



**Geiger Gibson /
RCHN Community Health Foundation Research Collaborative**

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**A Natural Fit:
Collaborations Between Community Health Centers and Family Planning Clinics**

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About the Geiger Gibson / RCHN Community Health Foundation Research Collaborative

The Geiger Gibson Program in Community Health Policy, established in 2003 and named after human rights and health center pioneers Drs. H. Jack Geiger and Count Gibson, is part of the School of Public Health and Health Services at The George Washington University. It focuses on the history and contributions of health centers and the major policy issues that affect health centers, their communities, and the patients that they serve.

The RCHN Community Health Foundation, founded in October 2005, is a not-for-profit foundation whose mission is to support community health centers through strategic investment, outreach, education, and cutting-edge health policy research. The only foundation in the country dedicated to community health centers, the Foundation builds on health centers' 40-year commitment to the provision of accessible, high quality, community-based healthcare services for underserved and medically vulnerable populations. The Foundation's gift to the Geiger Gibson program supports health center research and scholarship. Additional information about the Research Collaborative can be found online at www.gwumc.edu/sphhs/departments/healthpolicy/ggprogram or at rchnfoundation.org.

Executive Summary

Federally Qualified Health Centers (FQHCs) and family planning clinics funded through Title X of the Public Health Service Act are critical components of the health care safety net in urban and rural medically underserved communities. Although they share the common mission of serving vulnerable and low-income populations, health centers and Title X clinics possess different, but complementary, strengths. The Patient Protection and Affordable Care Act (Affordable Care Act) will expand coverage to an additional 32 million people while leaving 23 million uninsured. Most of the newly insured and the remaining uninsured will be residents of medically-underserved communities, and thus, positioning the safety net to meet demand will be highly important.

Their location and mission mean that health centers and family planning clinics typically serve as a patient's entry point into the health care system. Six in 10 women who obtain care at a family planning clinic describe it as their usual source of medical care. Surveys of health center patients show that 4 in 5 patients report that a health center is their usual source of care. Both programs have a long tradition of collaboration; indeed, collaboration is a basic expectation of the health centers and family planning programs.

Collaboration draws on the complementary strengths of both programs. On one hand, health centers offer a broad range of primary care services including family planning. On the other, family planning programs may offer an additional level of patient confidentiality, an even broader range of family planning services, and expertise in reaching hard-to-serve populations such as adolescents. Both programs also offer a high degree of compatibility on matters such as service to the entire community and the use of income-adjusted fee schedules.

Laws related to clinical integration of care, including the special laws governing both the health centers and family planning programs, permit a broad array of collaborative arrangements along a logical spectrum. At one end of the spectrum are cross-referral arrangements, and the spectrum includes an important array of contractual arrangements that preserve the autonomy of both providers while permitting the development of more integrated services and information exchange. At the opposite end of the spectrum is full integration through merger, a step that likely is an option only in highly selected instances but one that offers important potential when necessary and appropriate.

Introduction

Federally Qualified Health Centers (FQHCs) and family planning clinics funded through Title X of the Public Health Service Act are critical components of the health care safety net in urban and rural medically underserved communities. Although they share the common mission of serving vulnerable and low-income populations, health centers and Title X clinics possess different, but complementary, strengths. This shared mission, along with a rich tradition of working in partnership with other health care agencies, makes collaboration a natural fit.

The Patient Protection and Affordable Care Act (Affordable Care Act) has expansion of insurance coverage as its central aim; by 2019 an additional 32 million people are estimated to gain coverage, half through Medicaid.¹ Whether this coverage is through Medicaid or through private insurance, it will include a broad range of contraceptive methods and services, as has been the case under Medicaid since the 1970s and has been the norm for private coverage for at least a decade. The Affordable Care Act will formalize and expand this norm by requiring new private plans, including qualified health plans sold in state health insurance Exchanges, to cover the full range of Food and Drug Administration-approved contraceptive methods and well-woman visits with no patient out-of-pocket cost-sharing.

The majority of newly insured people will be low and moderate income individuals living in medically underserved communities.² Furthermore, even as the Act expands coverage, its expansions nonetheless will leave uninsured an estimated 23 million people, also disproportionately residing in medically-underserved communities. As a result, positioning the safety net to be able to meet a growing demand among newly insured individuals as well as the ongoing need of uninsured people is a matter of great importance.

Community Health Centers

Community health centers (known as federally qualified health centers (FQHCs) under the Medicare and Medicaid programs)³ represent the single largest primary care system in the United States. In 2010, 1,124 FQHCs provided primary care to approximately 20 million patients across more than 8,100 locations in every state and territory.⁴ Health

¹ S. Rosenbaum, P. Shin, E. Jones et al., *Community Health Centers: Opportunities and Challenges of Health Reform* (Menlo Park, Calif.: Kaiser Family Foundation, Aug. 2010).

² S. Rosenbaum, M. Zakheim, J. Leifer et al., *Assessing and Addressing Legal Barriers to the Clinical Integration of Community Health Centers and Other Community Providers* (New York, New York: Commonwealth Fund, July 2010).

³ The term "FQHC" encompasses both health centers funded under Section 330 of the Public Health Service Act as well as entities that are designated by CMS as FQHCs because they meet all health center requirements but receive no federal grants under Section 330. Examples would be nonprofit clinics that comply with all 330 requirements and are supported by patient revenues, and private, state, local and non-330 federal grants.

