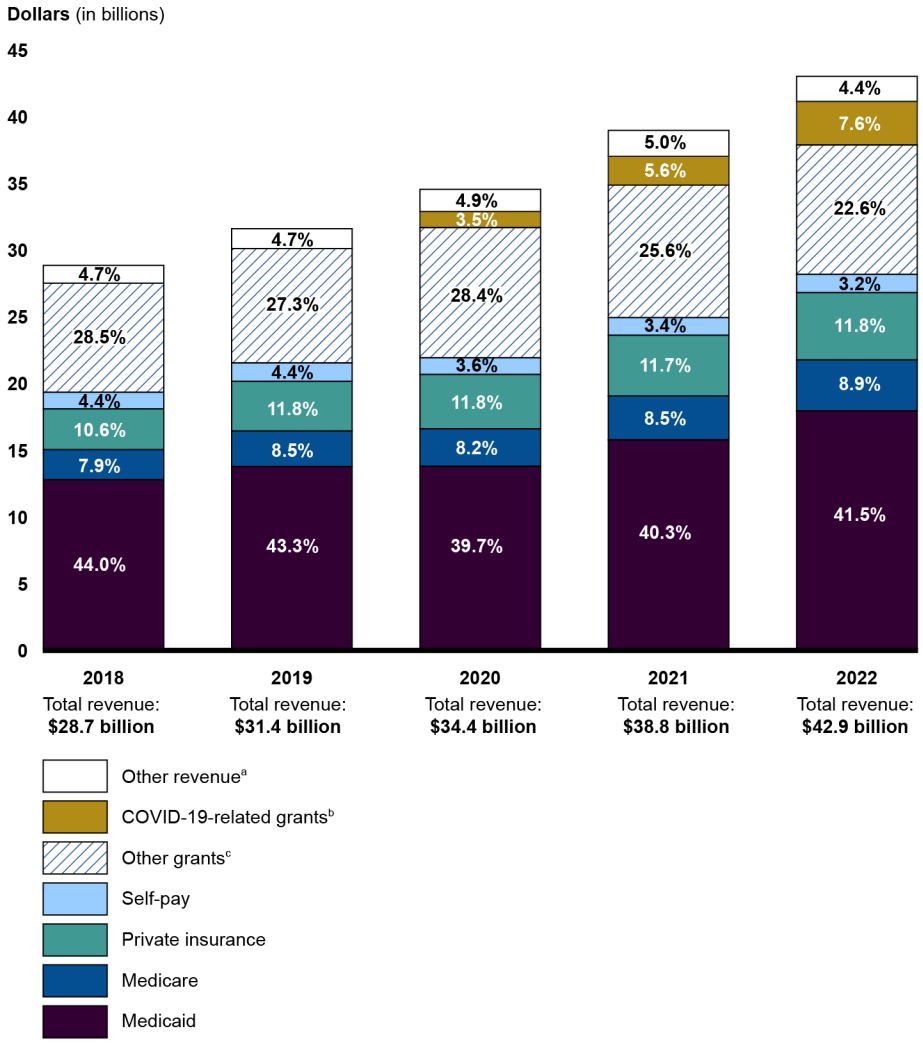
that demonstrate compliance for HRSA to remove the condition on the award.

Health Center Revenue Increased to Almost $43 Billion in 2022; Medicaid Was Largest Revenue Source Each Year

Our analysis shows that total revenue received by health centers nationwide increased from about $28.7 billion in 2018 to $42.9 billion in 2022—an increase of more than $14 billion.[22] The largest single source of revenue reported by health centers each year was Medicaid, accounting for more than one-third of total revenue each year (see fig. 2). The share of revenue received from Medicare and private insurance increased from 2018 to 2022, while the share of total revenue received directly from patients—or self-pay—decreased during the same period.

[22]When adjusted for inflation, revenue growth is lower. The increase is about $11.3 billion in 2022 dollars using the Personal Consumption Expenditures Health Price Index as a deflator.

Figure 2: Health Center Revenue Sources, 2018-2022



Source: GAO analysis of Health Resources and Services Administration and Department of Health and Human Services data. | GAO-24-106815

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

[a]Other revenue includes two categories from the Health Resources and Services Administration's (HRSA) Uniform Data System: (1) other public insurance, and (2) non-patient-related revenue not reported elsewhere, such as revenue from fundraising, rent from tenants, medical record fees, and vending machines.

[b]COVID-19-related grants include revenue from all Section 330 grants funded by the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020; the CARES Act; the Paycheck Protection Program and Health Care Enhancement Act; and the American Rescue Plan Act of 2021. Pub. L. No. 116-123, div. A, tit. III, 134 Stat, 146, 149; Pub. L. No. 116-136, § 3211, 134 Stat. 281, 368 (2020); Pub. L. No. 116-139, div. B, tit. I, 134 Stat. 620, 626 (2020); Pub. L. No. 117-2, § 2601, 135 Stat. 4, 43. COVID-19 revenue is not applicable in 2018 and 2019, before the onset of the COVID-19 pandemic in the United States.

[c]Other grants include both federal and non-federal grants. Specifically, this category includes Section 330 grants funded by non-COVID-19-related appropriations. It also includes other federal grants, such as grants from the Substance Abuse and Mental Health Services Administration and payments from the Provider Relief Fund to eligible providers who have health-care related expenses and lost revenues attributable to COVID-19; and non-federal grants and contracts, such as those from state governments, state/local indigent care programs, local governments, and foundations or other private sources.

While the total revenue received by health centers increased by more than $14 billion from 2018 through 2022, the share of revenue received from grants—specifically, non-COVID-19-related Section 330 grants and other federal and non-federal grants—decreased, from 28.5 percent of total revenue in 2018 to about 22.6 percent in 2022. However, one subcategory of those grants—specifically HRSA's non-COVID-19-related Section 330 grants—remained the second largest revenue source each year. See appendix II for more information on health centers' revenue from 2018 through 2022.

The percentage of health centers' revenue related to COVID-19 funding increased each year from 2020 to 2022, according to data provided by HRSA. In 2020, COVID-19 grant revenue accounted for 3.5 percent of all revenue (about $1.2 billion), which increased to 5.6 percent in 2021 (about $2.2 billion) and 7.6 percent in 2022 (about $3.3 billion) (see table 3). In 2020, the largest share of COVID-19 grant revenue came from the CARES Act, which totaled about $841 million in revenue for health centers that year. Revenue from the American Rescue Plan Act of 2021 surpassed revenue from the CARES Act in 2021 and 2022, totaling about $1.5 billion and $3.2 billion respectively.

