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Rural Health Systems in Oklahoma

What is a Community Health Center?

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Introduction

A Community Health Center (CHC) is one of many health organizations rendering care to Medicaid, Medicare, insured, and uninsured patients in the United States health care system. CHCs were designed to provide increased access to health care services for people across the U.S. CHCs adhere to the following principles: 1) they must be located in areas of highest need; 2) they must provide services to all people regardless of ability to pay; 3) they must provide comprehensive services including primary health, mental health, oral health, enabling services, and health education; and 4) CHCs must be governed by a community board of which 51 percent are patients of the center.

Since their initial establishment as a health organization in the early 1960s, adoption of the organizational structure has been rapid resulting in the establishment of more than 700 centers. CHCs continue to play a vital role within the U.S. health care system rendering care to millions of Americans, irrespective of their ability to pay.

The purpose of this fact sheet is to discuss six organizational elements that characterize a CHC, because many community leaders across the U.S. may be unaware of this type of health organization and how it may provide vital health care services to their communities. These six elements include: 1) a brief history of the CHC movement; 2) populations served; 3) scope of services; 4) economic incentives for establishment; 5) eligibility requirements; and 6) community benefits associated with establishment of a CHC. Concluding remarks provide an answer to a fundamentally important question regarding the future of CHCs: What are the possibilities to provide additional Americans with increased access to health care services through the CHC network?

Element One: A Brief History

The CHC movement began in 1965 when the first health center opened its doors as a demonstration project in Boston, Massachusetts.[1] Initial support was provided by the Office of Economic Opportunity to establish a demonstration project in President Johnson's "War on Poverty."[2] Initial demonstration projects were commonly known as neighborhood health centers. In total, eight centers were established in 1965 as part of the war effort to diminish poverty in the U.S. By the end of the decade, the health center movement was well underway.

Expansion continued in the early 1970s with approximately 150 health centers established—three of four were located in urban areas.[3] Through the development of the Rural Health Initiative in the early 1970s, health center resources were directed to rural America where at least half of the country's medically underserved people resided. Initially viewing the program as just an 'urban ghetto program,' the Rural Health Initiative changed the attitude of rural Congressmen who then became advocates for the federally-based health center program. By 1975, the neighborhood health center program evolved into the Community Health Center program through congressional action.[4]

In the 1980s, the newly evolving Community Health Center program went through a period of financial struggles and organizational changes. The Ronald Reagan administration of the 1980s attempted to reduce the role of the federal government in the U.S. health care system and improve governance of existing centers. By 1982, funding for 186 health centers was discontinued. However, as President George H.W. Bush took office, health care access issues and quality began to surface as areas of primary concern, which turned the political tide back to CHC development.[5] By the late 1980s, CHCs received an economic boost. Beginning in 1989, health centers realized much larger annual revenues primarily because of the passage of the Omnibus Budget Reconciliation Act. The Act created a Federally Qualified Health Center (FQHC) program. All CHCs in operation in 1989 receiving federal grant money became automatically eligible to be designated as an FQHC—provided they met a short list of statutory requirements for eligibility. Those facilities obtaining the FQHC designation became eligible to receive enhanced reimbursements from Medicaid and Medicare. As a result, revenues increased sharply as health centers received reimbursement for actual costs instead of receiving payment from a predetermined, standard fee schedule.

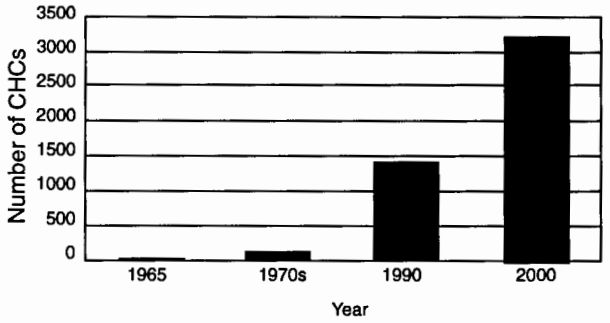

Figure 1. The CHC Movement in the United States.
Source: Bureau of Primary Care, Experts with Experience: 1990-2000, Bethesda, MD: BPHC, p. 8.