⁴ Data from the 2010 Uniform Data System (UDS), HRSA, a special mandatory national reporting system covering all federally funded health centers.

centers are organized around four basic principles: (1) location in or service to medically underserved communities or populations; (2) governance by a community board the majority of which is comprised of health center patients; (3) care for all residents of the service area regardless of ability to pay and, as applicable, in accordance with an income-related sliding fee schedule; and (4) provision of comprehensive preventive and primary care services (including family planning services) either directly or through contracts or cooperative agreements with other agencies.

The Affordable Care Act makes a five-year, \$11 billion investment in health centers between FY 2011 and 2015, as well as a \$1.5 billion investment in the National Health Service Corps (NHSC), in order to support health centers' expansion of sites and capacity in anticipation of the surge in health care use anticipated in 2014. Both the health center and the NHSC expansion funds are mandatory spending, although by reducing discretionary funding as part of the FY 2011 appropriations process, Congress effectively reduced these expansion funds by \$600 million for health centers and \$117 million for the NHSC.⁵ In addition, the Act includes several new initiatives to encourage integrated and community-based partnerships to broaden access to care. These initiatives include community-based collaborative care networks (networks of providers, including health centers, which use a joint governance structure and provide comprehensive coordinated and integrated health care services to low-income populations) and patient-centered medical homes. Health centers are also expected to be active participants in Accountable Care Organizations.

Family Planning Clinics

Family planning clinics provided services to 7.2 million clients at 8,200 sites nationwide in 2006,⁶ 4,300 of which (more than half) received some funding through Title X, which is dedicated to the provision of family planning services. Title X-funded clinics -which include sites operated by state and local health departments, hospitals, Planned Parenthood affiliates and other private, nonprofit organizations - are located in three-quarters of all counties nationwide. By regulation, services provided in Title X-funded sites are free of charge to clients with incomes below the federal poverty level, and in accordance with an income-adjusted fee schedule for others. Clinics receiving Title X funding must ensure that all services are voluntary and confidential, and that clients are able to choose from a broad range of contraceptive methods.⁷ Program guidelines require that clients be offered a package of contraceptive services and closely related preventive care, including a pelvic exam, Pap test to screen for cervical cancer, physical exam, blood pressure check and breast exam; women at high risk for sexually transmitted infections are expected to be tested and to receive appropriate counseling,

⁵ The continuing resolution for FY 11 (HR 1473) reduces discretionary health center outlays by \$600 Million and discretionary NHSC outlays by \$117 million, thereby reducing total available expansion funding by the amount needed to maintain current operations. However, the remaining expansion funds from ACA remain intact.

⁶ Gold RB et al., *Next Steps for America's Family Planning Program: Leveraging the Potential of Medicaid and Title X in an Evolving Health Care System*, New York: Guttmacher Institute, 2009.

⁷ 42 C.F.R § 59.5 and 59.11(2000).

treatment and medical referral.⁸ Since its enactment in 1970, the Title X statute has expressly prohibited the use of grant funds for abortions, also the case with health centers

A Shared Health Mission

Both the national family planning effort and community health centers have their roots in the Johnson administration's signature War on Poverty in the 1960s. Community health centers grew out of a pilot program launched by the Office of Economic Opportunity (OEO) in 1965.⁹ That same year, the OEO made the first federal family planning grants.¹⁰ Stemming from their shared roots in efforts to combat poverty and its health effects, both health centers and family planning clinics continue to focus on serving low and moderate income individuals who are often disenfranchised from the health care system by virtue of their income, insurance status, age, immigration status and/or place of residence. Overwhelmingly, both programs serve low-income individuals. Seventy percent of clients served at Title X-funded clinics in 2009 had incomes below the federal poverty line (\$22,350 for a family of four in 2011),¹¹ and 90 percent had incomes below twice the poverty level.¹² Figures for health centers are virtually identical: in 2010, 72 percent of all patients were poor and 93 percent had incomes below twice the federal poverty level.¹³ Both types of clinics serve pervasively uninsured populations: two-thirds of all clients at Title X-funded clinics, and 38 percent of health center patients. Similarly, populations served by both providers rely heavily on Medicaid, 20 percent in the case of clients at Title X sites and 39 percent of health center patients.

Figure 1
Key Facts: Community Health Centers and Family Planning Clinics

	Health Centers (2010)	Family Planning Clinics (2006)
Number of Sites	8,140	8,199
Patients Served	19,469,467	7,198,210
Patients aged <20	6,754,392	1,794,940
Geographic Locations	All 50 States and the District of Columbia	All 50 States and the District of Columbia
Scope of Services	Comprehensive primary health care and social services	Broad range of contraceptive services and related preventive care
Primary Grant Funding	Section 330 Grants (Federally-Funded Health Centers); State and Local Grants (Look-Alike FQHCs)	Title X Family Planning Grants

Source: 2010 Uniform Data System (UDS) Report; Guttmacher Institute, Contraceptive Needs and Services, 2006, 2009

⁸ Office of Population Affairs, *Program Guidelines for Project Grants for Family Planning Services*, Bethesda MD: United States Department of Health and Human Services, (2001).

⁹ S. Rosenbaum, M. Zakheim, J. Leifer et al., *Assessing and Addressing Legal Barriers to the Clinical Integration of Community Health Centers and Other Community Providers* (New York, New York: Commonwealth Fund, July 2010).

