



*Strengthening Oklahoma's Safety Net,  
One Community At A Time*

## **Board Bulletin**

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### **CHC Program Benefits Require Ongoing Action**

Community health centers (CHCs) make up the nation's largest network of primary care providers having over 7,900 locations and serving more than 20 million patients. CHCs are truly a return on investment in terms of saving health care dollars through preventive care, improving health outcomes and generating economic activity at the community level. To protect that investment, valuable program benefits have been made possible through Congressional action. CHC program benefits do not come easily – they must be earned and preserved.

#### **Program Benefits**

Federal grant dollars, an obvious benefit, require protective action to sustain CHCs and build program capacity. All Section 330-funded CHCs must submit Budget Period Renewal (BPR) Progress Reports annually within their assigned project period. At the end of the project period, CHCs must submit a Service Area Competition (SAC) grant to continue 330 funding – a rigorous application that requires demonstration of organizational capacity, performance improvement, and target population impact. In addition to grant funding, the following highlights the most treasured of CHC benefits instituted by Congress to protect the 330 investment:

- **Federal Tort Claims Act (FTCA)** – Section 224 of the Public Health Service Act, amended under the Federally Supported Health Centers Assistance Act of 1992 and 1995, provides CHCs the opportunity to receive FTCA (malpractice coverage) by submitting a deeming application to the Health Resources and Services Administration (HRSA)/Bureau of Primary Health Care (BPHC). Specific FTCA deeming instructions are outlined in Policy Information Notice (PIN) 2011-01, the FTCA Health Center Policy Manual. To become FTCA-deemed, CHCs must include an intensive Quality Assurance (QA) Plan that demonstrates effective risk management designed to protect federal resources (the FTCA fund). Re-deeming applications have to be submitted annually to retain the FTCA benefit and the requirements were enhanced this FFY with PIN 2011-05.
- **340B Drug Pricing Program** – The Veterans Health Care Act of 1992 (Public Law 102-585) created the 340B Drug Discount Program managed by HRSA's Office of Pharmacy Affairs (OPA). Program intent was to provide heavily discounted pharmaceuticals (estimated to be 20% to 50% cost savings and, in some cases, much more) for eligible patients – allowing scarce safety net resources to be directed to more comprehensive services. To receive the benefit, 330-funded CHCs must submit appropriate registration documents to OPA.
- **Prospective Payment System (PPS) Reimbursement** – PPS was added under Medicare effective October 1, 1991 by an amendment to the Omnibus Reconciliation Act of 1990. The cost-based reimbursement system (also known as enhanced Medicaid and Medicare reimbursement) is often misunderstood by the general public. PPS serves to protect the 330 investment by ensuring that all costs associated with CHC-required comprehensive services be adequately reimbursed by Medicare and Medicaid. When Medicaid reimbursement rates are low, CHCs cannot 'manage' financial risks by limiting patient panels since they must see all patients – regardless of ability to pay. While grant funding is meant to offset sliding fee discounts for individuals at or below 200% Federal Poverty Level (FPL), the program could not be sustainable without getting adequate Medicaid and Medicare reimbursement. The most recent certified Uniform Data System reports (2009 data) demonstrate that Oklahoma CHCs see those in greatest need of affordable health care. Oklahoma CHC patients by payor source were: 46% uninsured, 30% Medicaid, 9% Medicare and 15% private insurance. Oklahoma CHC patients by income show that 40% were at or below 100% FPL plus 12% at or below 200% FPL.
- **National Health Service Corps (NHSC)** – Instituted by the Emergency Health Personnel Act (Public Law 91-623) in response to the emerging health care crisis of the 1950s/1960s as rural health physicians retired or moved. NHSC expands access and improves patient outcomes by placing providers in Health Care Professional Shortage Areas (HPSAs) through scholarship and loan repayment programs, helping CHCs recruit and retain clinical workforce needed to deliver high quality, comprehensive services.

Not only must health centers take action to secure program benefits but proactively engage in performance improvement activities to retain them. To review the entire series, visit [www.okpca.org](http://www.okpca.org) and click on the home page *Board Bulletin* link.

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