With an improved business model, the health center movement continued to advance across the U.S. From 1990 to 2000, the number of CHC establishments more than doubled from 1,400 to 3,200 (Figure 1); CHCs also served 9.6 million Americans of which 41 percent were uninsured.[6]

Element Two: Populations Served

CHCs are located across the U.S. with a presence in every state. The patient mix is diversified and varies by location. CHCs provide services to people irrespective of income and age (Table 1). CHCs generally provide services to Medicare, Medicaid, and uninsured patients. In 1998, Medicaid was the largest source of funding for CHCs (35 percent); followed by support from federal grants (23 percent); state, local, and private grants (13 percent); Medicare (7 percent); private insurance (7 percent); and out-of-pocket payments (7 percent).[7]

Table 1. Age of Health Center Patients, 2001.

Age	Percent of Total
4 and younger	13.3%
5 to 12	14.3%
13 to 24	20.0%
25 to 64	45.3%
65 and older	7.2%

Source: Shekar, Sam S., speech, "Remarks to the National Association of Community Health Centers," United States Department of Health and Human Services, Health Resources and Services Administration, March 24, 2003. Available at: http://newsroom.hrsa.gov.

Element Three: Scope of Services

CHCs are required by law to offer a wide range of primary and preventative services, including lab tests and X rays. CHCs generally provide preventative, diagnostic, and therapeutic primary medical, dental, and mental health services. Centers may also offer a wide assortment of additional services that suit the needs of the community to improve access to vital health care services (Table 2).

Element Four: Economic Incentives

Providing comprehensive services is a business challenge for CHCs because such a large majority of patients treated are uninsured. Nevertheless, six strong, economic incentives exist to establish these health organizations.

Table 2. Scope of Services.

Major categories:
Family medicine Obstetrics Pediatrics
Internal medicine Gynecology

Diagnostic radiology and laboratory services.

Preventative services:
Prenatal and perinatal services
Breast and cervical cancer screening
Well-child services
Immunizations
Elevated blood lead level, communicable diseases, and cholesterol screening
Pediatric eye, ear, and dental screenings
Voluntary family planning services
Preventative dental services

Emergency medical services.

Pharmaceutical services as appropriate for individual centers.

Source: Public Health Service Act, "Health Centers Consolidation Act, "Public Law 104-2909, Subpart I, Section 330(b)(1)(i).

Section 330(e) Grant Funding–Section 330(e) of the Public Health Service Act authorizes funds to be distributed to health centers. In 2004, communities may receive up to $650,000 in federal grant dollars to establish and operate health centers. Of these funds, up to $150,000 may be spent on minor capital expenditures in the first year of service. In the subsequent years, the full amount is to be spent for operational costs only.[8]

Federal Tort Claims Act (FTCA)–CHCs may apply to qualify for malpractice insurance under FTCA. Coverage by the FTCA insures practitioners against malpractice liability by considering them as federal employees. As a result, FTCA coverage provides a strong incentive for physicians to seek employment at health centers. The four areas covered by FTCA include: 1) family practice; 2) pediatrics; 3) internal medicine; and 4) obstetrics and gynecology.

340B Drug Pricing–CHCs also have access to medicine at a discounted rate through the 340B Drug Pricing Program, or the Public Health Service Drug Discount Program. Access is available to health centers through a separate application process. Discounts to Community Health Centers may be from 19 to 50 percent.[9]

Enhanced Reimbursements–Medicaid is currently required to pay 100 percent reimbursement of average reasonable costs to CHCs; these are an average of actual costs across all health centers, not allowable costs.[10] Additionally, Medicare pays enhanced reimbursements to CHCs.

State and Local Funding–On average, CHCs receive 13 percent of funding from state and local sources.[11] Additionally, CHCs may also receive donations from community, non-profit organizations.

National Health Service Corps (NHSC)–The NHSC provides CHCs with assistance to recruit staff members.[12] The NHSC has several valuable resources including loan repayment and scholarship programs for beginning practitioners to practice in Health Professional Shortage Areas. Several of the practitioners placed through the NHSC are committed to working in communities where CHCs are located.

Element Five: Eligibility Regulations

Despite rapid growth, multiple health care service offerings, and strong economic incentives, CHCs can only be established in medically underserved areas.[13] The conditions for coverage are specifically listed in the Code of Federal Regulations Title 42, Chapter IV, Section 491.[14]

All CHCs must be located in Medically Underserved Areas (MUAs).[15] To illustrate, an area is assigned an Index of Medical Underservice (IMU) score. The IMU is a method of quantifying the need in an area based on the percentage of the population below the federal poverty level, the percentage of the population age 65 and over, the area's infant mortality rate, and the ratio of primary care providers per 1,000 people. For example, the lower the score between 0 and 100 the more underserved the population. An area must have an IMU score of 62 or less to gain MUA designation.