¹⁰ Gold RB et al., *Next Steps for America's Family Planning Program: Leveraging the Potential of Medicaid and Title X in an Evolving Health Care System*, New York: Guttmacher Institute, 2009.

¹¹ "Annual Update of the HHS Poverty Guidelines" *Federal Register* 76:13 (20 January 2011), p. 3627, <http://aspe.hhs.gov/poverty/11fedreg.pdf>.

¹² Fowler, CI, Gable, J, Wang, J, and Lloyd, SW. (November 2010). *Family Planning Annual Report: 2009 National Summary*. Research Triangle Park, NC: RTI International.

¹³ 2010 UDS, HRSA

Figure 2 Distribution of Patients by Income Level and Insurance Status			
	Title X Clinics (2009)	Health Centers (2010)	
Income Level		(including unknown)	(excluding unknown)
<=100% FPL	70%	55%	72%
101-150%	15%	11%	14%
151-200%	5%	5%	7%
>200%	6%	6%	7%
Unknown	3%	23%	--
Total All Users	100%	100%	100%

	Title X Clinics (2009)	Health Centers (2010)	
Insurance Status			
Public health insurance	1,021,164	9,461,640	
		1,461,485	Medicare
		7,505,047	Medicaid
		495,108	Other
Private health insurance	426,308	2,699,183	
Uninsured	3,419,915	7,308,644	
Unknown/not reported	318,880	--	
Total All Users	5,186,267	19,469,467	

Source: GW analysis of 2010 Uniform Data System (UDS) and 2009 Family Planning Annual Report (FPAR) national roll-up reports

Family planning programs and health centers serve large numbers of women of childbearing age, generally defined as between the ages of 15 and 44. Nearly all clients served at Title X-funded sites are women in this age group.¹⁴ Women comprise 59 percent of health center patients, nearly half (47 percent) of whom are of childbearing age.¹⁵ Twenty-three percent of health center patients, and 64 percent of female clients served at Title X clinics are 18-29, the age group most at risk of unintended pregnancy.¹⁶ In fact, DHHS already acknowledges that health centers and sites receiving Title X funding serve an intersecting population; for example, a grant program funding interventions designed to reduce risks for alcohol-exposed pregnancy singled out these two types of providers for funding specifically because they both serve low-income women at risk of an unintended pregnancy.¹⁷

¹⁴ Fowler, CI, Gable, J, Wang, J, and Lloyd, SW. (November 2010). *Family Planning Annual Report: 2009 National Summary*. Research Triangle Park, NC: RTI International.

¹⁵ GWU UDS analysis 2010 UDS data.

¹⁶ Finer LB and Zolna MR, Unintended pregnancy in the United States: incidence and disparities, 2006, *Contraception*, 2011, doi:10.1016/j.contraception.2011.07.013.

¹⁷ Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, "Reducing Risks for Alcohol-Exposed Pregnancy (AEP) in Women Attending Federally Funded Community Health Centers and Title X Programs," Grants Notice CDC-RFA-DD-10-1006 June 20, 2010,

Their locations and missions mean that health centers and family planning clinics typically serve as a patient's entry point into the health care system. Six in 10 women who obtain care at a family planning clinic describe it as their usual source of medical care.¹⁸ In fact, in many cases, a family planning clinic may be their exclusive source of care: according to one study conducted at Planned Parenthood clinics in Los Angeles, 29 percent of adults and 19 percent of teens said the center was their only source of medical care.¹⁹ Surveys of health center users show that 4 in 5 patients report that a health center is their usual source of care.²⁰

Complementary Strengths

Although Title X-funded family planning clinics and health centers serve similar populations and provide an overlapping scope of care, they have different, but complementary, strengths. Community health centers provide comprehensive primary health care, including family planning, which is a required health center service. Virtually all health centers (99 percent) report that they provided contraceptive management/birth control or infertility treatment and counseling and education, either on-site or through referral arrangement.²¹ In 2010, nearly 1.1 million patients received contraceptive management services (ICD-9 codes V25.xx) at community health centers.²² No data exist on the number and type of family planning services beyond receipt of contraceptive management or on the actual dispensing of contraceptive drugs or devices, although both George Washington University and the Guttmacher Institute are conducting more extensive studies of health centers' family planning services.

Because family planning services are part of a broader range of preventive and primary health care, patients who use health centers as their family planning providers can receive a full array of primary health care at one site. Services are holistic, and medical records can be fully integrated. An integrated approach also provides the opportunity for one-stop shopping, giving patients the convenience of being able to obtain all care at one place, possibly even in one visit. Finally, it offers the possibility of a medical home not only for the patient but the entire family as well.

available at

<http://www.grants.gov/search/synopsis.do?jsessionid=0JT6TSrB52V5f0jp1IN5bg641Tv6RxPqNywrKxQl8hC6l4WRsj9x!-2014031096>, accessed October 9, 2011.

¹⁸ Gold RB et al., *Next Steps for America's Family Planning Program: Leveraging the Potential of Medicaid and Title X in an Evolving Health Care System*, New York: Guttmacher Institute, 2009.

¹⁹ Sugerman S et al., Family planning clinic clients: their usual health care providers, insurance status, and implications for managed care, *Journal of Adolescent Health*, 2000, 27(1):25–33.

²⁰ The 2009 HRSA Health Center Patient Survey estimated 80 percent of all users reported health centers as their usual source of care and the 2006 Commonwealth Fund Health Care Quality Survey estimated 78 percent; notably, the 2002 HRSA Health Center Patient Survey found all adult female users reported health centers as their medical home.