Table 3: COVID-19-Related Revenue for Health Centers, 2020-2022

	2020		2021		2022	
Source	**Millions of dollars**	**Percent of total 2020 revenue**	**Millions of dollars**	**Percent of total 2021 revenue**	**Millions of dollars**	**Percent of total 2022 revenue**
Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020	$89.1	0.3%	$10.0	0.0%[a]	$0.3	0.0%[a]
CARES Act	840.9	2.4	423.0	1.1	39.2	0.1
Paycheck Protection Program and Health Care Enhancement Act	262.7	0.8	271.3	0.7	35.1	0.1
American Rescue Plan Act of 2021	—	—	1,453.7	3.7	3,176.5	7.4
Total COVID-19 revenue	**1,192.7**	**3.5**	**2,158.0**	**5.6**	**3,251.0**	**7.6**

Legend: — = not applicable

Source: GAO analysis of Health Resources and Services Administration data and Department of Health and Human Services data. | GAO-24-106815

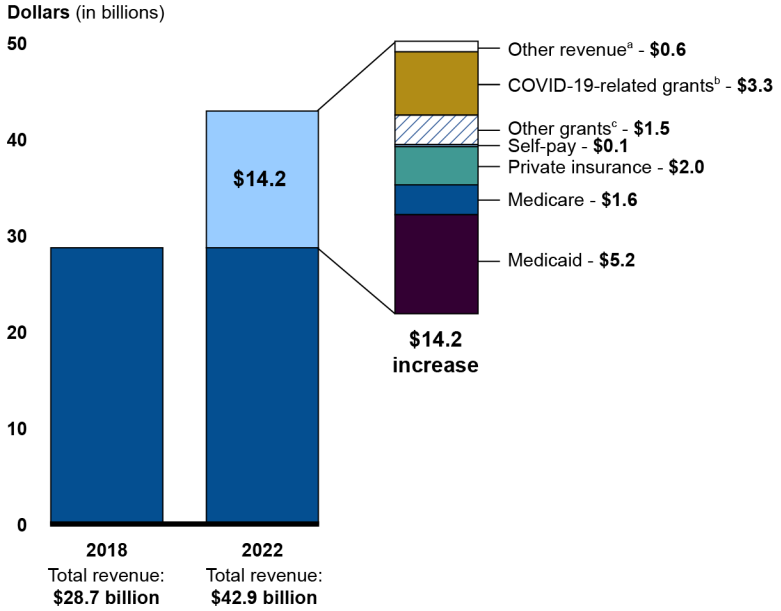
Notes: Total revenue for health centers, including COVID-19 revenue, was about $34.4 billion in 2020, $38.8 billion in 2021, and $42.9 billion in 2022. Dollars are nominal. Percentages may not sum to column total due to rounding.

COVID-19-related revenue includes revenue from all Section 330 grants funded by the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020; the CARES Act; the Paycheck Protection Program and Health Care Enhancement Act; and the American Rescue Plan Act of 2021. Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020, Pub. L. No. 116-123, div. A, tit. III, 134 Stat, 146, 149; CARES Act, Pub. L. No. 116-136, § 3211, 134 Stat. 281, 368 (2020); Paycheck Protection Program and Health Care Enhancement Act, Pub. L. No. 116-139, div. B, tit. I, 134 Stat. 620, 626 (2020); American Rescue Plan Act of 2021, Pub. L. No. 117-2, § 2601, 135 Stat. 4, 43. It does not include payments made from the Provider Relief Fund to eligible providers who diagnose, test, or care for individuals with possible or actual cases of COVID-19 and have health-care-related expenses and lost revenues attributable to COVID-19.

[a]Value rounded to zero because it is less than 0.05 percent.

Of the approximately $14 billion increase from 2018 to 2022 in total annual revenue received by health centers, Medicaid represented the largest individual source of additional revenue, increasing by $5.2 billion over this period (see fig. 3). COVID-19-related grant revenue accounted for the second largest source of additional revenue from 2018 to 2022, increasing by $3.3 billion. Other revenue categories such as self-pay, non-COVID-19-related Section 330 grants, and other federal grants each increased by under $500 million between 2018 and 2022.

Figure 3: Sources of $14 Billion Revenue Increase for Health Centers from 2018 to 2022



Source: GAO analysis of Health Resources and Services Administration and Department of Health and Human Services data. | GAO-24-106815

Note: Dollars are nominal.

[a]Other revenue includes two categories from the Health Resources and Services Administration's (HRSA) Uniform Data System: (1) other public insurance, and (2) non-patient-related revenue not reported elsewhere, such as revenue from fundraising, rent from tenants, medical record fees, and vending machines.

[b]COVID-19-related grants include revenue from all Section 330 grants funded by the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020; the CARES Act; the Paycheck Protection Program and Health Care Enhancement Act; and the American Rescue Plan Act of 2021. Pub. L. No. 116-123, div. A, tit. III, 134 Stat, 146, 149; Pub. L. No. 116-136, § 3211, 134 Stat. 281, 368 (2020); Pub. L. No. 116-139, div. B, tit. I, 134 Stat. 620, 626 (2020); Pub. L. No. 117-2, § 2601, 135 Stat. 4, 43. COVID-19 revenue is not applicable in 2018 and 2019, before the onset of the COVID-19 pandemic in the United States.

[c]Other grants include both federal and non-federal grants. Specifically, this category includes Section 330 grants funded by non-COVID-19-related appropriations. It also includes other federal grants, such as grants from the Substance Abuse and Mental Health Services Administration and payments from the Provider Relief Fund to eligible providers who have health-care related expenses and lost revenues attributable to COVID-19; and non-federal grants and contracts, such as those from state governments, state/local indigent care programs, local governments, and foundations or other private sources.