Beyond location, several other requirements exist and can be found in the Bureau of Primary Health Care (BPHC) Program Information Notice (PIN) 2004-02.[16] Some other stipulations include: 1) CHCs must have a non-profit status; 2) CHC boards must have between 9 to 25 members; 3) 51 percent of the total number of board members must be users of the center; 4) the remaining 49 percent must be community leaders with skills appropriate for the management of the center; and 5) no member of the board may be an employee of the center—a member of the board cannot be a family member of an employee either.[17]; 6) no more than half of the non-consumer board representatives may derive more than 10 percent of their annual income from the health care industry.[18] Finally, accessibility to health care services does not have to be provided 'in-house.' CHCs can use contractual arrangements to 'out-source' for services to be provided to patients.

Element Six: Community Benefits

Provided communities meet eligibility guidelines, the establishment of a CHC can have several direct and indirect community benefits. Direct benefits relate to how CHCs provide quality health services. Users of CHCs govern the organization and other leaders of CHCs take further action to customize care and meet the unique needs of patients. CHCs must abide by strict quality standards. Technical assistance and continuing education are included regularly in CHC activities, so staff members can continue to provide communities with quality care. Written policies and procedures are required for operations, which increases CHC accountability through the Office of Inspector General. Organizational information is annually submitted to a national reporting system, the Uniform Data System. Each CHC must apply annually for continued funding, which also improves quality of care by increasing transparency of operations to federal authorities. Finally, CHCs provide one organizational solution for communities to gain access to vital health services.

CHCs may also provide indirect benefits to communities as well. Establishment of a CHC may save resources at the state level, for example. Michigan and Oklahoma save an estimated $34.2 and $1.4 million annually in Medicaid expenditures, respectively.[19] Establishment of CHCs may also have another positive impact on local economies: increased access to affordable health care services may attract retirees and others to communities, all of which promote economic development through the creation of local jobs.[20]

Looking Beyond the Horizon

Whether or not community leaders choose to organize a CHC is a local, societal decision that each community across the U.S. must make collectively. In some cases where there exists limited access to health care services, a CHC may be the appropriate organizational structure to establish. In other communities, however, a CHC may play more of a coordination role as one provider within a larger, already established network of existing providers (e.g. alongside rural hospitals and clinics). The implication is: access to health care services should be viewed from a 'health systems' perspective, and on a community-by-community basis.

Though community leaders and their local governments will make these establishment decisions, one fact remains true for all communities across the U.S.: strong, economic incentives exist to establish CHCs. Currently, communities have a window of opportunity for CHC development through the Presidential Initiative to Expand Health Centers, FY2002-FY2006. Specifically, President Bush has purposed to add 645 new and 555 expanded health centers thereby increasing the number of health centers in America to 4,400 by 2006.[21] If realized, such expansions would deliver much needed health care services to an estimated additional 6.1 million Americans.[22]

Concluding Remarks

With a broad service network in place and increased funding, improving access to health care services in America through CHCs may become a reality. Nevertheless, barriers exist.[23] As such, institutions, hospitals, clinics, CHCs, associations, and other key stakeholders in communities may have to improve coordination within and across state boundaries to assure leverage of the sizable investments made by the Bush Administration. Otherwise, the U.S. health care system may remain exactly where it is today: lacking.[24]

Additional Community Resources

For additional information on CHCs and their organizational structure, please contact your Oklahoma State Cooperative Extension County office, James N. Barnes in the Department of Agricultural Economics at Oklahoma State University, or Judy Grant with the Oklahoma Primary Care Association (OPCA). The Department of Agricultural Economics website is: http://www.agecon.okstate.edu. OPCA's website is: http://www.okpca.org. Additional information on CHCs is also available from the National Association of Community Health Centers (NACHC). NACHC's website is: http://www.nachc.org.

References

1 For more on the history of the CHC movement, see Sardell, A., (1988) The U.S. Experiment in Social Medicine, University of Pittsburgh Press, Pittsburgh, PA.

2 Bureau of Primary Health Care (BPHC), Health Resources and Services Adminstration, U.S. Department of Health and Human Services. "Experts With Experience" Community & Migrant Health Centers Highlighting a Decade of Service (1990-2000), 2000. Available at: http://bphc.hrsa.gov/chc/chcmain.asp.