²¹ GWU analysis of 2007 UDS data.

²² 2010 UDS, HRSA

Yet some of the very features of comprehensive care that might be clear advantages for some women may act as impediments for others. Especially for adolescents and young adults who desire full confidentiality, using a health center for their family planning services, where they might be seen by relatives, friends or neighbors, can pose a problem. Additionally, having the same caregiver who is caring for, and known to, other family members may be an impediment. The Los Angeles study of women obtaining care at Planned Parenthood centers found that issues related to confidentiality were a major reason that women -- especially adolescents -- used the clinic despite the fact that they had a usual source of care. Among adolescents, more than half said that they were concerned that their usual provider would either send records home or tell family members.²³

Although health centers may be viewed as, and, given the politicization of family planning issues, may seek identification as a place to obtain a broad package of care, family planning clinics tend to be known specifically for the range of contraceptive services they provide. Additionally, family planning clinics may have specific expertise that is particularly salient for some women. They may have more specific expertise in counseling around sexual and reproductive health issues, which may be especially important for young women but also for women in some racial or ethnic communities or for women confronting complicated issues such as homelessness, domestic violence or substance abuse.

Finally, specialized family planning clinics can offer a somewhat wider choice of contraceptive methods than do health centers; research suggests that family planning clinics may be more likely to offer intrauterine devices (IUDs) and newer contraceptive methods, such as the patch and the ring.²⁴ Specialized family planning clinics also may be more likely to dispense both oral contraceptives and Depo Provera on site, rather than through prescriptions that might require dispensing elsewhere in cases in which health centers do not operate their own pharmacies. Together, oral contraceptives and Depo Provera are the primary contraceptive method used by nearly half of all women served at Title X-funded family planning clinics.²⁵

In short, specialized family planning clinics may provide more expansive contraceptive services along with breast and cervical cancer screening and screening for sexually transmitted infections (STIs). But unlike health centers, family planning clinics do not offer more integrated and comprehensive care. Health centers, by contrast, offer family planning and cancer and STI screening but because they serve a broader range of clients (including potentially, a patient's family members and neighbors), they may not offer the high level of confidentiality available at family planning clinics or as full a range

²³ Sugeran S et al., Family planning clinic clients: their usual health care providers, insurance status, and implications for managed care, *Journal of Adolescent Health*, 2000, 27(1):25–33.

²⁴ Jennifer Frost, "The Importance of Title X: Variation in Service Delivery Practices and Policies among Publicly Funded Clinics," presented at National Title X Grantee Meeting, Miami, Florida, August 2011.

²⁵ Fowler, CI, Gable, J, Wang, J, and Lloyd, SW. (November 2010). *Family Planning Annual Report: 2009 National Summary*. Research Triangle Park, NC: RTI International.

of family planning options. Thus, collaboration becomes an important consideration between the two types of health care providers.

Policy Environment Promoting Collaboration

The community health center and family planning programs both have a long and rich tradition of encouraging collaboration with other health care providers as a basic dimension of their program operations. Integration is a fundamental component of Section 330 of the Public Health Service Act, the statute that authorizes the community health centers program. In recognition of the fact that health centers might not directly furnish the full range of required services, the law permits health center grantees to provide services “either through the staff and supporting resources of the center or through contracts or cooperative arrangements.”²⁶ In addition, the statute specifically encourages centers to collaborate with other providers in their communities, requiring them to “make every reasonable effort to establish and maintain collaborative relationships with other health care providers in the [service] area of the center....”²⁷

The Bureau of Primary Health Care (BPHC) within the Health Resources and Services Administration (HRSA) administers the health center program. BPHC expanded on this statutory provision in the operational guidance that it has provided to program grantees. Policy Information Notice 98-23, Health Center Program Expectations, states “...collaboration is critical to ensuring the effective use of limited health center resources, providing a comprehensive array of services....and gaining access to critical assistance and support....Affiliations are desirable when they lead to integrated systems of care that strengthen the safety net for underserved clients.”²⁸ The collaboration expectation focuses on assuring that health centers have arrangements to support patients’ access to an appropriate continuum of care, including by establishing ongoing referral arrangements with providers of specialty, diagnostic and therapeutic services.”²⁹

In November 2010, BPHC issued new guidance related to the health center expansion under the Affordable Care Act. Program Assistance Letter 2011-02 reiterates the statute’s emphasis on working cooperatively with other community-based providers, in particular, in rural areas: “[C]ollaboration among safety-net providers is critical to maximizing resources and efficiencies in the health care system in the 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.” As a result, the guidance encourages health centers to “evaluate the location of other safety-net providers and the services they furnish when developing expansion plans and reflect in proposed expansion plans how the health center will collaborate with these

²⁶ See 42 U.S.C. §254b(a)(1).

²⁷ See 42 U.S.C. §254b(k)(3)(B).

²⁸ See PIN #98–23 at p. 9.

²⁹ S. Rosenbaum, M. Zakheim, J. Leifer et al., *Assessing and Addressing Legal Barriers to the Clinical Integration of Community Health Centers and Other Community Providers* (New York, New York: Commonwealth Fund, July 2010).

other providers in furnishing coordinated care to the underserved population in the service area.”

