

DATE: July 22, 1997

97-27

Document Title: Affiliation
Agreements of Community and
Migrant Health Centers

TO: Community Health Centers
Migrant Health Centers
Health Care for the Homeless Grantees
Health Services for Residents of Public Housing Grantees
Federally Qualified Health Center Look-Alikes
Primary Care Associations
Primary Care Offices

The Bureau of Primary Health Care (BPHC) encourages health centers to affiliate with other entities to strengthen their ability to achieve their mission. However, BPHC is concerned that some affiliation agreements may compromise health centers' compliance with requirements, particularly those of section 330 of the Public Health Service (PHS) Act. Failure to comply with these requirements may affect their eligibility for section 330 grants and/or Federally Qualified Health Center (FQHC) status, as well as associated benefits [e.g., malpractice protection through the Federal Tort Claims Act (FTCA), and reduced price pharmaceuticals through the Drug Pricing Program].

The enclosed Policy Information Notice (PIN) provides policy clarification regarding Community and Migrant Health Center (C/MHC) and FQHC Look-Alike affiliations. It is the product of almost two years of work by Federal staff and representatives of health centers during which relevant requirements and expectations were assessed in the context of the current health care environment. I know that some of you have been in a dialogue with the BPHC during the last year regarding proposed affiliations. This dialogue (including the exchange of documentation) has assisted the BPHC in distinguishing the issues

and determining their resolution, and has also helped us to understand what you are facing in your communities. Others have seen this document in draft form during the review and comment process and provided invaluable insights.

There is a precarious balance between the need for compliance with Federal grant-related requirements and the need for the flexibility to integrate the delivery systems in your communities. To be in compliance requires that the C/MHC or FQHC Look-Alike maintain full autonomy over health care, personnel, financial and quality assurance policy direction. The National Association of Community Health Centers (NACHC) has been a constant voice in support of a clear and firm policy that protects health center integrity and autonomy but allows for appropriate flexibility in a highly competitive environment.

Although the policy is slightly more flexible than we initially indicated it would be, the BPHC continues to be concerned about very real threats to health center integrity and/or autonomy that need to be considered before entering into affiliations (e.g., regarding corporate structure, governance, management and finance, and health services delivery). I strongly encourage health centers to consult with Field Office and headquarters staff prior to entering into such affiliation agreements.

Sincerely yours,

Marilyn H. Gaston, M.D.
Assistant Surgeon General
Associate Administrator
Director

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I. INTRODUCTION:

The Bureau of Primary Health Care (BPHC) encourages health centers to affiliate with other entities to strengthen their ability to achieve their mission. However, BPHC is concerned that some affiliation agreements may compromise health centers' compliance with grant requirements, particularly those of section 330 of the Public Health Service (PHS) Act (and implementing rules and program expectations). Failure to comply with these requirements may affect a health center's eligibility for section 330 grants and Federally Qualified Health Center (FQHC) status, as well as associated benefits [e.g., malpractice protection through the Federal Tort Claims Act (FTCA), and reduced price pharmaceuticals through the Drug Pricing Program].

This Policy Information Notice (PIN) serves to:

- 1) inform health centers that BPHC is examining its requirements and expectations regarding affiliations,
- 2) alert health centers to potential threats to their integrity and/or autonomy (e.g., regarding corporate structure, governance, management and finance, health services delivery) that may affect their eligibility for section 330 grants or FQHC Look-Alike status,
- 3) provide policy clarification on affiliations,
- 4) advise health centers that further policy clarification will be issued as additional decisions are made, and
- 5) encourage health centers to consult with BPHC prior to entering into affiliation agreements that may affect their health center's compliance with applicable Federal grant-related requirements pertaining to their integrity and/or autonomy.

BPHC has no intent to "grandfather in" any non-compliant existing affiliation agreement, but we will afford health centers that are not compliant a reasonable opportunity to come into compliance.

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This notice applies to:

1) health centers funded under section 330 of the PHS Act that:

a) serve a population that is medically underserved by providing services for all residents of the catchment area [i.e., "Community Health Centers" (CHCs) funded under section 330(e)], and/or

b) serve a special medically underserved population comprised of migratory and seasonal agricultural workers [i.e., "Migrant Health Centers" (MHCs) funded under section 330(g) for the purpose described in subsection (e)]; and

2) those entities designated as "Look-Alikes" for FQHC purposes by virtue of satisfying the requirements for Community and Migrant Health Centers (C/MHCs).

All other types of FQHCs are beyond the purview of this notice. Further guidance is forthcoming for other section 330 health center programs (i.e., Health Care for the Homeless and Health Services for Residents of Public Housing).

This affiliation policy clarification and BPHC's expectations related to networking, including the development and operation of integrated delivery systems, are complementary. The BPHC recognizes the necessity for health centers to collaborate and coordinate with others in their communities to survive and thrive in the changing health care environment. In some communities, health centers may conclude that it is in the best interest of their organization and the community's medically underserved people to enter into an affiliation which does not permit them to abide by the requirements herein, even though non-compliance will result in loss of their section 330 and/or FQHC status and associated benefits.