3 BPHC, 2000.

4 Cynthia Dailard, "Community Health Centers and Family Planning: What We Know," The Guttmacher Report on Public Policy, The Alan Guttmacher Institute, October 2001, Available at http://www.guttmacher.org/journals/toc/gr0405toc.html.

5 Although the CHC movement gained momentum through the 1970s, major legislative action to encourage the CHC network did not occur until 1996, when Congress passed the Health Centers Consolidation Act. The 1996 Act brought together CHC, migrant health centers, health care for the homeless, and health care for residents of public housing under Section 330 of the Public Health Service Act. See Dailard, 2001.

6 Dailard, 2001.

7 U.S. General Accounting Office (GAO), Community Health Centers: Adapting to Changing Health Care Environment Key to Continued Success, Washington, DC, 2000. Available at: http://www.gao.gov.

8 Communities interested in applying for federal funding to establish must apply to the Health Resources and Services Administration Grants Application Center using guidelines published by the Bureau of Primary Health Care in Program Information Notice 2004-02. Included in this application are a project summary and description, a demonstration of the need for assistance, a full business plan with a 3-year budget, and agreements of compliance. In FY 2004, the Bureau of Primary Health Care anticipates that $56 million dollars will be available to support new health center access points. See http://bphc.hrsa.gov/pinspals/pins.htm.

9 NGA Center for Best Practices, "Fact Sheet: The 340B Drug Pricing Program," National Governors' Association, 2003. Available at: http://www.nga.org/cda/files/032503FACTS340B.pdf.

10 Reimbursements to health centers from Medicare and Medicaid are administered through the Centers for Medicare and Medicaid (CMS) and paid through each state's fiscal intermediary. To learn more about CMS and find your state's fiscal intermediary view the CMS website: http://www.cms.gov.

11 GAO, 2000.

12 The National Health Service Corps website that describes fully who they are, what their mission is, and a description of the services they provide is available at: http://nhsc.bhpr.hrsa.gov/.

13 The CHC program is administered through the Bureau of Primary Health Care (BPHC). BPHC of the Health Resources and Services Administration (HRSA) enforce these eligibility guidelines. See http://bphc.hrsa.gov.

14 United States Code of Federal Regulations Title 42, Chapter IV, Section 491. Available at: http://www.access.gpo.gov/nara/cfr/waisidx_02/42cfr491_02.html.

15 Medically Underserved Area guidelines are fully provided by the Bureau of Primary Health Care and are available at: http://bhpr.hrsa.gov/shortage/muaguide.htm.

16 Available at: http://www.bphc.hrsa.gov/pinspals/pins.htm.

17 The Code of Federal Regulations requires that a member of the board shall specifically not be a spouse, child, parent, brother, or sister by blood or marriage of a health center employee: United States Code of Federal Regulations, Title 42, Chapter I, Section 51c.304.

18 Health Resources and Services Administration, Bureau of Primary Health Care, Program Information Notice 98-23. Available at: http://www.bphc.hrsa.gov/pinspals/pins.htm.

19 Mizeur, Heather, "Cost-effectiveness of Health Center Care," National Association of Community Health Centers, 2003.

20 For a discussion on the link between health organizations and economic development, see Doeksen, G., T. Johnson, C. Willoughby, "Measuring the Economic Importance of the Health Sector on a Local Economy: A Brief Review and Procedures to Measure Local Impacts. Starksville, MS: Southern Rural Development Center Publication, 1997. For case study evidence, see Doeksen, G., T. Johnson, D. Biard-Holmes, and V. Schott, "A Healthy Health Sector is Crucial for Community Economic Development, Journal of Rural Health, Vol. 14, Winter 1998.

21 Shekar, Sam S., speech, "Remarks to the National Association of Community Health Centers," United States Department of Health and Human Services, Health Resources and Services Administration, March 24, 2003. Available at: http://newsroom.hrsa.gov.

22 Hawkins, Dan, presentation to National Governors Association, National Conference of State Legislatures, and Association of State and Territorial Health Officials Webcast on President Bush's Health Center Initiative, "An Overview of Health Centers," National Association of Community Health Centers, August 2002. Available at: http://www.ncsl.org/programs/health/dhawkins/.

23 For an in-depth discussion of access barriers to health care services in the U.S., see Institute of Medicine. Access to Health Care in America, Washington, DC: National Academy Press, 1993.

24 Institute of Medicine. Insuring America's Health. Washington, DC: National Academy Press, 2003.

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