Finally, guidance for grantees and other “new start” organizations funded under the Affordable Care Act to establish “new access points” reiterates the importance the health center program places on collaboration. According to the 2011 funding announcement (to date, the most recent new access point funding opportunity available), one criterion used to evaluate the strength of applications will be whether they include written evidence of collaboration and coordination with other providers and agencies serving the same populations, along with evidence of efforts to coordinate with other social service and community initiatives.³⁰ Applicants that do not include those collaborative efforts are expected to justify their absence.³¹ Collaboration as an element of successful health center applications is no longer just a goal: it is an essential and expected component of a strong health center program.

The Title X family planning program places a similar high priority on collaboration. Program regulations require that projects make referrals to other health care facilities when necessary and that they “provide for coordination and use of referral arrangements with other providers of health care services, local health and welfare departments, hospitals, voluntary agencies, and health services projects supported by other federal programs.”³² Program guidelines elaborate on this requirement.³³ When services that are required under the project are provided by referral, rather than directly, grantees must have formal referral arrangements with other health care providers. In addition, “[f]or services determined to be necessary but which are beyond the scope of the project, clients must be referred to other providers for care.” In those cases, “[a]gencies must have written policies/ procedures for follow-up on referrals made as a result of abnormal physical examination or laboratory test findings,” and maintain a current list of local health care providers that can be used for referral purposes. The guidelines also require that programs provide referrals for additional services related to substance abuse, sexual abuse, domestic violence and nutrition.³⁴ Programs must also have referral systems in place for clients who need further genetic counseling and evaluation.³⁵ Significantly, some Title X grantees require even more specific protocols. The Texas Department of State Health Services, for example, requires family planning programs to establish communication with community health centers or other state-funded organizations providing primary care or services for breast or cervical cancer within their service area.³⁶

³⁰ See HRSA-11-017 at p. 47.

³¹ See HRSA-11-017 at pp. 47–48.

³² See 42 C.F.R § 59.5 (2000).

³³ See Section 7.4 in Office of Population Affairs, *Program Guidelines for Project Grants for Family Planning Services*, Bethesda MD: United States Department of Health and Human Services, (2001).

³⁴ See Section 9.3 in Office of Population Affairs, *Program Guidelines for Project Grants for Family Planning Services*, Bethesda MD: United States Department of Health and Human Services, (2001).

³⁵ See Section 9.4 in Office of Population Affairs, *Program Guidelines for Project Grants for Family Planning Services*, Bethesda MD: United States Department of Health and Human Services, (2001).

³⁶ Texas Department of State Health Services, Fiscal Year 2011 Policy and Procedure Manual for Title V, Title X and Title XX Family Planning Services, 2011, available at

Finally, program priorities issued for fiscal year 2012 by the Office of Population Affairs, the federal agency that administers Title X, includes “partnering with other community-based health and social services providers.” These priorities constitute overarching goals for the program and grantees are charged with including evidence of addressing these goals in their project plans.³⁷

In addition, the Medicaid state option to expand eligibility for family planning services (implemented on a demonstration basis prior to the Affordable Care Act and as a state plan option under the law) reflects this goal of integration and collaboration. The Centers for Medicare and Medicaid Services (CMS), which administers Medicare, Medicaid, and CHIP, requires that state family planning expansion initiatives include primary care referrals as medically indicated as well as information about where and how to obtain primary care.³⁸ Evaluations of the expansion programs conducted by several states indicate an extensive pattern of referrals. For example, 12 percent of recipients utilizing services under the expansion in Alabama in 2009 were told about other medical problems; of these 65 percent were given a referral.³⁹ California has, by far, the largest Medicaid family planning expansion; in fiscal year 2009-10, the program served over 1.8 million individuals.⁴⁰ According to an evaluation conducted for the state, approximately one in three clients receive a referral to access primary care at another site, and 68 percent of the family planning providers indicated that they pass on pertinent medical records to the outside provider when a referral is made.⁴¹

Because health centers and Title X-funded family planning programs have compatible missions, some issues that might otherwise impede collaboration do not come into play. Chief among these issues is the requirement that programs make services available to all individuals, regardless of their ability to pay. Section 330 requires health centers to provide services to all residents of their service area,⁴² and to waive or reduce patient payments to the extent necessary to ensure that no patient will be denied services because of an inability to pay.⁴³ As reaffirmed in numerous BPHC policies, this

<http://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589950252>, accessed May 9, 2011.

³⁷ Office of Population Affairs. *Title X Family Planning Program Priorities*. , available at <http://www.hhs.gov/opa/title-x-family-planning/title-x-policies/program-priorities/>, accessed October 13, 2011.

³⁸ Letter from Cindy Mann, Director, Center for Medicaid, CHIP and Survey and Certification, Centers for Medicare and Medicaid Services to Ronald Levy, Director, Missouri Department of Social Services, June 24, 2011 and attached Special Terms and Conditions, project number 11-W-00236/7, Missouri Women’s Health Program, #20.

³⁹ Janet Bronstein, University of Alabama at Birmingham, School of Public Health “Alabama’s Plan First Medicaid Demonstration Program Evaluation, Demonstration Year Nine, October 2008 to September 2009,” November 2010.

⁴⁰ Bixby Center for Global Reproductive Health. University of California, San Francisco. Family PACT Program Report, FY 2009-10. Sacramento, CA. 2011.

⁴¹ Ralph, L., and Brindis, C. *Facilitating access to primary care services for Family PACT clients: Findings from the 2008/09 Provider Referral Study*, San Francisco, CA.: Bixby Center for Global Reproductive Health. University of California, San Francisco. 2009.