The increase in Medicaid revenue noted above may be due in part to a greater percentage of health center patients insured through Medicaid, which reached 49.9 percent of patients in 2022 (see app. I). According to an organization representing health centers, the increase in patients insured through Medicaid may have resulted in part from a requirement to keep Medicaid beneficiaries continuously enrolled in the program during the COVID-19 public health emergency.[23]

HRSA Awarded Grant Funding Primarily to Support Existing Health Centers and Respond to COVID-19

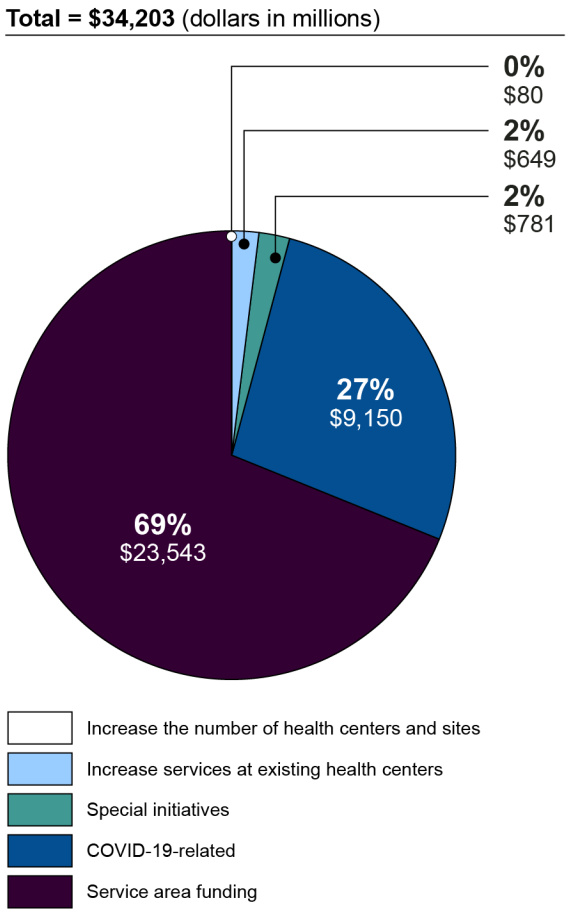
Our analysis of HRSA data shows that from fiscal year 2018 through 2022, HRSA awarded about $34 billion in total grant funding to health centers through 21 Section 330 grants; each of these grants provided

[23]States were allowed to resume coverage terminations (or disenrollments) on April 1, 2023, which may result in a reduction of health center patients with Medicaid coverage. HRSA officials noted that if patients who lose Medicaid coverage become uninsured, it could lead to a loss of revenue for health centers, which are required to treat patients without regard for ability to pay.

funding for multiple health centers.[24] About two-thirds of this funding was awarded for the purpose of service area funding, which supports ongoing operations and services, including existing and recently expanded services, across the nearly 1,400 health centers nationwide. The second largest category of funding was COVID-19-related funding, which assisted health centers in responding to the COVID-19 pandemic. Remaining grant funds were awarded for special initiatives, such as to support cancer screening; to increase the amount of services provided at existing health centers; and to increase the number of health centers and sites (see fig. 4).

[24]Funding for the 21 Section 330 grants came from three sources: HRSA's discretionary funding, the CHCF, and legislation that appropriated funds specifically to respond to the COVID-19 pandemic. Funding reported here is for Section 330 grants HRSA awarded in fiscal years 2018 through 2022 and differs from health center grant revenues described earlier in this report. Specifically, grant revenue data reflect the amounts drawn down by health centers, while grant funding data reported here reflect amounts HRSA awarded to health centers. Also, revenue data are captured on a calendar year basis, while grant funding is based on the federal fiscal year.

Figure 4: Total Health Resources and Services Administration (HRSA) Section 330 Grants by Purpose, Fiscal Years 2018-2022



Source: GAO analysis of HRSA information. | GAO-24-106815

Notes: The $80 million awarded to increase the number of health centers and sites is less than 1 percent of total funding and rounds to 0 percent. Special initiatives are grants that address identified priorities or emerging health care needs, such as cancer screening. Service area funding supports ongoing operations and services, including existing and recently expanded services, at health centers.

Service area funding. From fiscal year 2018 through 2022, HRSA awarded approximately $23.5 billion in grants for service area funding.[25] HRSA officials noted that service area funding includes support for new health centers, sites, and services after HRSA funds an initial grant period

[25]Service area funding grants are awarded through service area competitions and continued through yearly budget period renewals. About three-quarters of service area funding came from the CHCF, with the remainder from HRSA's discretionary funding.

of performance. After that initial performance period, the operational funding for subsequent years is provided to health centers as service area funding. For example, a grant that provided funding to hire health center staff to provide new dental services may be incorporated into health centers' future service area funding, so that health centers can continue to provide those dental services.

COVID-19. From fiscal year 2020 through 2022, HRSA awarded six grants totaling about $9.1 billion in funding to support health centers to prevent, mitigate, and respond to COVID-19. Most of this funding—three grants totaling about $7.5 billion—was general in nature, supporting a wide range of activities at health centers. The largest of these three grants, authorized by the American Rescue Plan Act of 2021, funded health centers to, among other things, administer COVID-19 vaccines; detect and diagnose COVID-19; expand and sustain the health care workforce; and modify and expand health care services and infrastructure. The remaining three grants were awarded for the following purposes:

- **Capital improvements**. One grant provided about $954 million to 1,292 health centers for construction of new facilities, expansion and renovation of existing facilities, and other capital improvements.[26] Officials from one primary care association we spoke with told us health centers used these capital improvement awards for a variety of projects, such as opening a new clinic site, adding a pharmacy, or completing a major renovation. For example, one health center used its award to help fund the construction of a new health center site offering women's health and mammography services in an underserved area (see fig. 5).

[26]HRSA's notice of funding opportunity for this grant encouraged health centers to consider projects that, among other things, facilitate equitable access to COVID-19 vaccination, testing, and treatment, and that address current and anticipated COVID-19 and primary health care needs.

Figure 5: New Health Center Site Partly Funded by an American Rescue Plan Act of 2021 Capital and Construction Grant

Source: Withheld at request of the copyright holder. | GAO-24-106815

- **Health information technology**. One grant provided about $83 million to support health information technology improvements to help health centers better respond to and mitigate the spread of COVID-19. Among other things, this grant was intended to support health centers' efforts to report high-quality, patient-level data to HRSA through the agency's Uniform Data System.[27]
- **Testing**. One grant provided about $583 million in funding to support health centers to purchase, administer, and expand capacity for testing to monitor and suppress COVID-19.

Special initiatives. From fiscal year 2018 through 2022, HRSA awarded $781 million in grants to health centers to support special initiatives and to address identified priorities or emerging health care needs. Specifically, HRSA awarded grants for the following purposes:

- **Cancer screening**. One grant provided about $5 million to support increased access to cancer screening and referral for care and

[27]HRSA is in the process of modernizing its Uniform Data System. This system currently receives aggregated data from health centers, such as the total number of patients that fall into certain age groups. Starting with calendar year 2023 submissions, health centers may also voluntarily submit de-identified patient-level data. HRSA intends to make submitting patient-level data a requirement. As of November 2023, HRSA had not determined a date when this requirement would go into effect. HRSA officials said the agency plans to use the 2023 submissions as a test year to identify any issues with submission and reporting before requiring patient-level reporting.

treatment by enhancing patient education, case management, outreach, and other enabling services.