II. AFFILIATION AGREEMENTS WHICH POSE RISK:

An affiliation agreement is an agreement that establishes a relationship between a health center and one or more entities.

The subject of this notice is affiliation agreements that affect, or may affect, the health center's compliance with applicable Federal grant-related requirements pertaining to their integrity and/or autonomy. The characteristic of concern to BPHC regarding the affiliation agreements that are the subject of this notice is that a health center's compliance with governance, management or clinical operations requirements is, or may be, diminished by virtue of the powers given to one or more other entities in the proposed affiliation agreement.

The entities with which health centers affiliate include, but are not limited to, other health centers, primary care providers, specialists, hospitals, health and human services agencies, managed care organizations, and management services organizations. Types of formal affiliations include, but are not limited to: contractual arrangements, joint ventures (e.g., partnerships, limited liability corporations, various kinds of networks), and corporate integration (e.g., parent-subsidiary models, acquisitions, mergers).

BPHC is concerned that through some affiliation agreements, centers will be out of compliance with section 330 requirements. That is, they will diminish their substantive section 330 role in carrying out health center activities, merely serve as a conduit to another party for a grant award and/or other benefits (e.g., those of FQHC, FTCA, and the Drug Pricing Program), and/or vest in another party the ultimate authority to oversee and approve key aspects of health center activities. Those affiliation agreements that contain elements which do, or may, pose risks to center integrity or autonomy are the subject of this notice.

III. CONTINUUM OF RISK:

In many instances, centers do not risk loss of integrity or autonomy with potential affiliation agreements. For example, contracts for specific services (e.g., ancillary services and allied health services) generally do not pose such risks (unless, for example, significant management or clinical services will be furnished by another entity). Such affiliation agreements which pose no risk to health center integrity or autonomy, and therefore are not the subject of this PIN, are at one end of the continuum of risk.

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In contrast, considering the threat to health center integrity, BPHC is greatly concerned about health center autonomy in affiliations between health centers and entities that are not subject to the same section 330 grant-related requirements. The basic mission, goals and objectives of the other entities may vary markedly, and their commitment to community-based care for the underserved may be less than that required of health centers. While health center-to-health center affiliation agreements that contain elements which do, or may, pose risks to center integrity or autonomy are included in the subject of this PIN, BPHC is less concerned about threats to health center autonomy when section 330 funded C/MHCs are affiliating with other section 330 funded C/MHCs, given that the requirements are the same and the monitoring processes for section 330 funded C/MHCs provide a greater assurance of compliance. Indeed, it is BPHC's intent to afford flexibility relative to health center autonomy, when section 330 funded C/MHCs are affiliating with other section 330 funded C/MHCs for purposes of cost efficiencies and shared expertise. While the affiliation policy clarification in this PIN stipulates the standard against which all affiliations will be compared, the flexibility for section 330 funded health center-to-health center affiliations will be provided in the form of exceptions to specific policy provisions that are not explicit in law and regulations. For example, C/MHCs may be permitted under certain circumstances to share a finance director. This approach is consistent with the BPHC's expectations regarding networking, as well as with certain conditions and remarks on notices of grant award which encourage health centers to work together and to integrate functions where appropriate.

BPHC is also willing to afford greater flexibility in the form of exceptions to specific policy provisions that are not explicit in law and regulations for affiliations between section 330 funded C/MHCs and organizations controlled by health centers, such as some managed care networks and plans. The term "controlled by health centers" shall, in this document, mean that the health center or health centers in the organization collectively have the authority to appoint a minimum of 51 percent of the organization's board members. In addition:

- (i) In for-profit organizations, the health center(s) in the organization must hold a minimum of 51 percent of the equity in the organization, and have the right to a minimum of 51 percent of any distribution of the profits; and,

(ii) In non-profit organizations, subject to State law and applicable tax laws, the health center(s) in the organization must have a right to a minimum of 51 percent of any distribution of excess revenues. Further, if the non-profit corporation is a membership corporation, the health center(s) must have a minimum of 51 percent of the membership.

IV. BACKGROUND:

The BPHC expects and encourages C/MHCs and FQHC Look-Alikes to affiliate with other entities in ways that will strengthen the health center's ability to achieve its mission of increasing access to primary health care for underserved populations and improving health outcomes, while preserving or enhancing the health center's integrity and autonomy. As a health center considers the value and costs involved in a proposed affiliation, there are several issues to be considered that pertain to health center integrity and autonomy.