⁴² See 42 U.S.C. § 254b(a)(1).

⁴³ See 42 U.S.C. § 254b(k)(3)(G)(iii).

requirement has been interpreted to require health centers to make services included in their federally-approved service packages readily available and reasonably accessible to all patients equally regardless of ability to pay and thus, to make services available on a sliding fee scale.⁴⁴ The Title X statute similarly requires that an individual's "economic status shall not be a deterrent to participation."⁴⁵ Reinforcing this point, the program guidelines require that clients "must not be denied project services or be subjected to any variation in quality of services because of the inability to pay."⁴⁶

Moreover, both programs utilize a sliding fee scale designed to put services within reach of low-income individuals, although minor differences exist in how the sliding fee scale is structured and applied. The sliding fee scale for health centers tops out at 200 percent of the Federal Poverty Level (above which patients must be charged full fee), while the Title X sliding fee scale extends up to 250 percent of the Federal Poverty Level.⁴⁷ For patients with incomes below 100 percent of the Federal Poverty Level, Title X services must be provided free of charge, while health centers may charge patients earning at or below 100 percent a nominal fee, provided that the fee does not create a barrier to care. However, health center and family planning sliding fee scales can be readily aligned in order to reconcile inconsistencies. For example, if the health center has a non-Section 330-related source of funds (such as other federal grants, or state, local or private funds) dedicated to supporting care for patients who do not otherwise qualify for Section 330 discounts, it can use those funds to support the cost of care provided to individuals at or below 100 percent of the Federal Poverty Level (FPL) or between 201 percent and 250 percent of the FPL.

Similarly, agencies funded through both programs are eligible for discounts on the costs of procuring prescription drugs under the federal 340B program, and are mandated to comply with a range of rules established by the federal Office of Management and Budget. Depending on the specific type of collaboration that may be considered, some other issues, such as the health centers' unique governance requirements and Federal Tort Claims Act coverage, may pose challenges to collaboration with family planning programs, but likely only if programs are contemplating an extensive integration, rather than a more limited collaboration.

Potential Collaborations Along an Integration Spectrum

Numerous collaboration options are available to health centers and family planning clinics that seek greater integration. Collaboration options span the full spectrum of integration, from retention of full organizational independence for both health centers and Title X clinics at one end, to complete integration of the organizations at the other. Under the least integrated model, each clinic would maintain a fully independent status but the two providers could agree to coordinate around referrals and information

⁴⁴ See PIN #2008-01 at pp. 10-11.

⁴⁵ See 42 U.S.C. § 300a-4.

⁴⁶ See Section 6.3 in Office of Population Affairs, *Program Guidelines for Project Grants for Family Planning Services*, Bethesda MD: United States Department of Health and Human Services, (2001).

⁴⁷ See 42 C.F.R. §59.5 (2000).

exchange, allowing patients to move more freely and in a more coordinated fashion between two separate systems of care. For instance, a family planning program and a community health center might establish a referral arrangement through which individuals could seek primary care services through the health center and family planning services through the family planning clinic, either because specific services might not be available at the health center or because, as is the case with many affluent people, the preference is for separate sources of primary care and reproductive-related health care. The health center and family planning partners would agree to provide their services to these referred individuals on a preferred or expedited basis, and each would remain fully responsible for the services it provides.

While the joint referral model maintains maximum flexibility and independence for the parties, it may also raise issues in an environment in which patients, as a condition of coverage under Medicaid or another source of insurance, must be enrolled in a managed care arrangement. In the case of Medicaid, access to the family planning provider of choice is guaranteed, although it is unclear whether state Medicaid programs require managed care organizations to honor referrals from family planning providers back to a member's provider network; that is, whether state agencies require such referrals to be treated as in-network even though the source of the referral was an out-of-network provider. Furthermore, under the Affordable Care Act, Qualified Health Plans (QHP) offered through state health insurance Exchanges will be required to have some relationship with essential community providers (including clinics receiving Title X funding), but the exact nature of the relationship is not clear under either the statute or proposed implementing regulations issued in July, 2011. As a result, individuals who obtain coverage through a QHP and premium assistance may find that their use of family planning services out of network is not covered and furthermore, Title X clinics not included in QHP networks may find that they cannot bill for services.

For these reasons, fuller integration may be something for health centers and family planning clinics to consider. Under the most fully integrated approach, a family planning clinic and a health center could develop a comprehensive affiliation agreement under which the family planning clinic becomes an actual part of the health center, similar to current health centers that have direct Title X funding. This would allow Title X family planning services to be offered along with the broader array of services the health center offers, under the same organizational umbrella. However, because this approach would also merge the family planning clinic into the health center, the Title X family planning clinic would lose its status as an independent organization.

A more limited approach to integration might offer a middle ground that fosters collaboration, provides access to family planning services, and better assures a referral pathway back to the health center. Under this model, access to and continuity of care would be improved without a loss of independent status for the family planning clinic. For example, a health center could contract with a Title X clinic for basic family planning services. Under this type of arrangement, the health center would pay the Title X clinic to deliver family planning services to the health center's patients on behalf of the health center. The services could be provided at either the family planning clinic site or the

health center site. Because the health center would be providing payment to the family planning clinic, the health center would maintain responsibility for the services and monitor their provision; however, the family planning clinic would maintain complete organizational independence. In this model, the health center would essentially include the family planning clinic in its service network, allowing the health center to treat the family planning clinic as part of its service package for managed care participation purposes (as well as for purposes of fulfilling its service-related obligations under Section 330). Similarly, as a contractor to the health center, the family planning clinic could make referrals with ease, since for health center patients who are members of managed care plans or enrolled in QHPs, the clinic would effectively become an in-network provider for any covered services offered by the clinic.

