U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration

Program Assistance Letter

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DOCUMENT TITLE: Health Center Collaboration

TO: Health Center Program Grantees
Federally Qualified Health Center Look-Alikes
Primary Care Associations
Primary Care Offices
National Cooperative Agreements

I. Purpose

The purpose of this Policy Assistance Letter (PAL) is to support health centers in maximizing opportunities to collaborate with other health care safety net providers. It provides information regarding Health Center Program requirements for collaborations, considerations when establishing contractual relationships, and a list of resources that may be helpful in facilitating effective collaborations.

II. The Critical Role of Collaboration in the Health Center Program

Since its inception, the Health Center Program has placed a strong emphasis on collaboration between health centers and other area safety net and social service providers in the provision of services to the center's target population. The Health Center Program statute, located at section 330 of the Public Health Service (PHS) Act, as amended, specifically requires that health centers demonstrate that they have made and will continue to make every reasonable effort to establish and maintain collaborative relationships with other health care providers in their catchment area.[1] It also explicitly permits health centers to provide both required primary health services and additional health services (as further defined within the statute) necessary for the adequate support of required primary health services to residents of the area served by the center through contracts and/or cooperative arrangements.[2] Further, the Affordable Care Act amended section 330(r)(2)(4) of the PHS Act to expressly state that health centers are allowed to contract with many types of rural providers for the delivery of primary health care services:

[1] Section 330(k)(3)(B) of the PHS Act, as amended.
[2] Section 330(a)(1) of the PHS Act, as amended.

….(4) RULE OF CONSTRUCTION WITH RESPECT TO RURAL HEALTH CLINICS.—

> ‘‘(A) IN GENERAL.—Nothing in this section shall be construed to prevent a community health center from contracting with a Federally certified rural health clinic (as defined in section 1861(aa)(2) of the Social Security Act), a low-volume hospital (as defined for purposes of section 1886 of such Act), a critical access hospital, a sole community hospital (as defined for purposes of section 1886(d)(5)(D)(iii) of such Act), or a medicare-dependent share hospital (as defined for purposes of section 1886(d)(5)(G)(iv) of such Act) for the delivery of primary health care services that are available at the clinic or hospital to individuals who would otherwise be eligible for free or reduced cost care if that individual were able to obtain that care at the community health center. Such services may be limited in scope to those primary health care services available in that clinic or hospitals.
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> ‘‘(B) ASSURANCES.—In order for a clinic or hospital to receive funds under this section through a contract with a community health center under subparagraph (A), such clinic or hospital shall establish policies to ensure—
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> > ‘‘(i) nondiscrimination based on the ability of a patient to pay; and
> >
> > ‘‘(ii) the establishment of a sliding fee scale for low-income patients.’’[3]

Collaboration among safety net providers is critical to maximizing resources and efficiencies in the health care system in underserved areas. As health centers seek new opportunities to create access to high-quality, coordinated care for patients, this collaboration will become even more important. The Health Resources and Services Administration (HRSA) has also placed an increased emphasis on collaboration within its funding opportunities for health centers. In particular, as part of a New Access Point (NAP) submission, NAP applicants are asked to provide either letters of support from current Federally Qualified Health Centers (FQHCs), FQHC Look-Alikes, Rural Health Clinics (RHCs), health departments, and/or Critical Access Hospitals (CAHs) that could potentially serve their target population, or a justification as to why such letters cannot be obtained. In addition, these applications will be assessed and scored by an Objective Review Committee on the extent to which they demonstrate formal and informal collaboration and coordination of services with other health care providers. These assessments will factor into decisions about which applications HRSA will fund.

HRSA recognizes that collaboration and coordination can be especially critical in rural areas that face unique challenges in providing an integrated system of care due to a number of factors. This includes challenges attracting health care clinicians as well as difficulties in achieving economies of scale in terms of service delivery. Rural residents also face long distances and potential geographic barriers between providers and patients. Because other safety net providers often play a key role in serving these medically underserved populations, it is imperative that health centers thoroughly research as part of any expansion plan where these other safety net providers are located and the services they are providing. The ability to contract with existing rural providers to meet the needs of the underserved may also help avoid duplication of infrastructure and services. Expansion proposals should reflect the ways in which the health center will collaborate with these other safety net providers in providing coordinated care to the underserved population in the service area.

[3] P.L. 111-148, Title IV, Section 5601(b).

III. Specific Considerations when Contracting

Based on their own individual community circumstances, health centers may determine that the most effective and efficient way to ensure access to high-quality primary care services may include contractual arrangements between the health center and other area health care providers. Congress has emphasized this option for rural communities in the Affordable Care Act.

When assessing whether contractual arrangements between a health center and another provider are the most appropriate form of collaboration, the following factors must be considered by both parties:

- Health centers are responsible for maintaining oversight over all sites and services within their federally approved scope of project, including assuring that patients have access to the health center's full range of services;
- Health centers must assure that all services included under their federally approved scope of project, including those performed under contract, are available to patients regardless of their ability to pay;
- Health Center Program grantees must comply with section 330 of the PHS Act and the HHS grant regulations, including those specific to the provision of required services (and payment for those services to the extent that they are not provided directly by the health center) and to procurement of goods and services, as outlined in 45 CFR § 74.40 through 74.48 or 45 CFR § 92.36(b) through (i), as applicable; and
- Benefits that are afforded to health centers from programs other than under Section 330 (i.e., Federal Tort Claims Act coverage, 340B pricing, reimbursement as a FQHC under Medicare/Medicaid/CHIP) are determined by the applicable laws and rules of the respective programs. Therefore, the terms of the contractual agreement should be constructed accordingly.

IV. Resources and Contacts

Health centers are encouraged to take advantage of numerous resources that are available to assist them in maximizing collaboration with their safety-net partners, including:

- UDS Mapper Tool: To access preliminary information on existing safety-net providers in a community, health centers can use the UDS Mapper tool, available online at http://www.udsmapper.org. This tool includes information on health center service area by ZIP code tabulation area (ZCTA), patients served as reported by Uniform Data System (UDS) data, locations of health center service sites, and locations of federally-linked providers such as Rural Health Clinics and National Health Service Corps (NHSC) provider sites.

- National Cooperative Agreements (NCAs): NCAs are able to offer technical assistance to organizations in identifying opportunities for collaboration. A list of the NCAs can be found on the HRSA/Bureau of Primary Health Care (BPHC) Web site at http://www.bphc.hrsa.gov/technicalassistance/.

- State/Regional Primary Care Associations (PCAs): PCAs are able to offer health centers and other providers in the State/region with technical assistance on seeking and creating collaborative arrangements in rural and other underserved areas. A list of the PCAs can be found on the HRSA/BPHC Care Web site at http://www.bphc.hrsa.gov/technicalassistance/.

- State Offices of Rural Health (SORHs): SORHs may also be able to provide technical assistance on rural health care delivery systems. A list of SORHs is available on the HRSA/Office of Rural Health Policy Web site at http://www.hrsa.gov/ruralhealth/about/hospitalstate/stateoffices.html.

- BPHC staff: BPHC Project Officers can assist health centers in reviewing proposed collaborative agreements from the standpoint of compliance with programmatic requirements. It is always recommended that these agreements be reviewed by the health center's own legal counsel for considerations beyond program compliance.

If you have further questions regarding this PAL, please contact the Bureau of Primary Health Care, Office of Policy and Program Development at OPPDGeneral@hrsa.gov.

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