- **Disaster recovery**. Two grants provided a total of $138 million to health centers affected by certain hurricanes and other natural disasters to support equipment costs and minor alterations and renovations.
- **HIV**. One grant provided about $124 million to increase access to HIV care and prevention services. This grant specifically targeted prevention and treatment services in HIV "hot spots," which are communities most affected by HIV.
- **Quality improvement**. Three grants provided about $493 million to support health centers' quality improvement efforts. Most of this funding—about $348 million—was awarded to health centers that displayed high-quality performance or that made significant quality improvements so they could continue to improve the quality, efficiency, and effectiveness of health care delivered to the communities served. The remainder of the funding was awarded to support specific quality improvement initiatives for controlling hypertension and for optimizing the use of virtual care, such as telehealth.
- **Participation in research**. One grant provided $21 million to support health center participation in the National Institutes of Health's All of Us Research Program. This program aims to enroll 1 million individuals from diverse backgrounds, including those historically underrepresented in biomedical research.

Increasing services at existing health centers. In fiscal years 2018 and 2019, HRSA awarded a total of $649 million in initial year grants to help increase the amount of services offered at existing health centers. Specifically, these grants were awarded for the following purposes:

- **Behavioral health services**. Three grants provided a total of $564 million for health centers to expand access to behavioral health services, which address mental health and substance use disorders.

These awards focused on expanding access to integrated behavioral health services and enhancing the behavioral health workforce.[28]

- **Oral health**. An $85 million grant was awarded to support oral health infrastructure enhancements, such as purchasing dental chairs, so that health centers could provide new, or enhance existing, oral health services.

Increasing the number of health centers and sites. In fiscal years 2019, 2021, and 2022, HRSA awarded a total of $80 million to organizations to help establish new health centers or new sites at existing health centers. Specifically, HRSA awarded grants for the following purposes:

- **New Access Points awards**. Most of the funding to increase access to health centers—about $50 million of the $80 million—was provided through New Access Points awards. These funds may be used either to allow a new organization to become a health center or an existing health center to add one or more service sites. In fiscal year 2019, HRSA provided 77 such awards—29 awards were made to organizations to become new health centers and 48 were made to existing health centers to add one or more service sites, according to HRSA officials.
- **School-Based Service Sites awards**. In fiscal years 2021 and 2022, HRSA funded 152 School-Based Service Sites awards—27 in 2021 and 125 in 2022—for a total of about $30 million. Funds were for health centers to add new service delivery sites at schools (preschool through high school), or to expand services at existing health center sites located in schools. HRSA officials said that, across fiscal years 2021 and 2022, health centers that received this funding proposed a total of 195 new school-based service sites.

See appendix III for a complete list of HRSA grants that provided funding to health centers from fiscal year 2018 through 2022, by category.

[28]HRSA defines integrated behavioral health care as collaborative health care that results when a team of primary care and behavioral health clinicians work together with patients, families, and community organizations to provide patient-centered care. According to HRSA, integrating mental health, substance use disorder, and primary care services can improve the prevention, detection, and treatment of behavioral health conditions, as well as the management of co-occurring physical conditions.

Health Centers Can Offer Extended Hours and Use Clinicians for Triage to Meet Certain Access-to-Care Requirements

According to officials from the five primary care associations we interviewed, health centers in their states used various methods to meet requirements to provide care at accessible locations and hours, and to provide coverage for medical emergencies after regularly scheduled hours.[29] To meet the accessible locations and hours requirement, health centers conduct needs assessments, survey patients, and obtain other patient feedback, according to officials from all five primary care associations. Health centers use this information to determine whether there are patient barriers, such as transportation barriers, that may prevent patients from accessing sites, or other challenges in accessing appointments during scheduled hours.

Primary care association officials said that in some cases, patients may have difficulty accessing an appointment during existing hours due to work schedules, so health centers may extend hours either in the morning, evening, or on weekends to accommodate them. For example, officials from one primary care association said that coal mining is a significant industry in their state, so health centers may offer evening and weekend hours to enhance access to care. Officials from another primary care association said that health centers with patients who are teachers may offer early morning hours to provide accessible appointment hours before school begins. Officials from each of the five primary care associations we interviewed said that most, if not all, health centers in their states have at least one site that routinely offers extended hours.

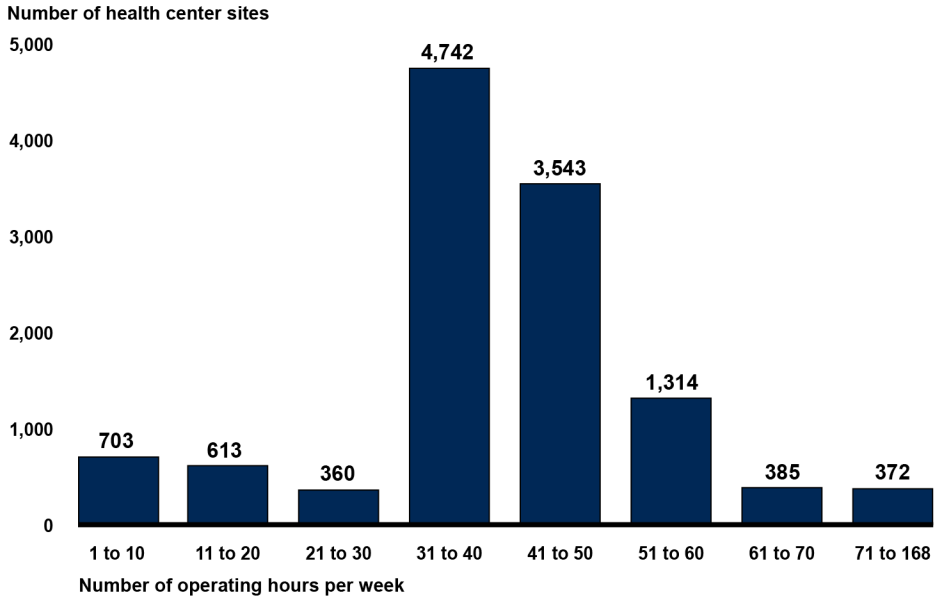
Officials from all five primary care associations said they do not collect information on the operating hours of health centers in their states, and HRSA does not require health centers to report the hours a site is open each day. However, HRSA requires health centers to report the total weekly hours each health center site is open. Based on our review of data for over 12,000 sites for which health centers reported operating hours information to HRSA in 2022, we found most health center sites—a total of 8,285—were open from 31 to 50 hours each week (see fig. 6).[30] Health centers reported that a smaller number of sites were open 71 hours or more each week, including 113 that reported being open 168 hours—

[29]HRSA does not define regularly scheduled hours. However, according to the National Committee for Quality Assurance, regular operating hours for health care providers are 8:00 a.m. to 5:00 p.m., Monday through Friday. The National Committee for Quality Assurance is a nonprofit organization that develops health care quality measures, and under a contract with HRSA, provides technical assistance to health centers.