Of course, health centers and family planning clinics can and do make informal referrals. But the scenarios below illustrate more formalized arrangement possibilities, which may also entail a need for the development of more structured legal relationships, not only to address matters of corporate structure, but also to assure full compliance with federal laws governing conditions of participation in both programs as well as those aimed at protecting against fraud and abuse.

Cross Referral: Even where the two entities remain fully independent, a health center could develop an affiliation with the family planning clinic under which the family planning clinic and the health center share joint referral protocols to assure a clear pathway for patients moving in either direction. Under such an arrangement, which could be thought of as a “no wrong door” approach, the two clinics could share a navigation protocol that assures that patients who enter through either “door” receive robust referrals to the other for necessary care. Many clients, especially those new to the health care system, view the family planning clinic as a gateway to the health care system and come to a family planning visit with needs beyond the scope of services Title X clinics provide. They may need treatment for conditions as diverse as bronchitis and eye infections, or they may have issues related to dental health, mental health or substance abuse. Moreover, significant medical concerns are frequently identified in the course of a family planning visit. Family planning clinics regularly screen for sexually transmitted infections (including HIV), breast or cervical cancer or even elevated blood sugar or blood pressure levels. In such instances, the family planning clinic could refer the patient to the health center for additional services the clinic does not provide directly. Similarly, patients receiving services at health centers who need a family planning service or screening available only through the family planning clinic or who express a preference for receiving their care from the family planning clinic could be referred to that site.

Because the patient navigation would involve individuals who are patients of both programs, the two agencies could set up an electronic information exchange for these shared patients that would (with a patient’s permission) facilitate the receipt of additional care. The goal would be to establish a system that would enable a client needing follow-up care to leave the site not just with a name and a phone number of a referral provider but with an actual appointment for follow-up care and with her medical

information having been transmitted to that provider; such a system would also enable the family planning clinic to arrange for that follow-up care to be expedited when necessary. These systems could be similar to the eConsult system already in use in some collaborations established by community health centers⁴⁸ or the eReferral system developed by the University of California San Francisco and San Francisco General Hospital.⁴⁹ This sort of electronic information exchange would also give the family planning clinic access to information on the follow-up care received, so that its records will be complete when the client returns for additional family planning services at a later date.

Contractual Collaboration: A family planning program and a health center could enter into a more fully structured arrangement for clinical integration under which patients of the family planning program become patients of the health center for certain family planning services and patient navigation purposes. Generally, this is accomplished through a “lease of services or capacity,” under which the health center leases capacity from the family planning program to provide certain family planning services to the health center’s patients on behalf of, and under the aegis of, the health center (the “middle ground” option discussed above). Under the lease option, the health center may purchase all or only a portion of the services provided by the family planning clinic, provided that all leased services are available equally to all health center patients in need of such services. To the extent that the health center leases only a portion of the services offered by the family planning clinic, the family planning clinic would continue to provide the balance of its complement of services (such as specialized services) or to serve the balance of its clients on its own behalf – the services would not be under the health center and the patients served would be considered the family planning clinic’s patients.

If the family planning program acts as a provider of health care and case management services to the health center’s patients, and if the affiliation is approved by HRSA as part of the health center’s “scope of project,” then the family planning service would be considered a service of the health center for registered patients of the health center. In this way, both the treatment and the case management services could be billed as an FQHC service for Medicaid, and CHIP purposes, provided that the services purchased/leased from the family planning clinic and the clinic’s site at which the services are furnished are both included within the health center’s scope of project to the extent that the site is providing services to the health center’s patients (rather than to patients of the family planning clinic). Unlike an option under which the family planning clinic merges into the health center, however, the family planning clinic will not lose its status as an independent organization simply by virtue of the health center adding the clinic to its scope for the purposes of the leased services. There is no change in corporate structure – just a series of contracts to establish the arrangement.

⁴⁸ S. Rosenbaum, M. Zakheim, J. Leifer et al., *Assessing and Addressing Legal Barriers to the Clinical Integration of Community Health Centers and Other Community Providers* (New York, New York: Commonwealth Fund, July 2010).

⁴⁹ Chen, L., Kushel, Grumbach, M., and Yee, Jr., H., “A Safety-Net System Gains Efficiencies Through ‘eReferrals’ To Specialists,” *Health Affairs*, 29, no.5 (2010):969-971.