[30]We limited our analysis to permanent health center sites, excluding about 2,800 sites that health centers reported were mobile van or seasonal sites.

which represents a schedule of 24 hours, 7 days per week. On average, health centers reported their sites being open 42 hours each week, with a median of 40 hours each week. HRSA officials said health center sites that have fewer daily operating hours include school-based service sites, sites at homeless shelters, or sites that serve agricultural workers.

Figure 6: Number of Health Center Sites by Total Operating Hours Per Week as of December 31, 2022



Source: GAO analysis of Health Resources and Services Administration data. | GAO-24-106815

Note: Our analysis included about 12,000 permanent health center sites and excluded about 2,800 sites that health centers reported were mobile van or seasonal sites.

Despite health centers offering extended hours at some sites, officials from all five primary care associations told us that health centers in their states have experienced staffing challenges that make it difficult to add operating hours. Officials said that shortages in clinical staff have become more widespread since the onset of the COVID-19 pandemic, as more experienced staff have retired or resigned. For example, officials from one primary care association said that newer staff tend to be younger and are less willing to work evenings or on weekends than the more experienced staff that left the workforce.

Regarding the requirement to provide coverage for after-hours medical emergencies, officials from each of the primary care associations said that health centers in their states have arrangements to ensure patients

with after-hours medical emergencies are evaluated by a clinical professional and referred to emergency care or local urgent care if needed. Officials described three general patient-triage models health centers may use to provide coverage for after-hours medical emergencies:

- **In-house clinical**. Health center clinical staff, such as a nurse, answer after-hours calls during which they triage patient symptoms and advise patients on follow-up care.
- **Contracted non-clinical**. Health centers contract with a call center with non-clinical staff who connect the patient with a clinician, such as a nurse, who can triage their symptoms.
- **Contracted clinical**. Health centers have an arrangement with a contractor, who employs clinical staff, such as a nurse, who answer calls. The clinician then triages the patient's symptoms and recommends follow-up care as needed.

Regardless of the triage model, primary care association officials said that if the patient reports an obvious emergency, the person answering the call will direct the patient to call 911 or go to the nearest emergency room. Officials said if the clinician determines the patient's symptoms do not represent a medical emergency, he or she will provide the patient with advice on needed care, including asking the patient to contact the health center to arrange for an appointment during regularly scheduled hours.

Based on our analysis of HRSA's operational site visit findings, we found that HRSA determined most health centers—over 93 percent of the 1,391 health centers that had a site visit from 2018 through 2022—complied with the requirements to provide care (1) within accessible locations and hours and (2) for medical emergencies after regularly scheduled hours. HRSA determined a total of 15 health centers did not fully comply with the requirement to provide services through accessible locations and hours, and 86 heath centers did not fully comply with the requirement to provide coverage for medical emergencies after hours (see table 4).[31]

[31]Five health centers did not comply with both requirements, so the total number of health centers that did not comply with one or more of the requirements was 96.

Table 4: Health Center Noncompliance with Certain Access-to-Care Requirements and Examples of Corrective Actions Taken, Calendar Years 2018-2022

Requirement	Number not in compliance	Key reasons for noncompliance	Examples of corrective actions taken
Provide care within accessible locations and hours[a]			
Accessible locations	5	• Did not consider the needs of patients, including patients experiencing homelessness, when determining locations • Reported inaccurate site information	Conducted patient surveys and needs assessments to document decisions on site locations
Accessible hours	13	• Did not consider patient needs when setting clinic hours • Reported inaccurate hours information	Conducted patient surveys to document decisions on hours; some health centers decided to add clinic hours by offering extended or weekend hours
Provide coverage for medical emergencies after hours[a]			
Procedures or arrangement for after-hours coverage	70	• Did not provide access to after-hours coverage for patients with limited English proficiency • Did not have clinical staff available who could effectively assess a patient's symptoms • Lacked documented policies or other arrangements to provide coverage	Updated after-hours coverage policies and procedures and implemented arrangements to triage patients, including those with limited English proficiency
After-hours call documentation	27	• Did not document after-hours calls or follow-up with patients to provide the proper continuity of care • Did not have a working after-hours phone number	Provided call logs that documented after-hours calls and follow-up, established after-hours phone number

Source: GAO analysis of Health Resources and Service Administration information. | GAO-24-106815

Notes: Information is based on findings from operational site visits conducted by the Health Resources and Services Administration during calendar years 2018 through 2022 for the 96 health centers found to be noncompliant with at least one of the specified requirements.

[a]Some health centers were not in compliance with both elements of this requirement.

According to HRSA officials, all the health centers cited for noncompliance provided the agency with sufficient documentation to support corrective actions they took to address the findings. Some examples we found included:

- One health center provided HRSA with documentation showing the center had assessed its clinics' locations and operating hours based on the center's patient population and access to public transportation, and indicated the health center had added Saturday hours for patients who work during the week.

- Three health centers provided HRSA with their contracts with a nurse triage service. The contracts specified that when patients call a phone line, a nurse will triage the patient symptoms using an agreed upon set of protocols and recommend appropriate care. The triage nurse will document all calls and responses, which will be provided to the health center. The contracts also provided for language translation services for those patients with limited English proficiency.
- Two health centers provided HRSA with copies of call logs they used to document after-hours phone calls from patients, including information on the results of the call and recommendations for follow-up care.

Agency Comments

We provided a copy of this draft report to the Department of Health and Human Services for review and comment. The Department provided technical comments, which we incorporated as appropriate.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days after its issuance date. At that time, we will send copies of this report to the appropriate congressional committees, the Secretary of Health and Human Services, and other interested parties. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov.

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

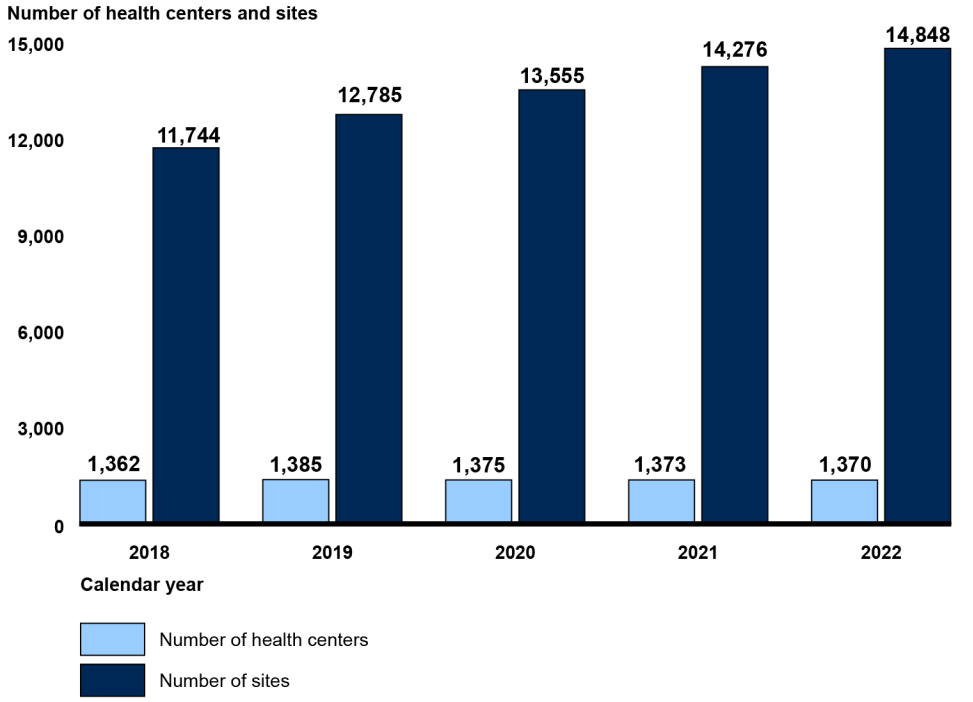
Michelle B. Rosenberg
Director, Health Care

Appendix I: Information on Health Centers and Patients Served

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

- figure 7 illustrates the number of health centers and sites from 2018 through 2022;
- figure 8 illustrates the number of patients served at health centers from 2018 through 2022;
- table 5 provides information on payer mix for patients served at health centers from 2018 through 2022; and
- table 6 provides demographic information on patients served at health centers from 2018 through 2022.

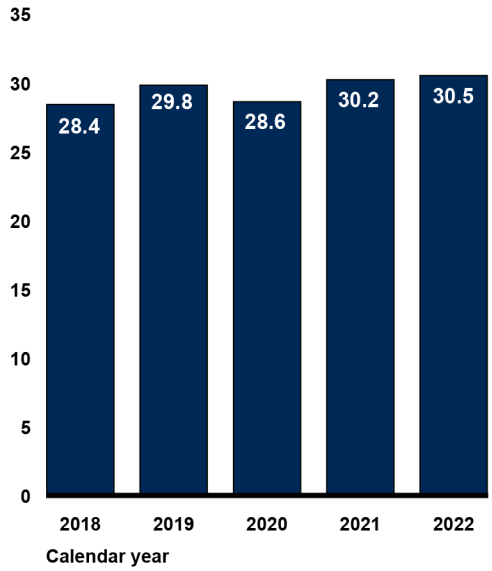
Figure 7: Number of Health Centers and Sites, 2018-2022



Source: GAO analysis of Health Resources and Services Administration and National Association of Community Health Centers data. | GAO-24-106815

Note: Most health centers operate facilities at several locations—referred to as sites.

Figure 8: Number of Patients Served at Health Centers, 2018-2022



Source: GAO analysis of Health Resources and Services Administration data. | GAO-24-106815

Table 5: Percentage of Health Center Patients by Insurance Status, 2018-2022

Year	Percentage covered by Medicaid	Percentage covered by Medicare	Percentage covered by other public insurance[a]	Percentage covered by private insurance	Percentage uninsured
2018	48.4	9.7	1.0	18.4	22.6
2019	47.6	9.8	0.9	18.9	22.7
2020	46.3	10.4	0.9	20.6	21.8
2021	47.9	10.6	0.8	20.3	20.3
2022	49.9	10.9	0.7	19.9	18.6

Source: GAO analysis of Health Resources and Services Administration (HRSA) Uniform Data System data. | GAO-24-106815

Note: Row totals may not equal 100 due to rounding.

[a]HRSA's Uniform Data System defines other public insurance as state and/or local government programs that provide a broad set of benefits for eligible individuals.

Table 6: Demographic Information on Patients Served at Health Centers, 2018-2022

Characteristic	2018	2019	2020	2021	2022
Patient age					
Under 18 years	30.8	30.9	27.5	28.6	28.9
18-64 years	60.1	59.6	62.2	60.5	59.4
65 years or older	9.2	9.6	10.3	10.9	11.7
Patient sex					
Male	42.4	42.5	42.5	42.7	42.5
Female	57.7	57.5	57.5	57.3	57.5

Source: GAO analysis of Health Resources and Services Administration Uniform Data System data. | GAO-24-106815

Notes: Row totals may not equal 100 due to rounding. Patient sex refers to whether patients were assigned male or female at birth and may not reflect patients' gender identity.