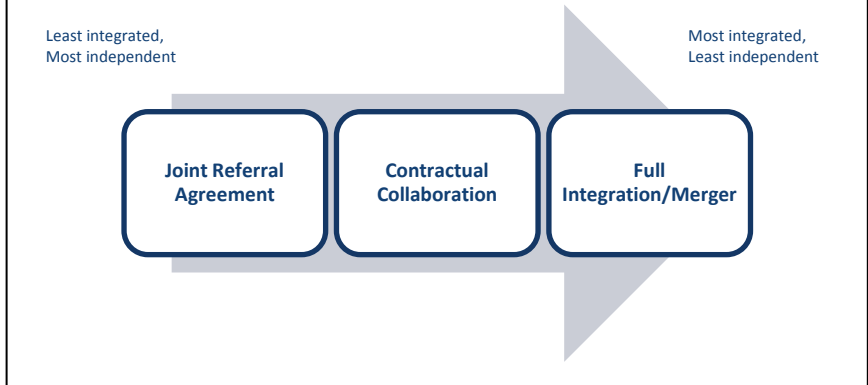
While it is also possible for family planning providers to deliver services directly to health center patients at the health center's sites, such arrangement could raise additional considerations for family planning providers. When a family planning provider delivers services at a health center site, on behalf of the health center, the family planning provider will not be distinguished from other health center staff and will be subject to all of the health center's policies and procedures when providing care (and not just certain clinical protocols and policies). As a result, the Title X or family planning identity of the provider would not be known to health center patients. Further, the patients served at the health center's site could be receiving family planning services from the same facility at which they obtain the rest of their health care, or perhaps where family members or neighbors obtain their care – a situation that may not be preferable to some patients.

On the other hand, a lease arrangement that results in the family planning clinic site being added to the health center's scope of project, would allow health center patients access to a greater complement of family planning services provided by practitioners with specialized family planning expertise that may not have been previously available at the health center. For instance, health center patients seen by the partnering family clinic providers may have access to a greater choice in contraceptive methods—such as IUDs or new methods such as the contraceptive patch or ring—that might not be readily available through the health center itself. Access to specialized complex sexual and reproductive care would also be increased for health center patients.

The arrangement would also assure that health center patients receive all necessary follow-up care, along with non-family planning services (e.g., acute care, dental care, and other preventive services) through the health center. Importantly, as noted above, patients covered by the agreement would be recognized as patients of the health center for purposes of FQHC payment because the Title X clinic would be operating for these patients as a clinical arm of the health center. It is important to note that, because the health center's patients seen at the family planning clinic would be considered "health center patients," generally, billing and collection of revenues for services rendered would be performed by the health center in accordance with its policies. Thus, the sliding fee scale will only apply up to (and including) 200 percent of the FPL, meaning that the family planning provider will have two different scales—one for health center patients and one for family planning patients. However, as noted above, payments for health center patients above 200 percent FPL may be reduced if the health center obtains non-Section 330 related funding to support the costs of care provided to patients who do not otherwise qualify for the health center's sliding fee discounts. Reconciling the differences in the sliding fee scales takes thought and careful planning, but it can be, and has been, done successfully.

If a health center and a family planning program were to establish a lease arrangement, they also could utilize referrals to ensure that patients with specialized reproductive needs or who prefer to obtain care at a family planning clinic have access to Title X services and family planning clients are referred to the health center for primary care and other non-family planning services (such as dental

Figure 3
Possible Collaborations Between Family Planning Clinics and Community Health Centers



and behavioral health services). While there may be instances when the needs of both the health center and the family planning clinic would render a referral arrangement without the lease option as the best choice for collaboration, in many cases adding the family planning site to the health center's scope of project would likely be the most agreeable option for both parties.

To ensure seamless patient care, the two agencies could establish an electronic information exchange that would facilitate the transmission of medical information for shared patients as well as referrals between the two.

Full integration: A family planning program also has the option of merging into the health center. However, if the family planning program were to integrate fully into the health center, the family planning program would be giving up its autonomy and its separate identity. While full integration may be mutually beneficial in certain situations, it is the most comprehensive and permanent arrangement, a step that most organizations likely would not consider when evaluating collaboration options. However, as discussed above, a range of highly effective collaboration options for health centers and family planning clinics allow both organizations to maintain their independent identities while providing great community benefit.

Conclusion

Health centers, family planning clinics and other safety-net providers share the common mission of ensuring access to care for the communities they serve. Similarities in the populations they care for, along with complementary strengths and rich traditions of collaboration make partnerships between community health centers and family planning clinics a natural fit. Further, the demands and strains that the implementation of the Affordable Care Act is likely to put on safety-net providers of all types may make collaboration between these two systems a virtual necessity.

Obtaining contraceptive services represents a major reason that women of reproductive age access the health care system; accessing contraceptive services is often women's first interaction with the healthcare system as teenagers or adults. In many cases, women prefer to obtain these services from specialized family planning providers, perhaps because of concerns over confidentiality, familiarity with the provider, need or desire for extensive counseling, or even the availability of specific contraceptive methods that might not be readily accessible elsewhere. Collaboration between family planning clinics that receive some Title X funding and health centers offers the possibility to leverage the unique strengths of both these systems to ensure that there really is "no wrong door" to the health care system. If a woman enters the system through a family planning clinic that receives Title X funding, a collaboration with a health center could offer the potential of connecting the woman not only to the insurance coverage for which she will be eligible under the Affordable Care Act but also to the full range of medical care she may need; in other words, once a woman enters that door, she would truly be inside the system and able to access the services she needs and for which she is eligible.

Where health centers and family planning clinics choose to partially or fully integrate (rather than develop informal referral arrangements) the family planning clinic effectively could take on an additional role as a site of care for the health center's patients. By the same token, women who are patients of Title X clinics can be referred to health centers, where they could establish a second set of patient relationships in order to receive follow-on treatment as well as care not available through the family planning clinic. In this sense, the health center/family planning relationship could be thought of as evolving along a spectrum, ranging from coordination of services across two independent providers all the way to a formal, federally approved relationship in which the family planning clinic becomes an official care site for health center patients. The potential for these collaborations is significant and should be explored fully.