Appendix II: Sources and Amounts of Revenue for Health Centers, 2018-2022

Table 7: Health Resources and Services Administration (HRSA) Funded Health Center Revenue Sources, 2018-2022

	2018		2019		2020		2021		2022	
Source	**Billions of dollars**	**Percent of total 2018 revenue**	**Billions of dollars**	**Percent of total 2019 revenue**	**Billions of dollars**	**Percent of total 2020 revenue**	**Billions of dollars**	**Percent of total 2021 revenue**	**Billions of dollars**	**Percent of total 2022 revenue**
Medicaid	$12.6	44.0%	$13.6	43.3%	$13.6	39.7%	$15.6	40.3%	$17.8	41.5%
Medicare	2.3	7.9	2.7	8.5	2.8	8.2	3.3	8.5	3.8	8.9
Other public insurance[a]	0.3	1.2	0.4	1.2	0.4	1.2	0.6	1.5	0.4	0.9
Private insurance	3.0	10.6	3.7	11.8	4.1	11.8	4.6	11.7	5.0	11.8
Self-pay	1.2	4.4	1.4	4.4	1.2	3.6	1.3	3.4	1.4	3.2
Non-COVID-19-related Section 330 grants	4.8	16.8	5.0	15.9	4.8	13.9	5.2	13.5	5.1	12.0
COVID-19-related grants[b]	—	—	—	—	1.2	3.5	2.2	5.6	3.3	7.6
Other federal grants[c]	0.5	1.6	0.5	1.5	1.4	4.1	1.2	3.0	0.9	2.1
Non-federal grants or contracts[d]	2.9	10.1	3.1	9.8	3.6	10.4	3.5	9.1	3.7	8.6
Other revenue[e]	1.0	3.5	1.1	3.6	1.2	3.6	1.4	3.6	1.5	3.5
Total revenue	**$28.7**	**100.0%**	**$31.4**	**100.0%**	**$34.4**	**100.0%**	**$38.8**	**100.0%**	**$42.9**	**100.0%**

Legend: — = not applicable

Source: GAO analysis of HRSA and Department of Health and Human Services data. | GAO-24-106815

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

[a]HRSA defines other public insurance as state and/or local government programs that provide a broad set of benefits for eligible individuals.

[b]COVID-19-related grants include revenue from all Section 330 grants funded by the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020; the CARES Act; the Paycheck Protection Program and Health Care Enhancement Act; and the American Rescue Plan Act of 2021. Pub. L. No. 116-123, div. A, tit. III, 134 Stat, 146, 149; Pub. L. No. 116-136, § 3211, 134 Stat. 281, 368 (2020); Pub. L. No. 116-139, div. B, tit. I, 134 Stat. 620, 626 (2020); Pub. L. No. 117-2, § 2601, 135 Stat. 4, 43. This revenue source is not applicable in 2018 and 2019, before the onset of the COVID-19 pandemic in the United States.

[c]Other federal grants in HRSA's Uniform Data System include any other federal grants received directly by the health center. These include Ryan White HIV/AIDS Program Part C Early Intervention Services grants, Medicare and Medicaid Electronic Health Record Incentive grants (now known as "Promoting Interoperability programs"), and other grants from the Office of Minority Health, the Indian Health Service, the Department of Housing and Urban Development, and the Substance Abuse and Mental Health Services Administration. This category also includes payments from the Provider Relief Fund, which were made to eligible providers who have health care-related expenses and lost revenues attributable to COVID-19.

[d]HRSA defines non-federal grants or contracts as grants and contracts from state governments, state/local indigent care programs, local governments, and foundations or other private sources.

[e]HRSA defines other revenue as non-patient-related revenue not reported elsewhere. Examples include revenue from fundraising, rent from tenants, medical record fees, and vending machines.

Appendix III: Health Resources and Services Administration Grant Awards for Health Centers, Fiscal Years 2018-2022

This appendix provides information on the amounts and purposes of the 21 Section 330 grants—15 non-COVID-19-related and six COVID-19-related-—the Health Resources and Services Administration (HRSA) awarded to health centers from fiscal year 2018 through 2022.[1] Table 8 provides this information for the 15 non-COVID-19-related grants, which were funded by HRSA's discretionary funding, by mandatory appropriations from HRSA's Community Health Center Fund (CHCF), or both. These grants provided about $25 billion in funding, of which about 76 percent came from the CHCF. HRSA identified six of the 15 grants as providing ongoing funding for health centers. According to HRSA officials, health centers that received ongoing funding would generally receive increases in their future service area funding commensurate with their grant award amount after the grant's initial period of performance had ended.[2] HRSA officials said these increases in service area funding were intended to help cover the costs of maintaining the services provided under the grant.

Table 8: Information on Health Resources and Services Administration (HRSA) Non-COVID-19 Grants Awarded to Health Centers, Fiscal Years 2018-2022

			Amount awarded in millions of dollars				
Grant name	**Funding source**	**Purpose of funding**	**2018**	**2019**	**2020**	**2021**	**2022**
Service area funding							
Service area funding	HRSA discretionary funding and Community Health Center Fund (CHCF)	Ensure continued access to primary health care services for communities currently served by the Health Center Program	$4,403	$4,606	$4,775	$4,808	$4,951
Special initiatives							
Cancer							
Accelerating Cancer Screening	HRSA discretionary funding	Increase access to cancer screening and referral for care and treatment by enhancing patient education, case management, outreach, and other enabling services.	—	—	—	—	5[a]
Disaster recovery							

[1]When discussing the purposes of HRSA grant funding for health centers in this report, we use the term "grant" to refer to a funding opportunity for which funds have been awarded. Each of the 21 grants provided funding for multiple health centers.

[2]HRSA officials noted that continuation of funding is subject to the availability of appropriations and satisfactory progress by grantees.

Grant name	Funding source	Purpose of funding	Amount awarded in millions of dollars				
			2018	2019	2020	2021	2022
Capital Assistance for Hurricane Response and Recovery Efforts	CHCF	Support for minor alteration/renovation and equipment costs to assist health centers affected by Hurricanes Harvey, Irma, and Maria with disaster response and recovery activities	59	—	—	—	—
Capital Assistance for Disaster Response and Recovery Efforts	CHCF	Assist health centers affected by certain natural disasters in 2018 or 2019 with disaster response and recovery efforts	—	—	79	—	—
HIV							
Ending the HIV Epidemic-Primary Care HIV Prevention	HRSA discretionary funding and CHCF[b]	Expand HIV prevention services that decrease the risk of HIV transmission in geographic locations identified as HIV hot spots, focusing on supporting access to pre-exposure prophylaxis medications	—	—	54[a]	49[a]	21[a]
Quality improvement							
Quality Improvement	CHCF	Support health centers that displayed high levels of quality performance or that made significant quality improvements	125	106	117	—	—
National Hypertension Control	CHCF	Support the implementation of evidence-based practices to increase the number of adult patients with controlled hypertension.	—	—	—	90	—
Optimizing Virtual Care	CHCF	Support the development, implementation, and evaluation of evidence-based strategies to optimize the use of virtual care.	—	—	—	—	55
Participation in research							
Advancing Precision Medicine	CHCF	Support health center participation in the National Institutes of Health's All of Us Research Program, which aims to enroll 1 million individuals from diverse backgrounds, including those historically underrepresented in biomedical research.	21	—	—	—	—
Increase services at existing health centers							

Grant name	Funding source	Purpose of funding	Amount awarded in millions of dollars				
			2018	2019	2020	2021	2022
Behavioral health							
Enhancing Behavioral Health Workforce	CHCF	Improve access to quality opioid use disorder and other substance use disorder treatment by increasing the number of health center staff trained to deliver team-based behavioral health and primary care services.	11	—	—	—	—
Expanding Access to Quality Substance Use Disorder and Mental Health Services	CHCF	Expand access to quality integrated substance use disorder and mental health services, with a focus on mental health conditions that increase the risk for, or co-occur with, substance use disorders	352[c]	—	—	—	—
Integrated Behavioral Health Services	CHCF	Increase access to high-quality integrated behavioral health services, including prevention or treatment of mental health conditions and substance use disorders, including opioid use disorder	—	201[a]	—	—	—
Oral health							
Oral Health Infrastructure	HRSA discretionary funding and CHCF	Support infrastructure enhancements to provide new or enhance existing high-quality, integrated oral health services in health centers	—	85	—	—	—
Increase the number of health centers and sites							
New Access Points	CHCF	Increase number of health centers (organizations or sites at existing centers)	—	50[a]	—	—	—
School-Based Service Sites	HRSA discretionary funding	Expand access to health center services by increasing the number of patients who access comprehensive primary health care through health center sites located at schools (preschool through high school)	—	—	—	5[a]	25[a]

Legend: — = no grant awarded during this fiscal year

Source: GAO analysis of HRSA information. | GAO-24-106815

Notes: Non-COVID-19-related grant funding for fiscal years 2018 through 2022 totaled about $25 billion. Fiscal year indicates when HRSA awarded funds and does not reflect when funds were drawn down by health centers.

[a]According to HRSA officials, health centers that received this grant will generally receive ongoing funding, which will be added to service area funding after the grant's initial period of performance. HRSA officials noted that continuation of funding is subject to the availability of appropriations and satisfactory progress by grantees.

[b]Funding in fiscal year 2020 came from both HRSA discretionary funding ($50 million) and the CHCF ($4 million). The fiscal year 2021 and 2022 grants were funded solely by HRSA discretionary funding.

[c]Of the $352 million awarded, $152 million was awarded as ongoing funding, meaning that HRSA would generally increase recipients' service area funding after the initial period of performance. The remaining $200 million was awarded as one-time grant funding.

Table 9 provides information on the six COVID-19-related grants HRSA awarded in fiscal years 2020 through 2022, which totaled about $9.1 billion. Funding for these grants came from four COVID-19 relief laws that contained funding for health centers to support their ability to respond to the COVID-19 pandemic: 1) Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020; 2) CARES Act; 3) Paycheck Protection Program and Health Care Enhancement Act; and 4) American Rescue Plan Act of 2021.[3] All grants provided one-time funding to health centers.

Table 9: Health Resources and Services Administration (HRSA) COVID-19-Related Grants and Amounts Awarded to Health Centers, Fiscal Years 2020-2022

		Amount awarded in millions of dollars		
Grant name	**Purpose of funding**	**2020**	**2021**	**2022**
COVID-19-related, general				
Coronavirus Supplemental Funding for Health Centers	Prevent, prepare for, and respond to COVID-19, such as by expanding COVID-19 screening and testing capacity	100	—	—
CARES Act Funding for Health Centers	Support health centers to detect, prevent, diagnose, and treat COVID-19, and to maintain or increase capacity and staffing levels during the COVID-19 public health emergency	1,316.4	—	—
American Rescue Plan Act Funding for Health Centers	Support health centers to (i) administer COVID-19 vaccines; (ii) detect and diagnose COVID-19; (iii) purchase equipment for COVID-19 testing or vaccinations; (iv) expand and sustain the health care workforce; (v) modify and expand health care services and infrastructure; and (vi) conduct community outreach and education related to COVID–19	—	6,113.5	—
Capital improvements				

[3]Pub. L. No. 116-123, div. A, tit. III, 134 Stat, 146, 149; Pub. L. No. 116-136, § 3211, 134 Stat. 281, 368 (2020); Pub. L. No. 116-139, div. B, tit. I, 134 Stat. 620, 626 (2020); Pub. L. No. 117-2, § 2601, 135 Stat. 4, 43.

Grant name	Purpose of funding	Amount awarded in millions of dollars 2020	2021	2022
American Rescue Plan Act–Health Center Construction and Capital Improvements	Support infrastructure costs for health center construction, expansion, alteration, renovation, and other capital improvements, particularly those that improve equitable access to COVID-19-related services and that address social determinants of health	—	954.3	—
Health information technology				
American Rescue Plan Act Uniform Data System Patient-Level Submission	Support high-quality, patient-level Uniform Data System submissions; funds may also be used for other allowable activities under the American Rescue Plan Act, such as administering COVID-19 vaccines and COVID-19 testing and treatment.	—	—	82.8
Testing				
Expanding Capacity for Coronavirus Testing	Purchase, administer, and expand capacity for testing to monitor and suppress COVID-19	582.7	—	—

Legend: — = no grant awarded during this fiscal year

Source: GAO analysis of HRSA information. | GAO-24-106815

Notes: Total funding awarded for COVID-19-related grants was about $9.1 billion in one-time funding. These grants were funded by the following COVID-19 relief laws: 1) Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020; 2) CARES Act; 3) Paycheck Protection Program and Health Care Enhancement Act; and 4) American Rescue Plan Act of 2021. Pub. L. No. 116-123, div. A, tit. III, 134 Stat, 146, 149; Pub. L. No. 116-136, § 3211, 134 Stat. 281, 368 (2020); Pub. L. No. 116-139, div. B, tit. I, 134 Stat. 620, 626 (2020); Pub. L. No. 117-2, § 2601, 135 Stat. 4, 43. In addition to grants to health centers, HRSA awarded grants to organizations to provide training and technical assistance to health centers. In fiscal year 2021, the agency awarded three such grants for a total of about $32.5 million from the American Rescue Plan Act of 2021.

Appendix IV: GAO Contact and Staff Acknowledgments

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Staff Acknowledgments

In addition to the contact named above, Karen Doran (Assistant Director), Hannah Locke (Analyst-in-Charge), Laura Elsberg, Blake Faucher, Julianne Flowers, Sandra George, David Lichtenfeld, Ravi Sharma, Roxanna Sun, and Jennifer Whitworth made key contributions to this report.

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