Section 330 of the PHS Act authorizes grants to support the operation of C/MHCs. The statute and implementing regulations (42 CFR Part 51c for CHCs and 42 CFR Part 56 for MHCs), as well as applicable grants regulations (45 CFR Part 74 for private, non-profit health centers and 45 CFR Part 92 for public centers), impose certain requirements which are relevant to the interaction of the centers and other entities with which they may affiliate. Furthermore, the "Program Expectations for Community and Migrant Health Centers", dated May 1, 1991, which describe the expectations for operational C/MHCs (including priorities and elements associated with successful programs), and the PHS Grants Policy Statement, dated April 1, 1994, are relevant to affiliation agreements. Some of these documents are available on BPHC's web site at:

<http://www.bphc.hrsa.dhhs.gov>

Some of these documents are also available through the National Clearinghouse for Primary Care Information at:

Suite 600, 8201 Greensboro Drive
McLean, VA 22102
(703) 821-8955, ext. 248

If you need help in obtaining any of these documents, contact the appropriate HRSA Field Office (see the Attachment to this PIN).

The required control over the health center is accomplished through various mechanisms, including but not limited to:

- 1) the corporate structure of the organization which operates a health center,
- 2) the selection process and composition of the governing board,
- 3) the authorities and responsibilities of the governing board, and
- 4) specific management and clinical requirements for health centers.

These requirements ensure that health centers maintain their focus on providing community-based, responsive health care to the medically underserved, including the uninsured and underinsured.

V. CRITICAL INTEGRITY AND AUTONOMY CONSIDERATIONS:

Critical integrity and autonomy considerations identified to date, specific to C/MHCs and FQHC Look-Alikes, are set forth below. BPHC, through its review process, will determine whether or not health centers meet requirements. Further policy clarification related to these and other issues will be stipulated in one or more forthcoming guidance documents as decisions are made.

A. Corporate Structure

Health centers considering affiliation agreements should examine the proposed affiliation to assure that their corporate structure remains in compliance with all section 330 requirements.

This notice serves as an alert that BPHC, in reviewing affiliation agreements, will evaluate corporate structure, paying particular attention to corporate integration, i.e., structural relationships between the health center and any other entity or entities. Corporate integration involves a change in the

corporate structure and identity of one or both of the parties to the affiliation. The BPHC is particularly (but not exclusively) concerned about the "parent-sub subsidiary model" of corporate integration in which the health center becomes a subsidiary of another corporation. "Sole corporate member" refers to a single entity (i.e., an organization, such as a hospital, or an individual) which is the only "member" of a corporation, having certain powers and authorities which could supersede those of the corporation's board (e.g., a hospital is a sole member of the health center corporation, having certain powers and authorities which can supersede those of the health center board). When the parent-sub subsidiary model (most particularly the sole corporate member approach) is used, specific authorities, that are required under section 330 of the PHS Act to be vested in the health center board, are reserved (by State law in a number of States) to the affiliate parent. Examples include selection and removal of board members, selection and removal of the chief executive officer, and approval of plans and budgets.

Policy Clarification: No sole corporate member or any other parent-sub subsidiary approach to corporate integration, or any approach with a different name that appears to be structurally similar, will be deemed to have met all statutory and regulatory requirements unless there is no violation of any aspect of the affiliation policy clarification. Based on our understanding of State law we believe that few, if any, sole corporate member approaches to integration will be able to comply with the applicable requirements described herein. Therefore, the onus is on the grantee or applicant, to a greater extent than with other affiliation approaches, to demonstrate in its documentation the acceptability of the approach. The Bureau may require the grantee or applicant to provide legal and/or management analyses.

B. Governance

In light of governance requirements specified in the law and regulations, health centers considering an affiliation agreement should examine the proposed affiliation to assure that their governing boards will remain in compliance with all relevant governance provisions. To maintain compliance with requirements, the health center board must, in general:

- 1) be composed of at least 9 but not more than 25 individuals, a majority of whom are being served by the

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center and who, as a group, represent the individuals being served by the center in terms of demographic factors such as race, ethnicity and sex,

2) have less than one-quarter of the board members be individuals who derive more than 10 percent of their annual income from the health care industry,

3) be representative of the community in which the service area is located and have appropriate expertise in community affairs, local government, finance and banking, legal affairs, trade unions, and other commercial and industrial concerns, or social service agencies within the community,

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4) not have an employee of the center (or spouse or child, parent, brother or sister by blood or marriage of such an employee) on the board,

5) retain, and not be restricted in, its prescribed authorities, functions and responsibilities, such as: meeting at least once a month, selecting the services to be provided by the center, scheduling the hours during which such services will be provided, approving the center's annual budget, approving the selection and dismissal of a director for the center, adopting health care policies, evaluating center activities, assuring that the center is operated in compliance with applicable laws and regulations, and, except in the case of a governing board of a public center, establishing general policies for the center), and

6) be chosen through a selection process, subject to the approval of BPHC, which is prescribed in the by-laws of the center.

This notice serves as an alert that BPHC, in reviewing affiliation agreements, will evaluate:

- 1) the composition and expertise of the health center board,
- 2) any authorities, functions or responsibilities relative to the health center that are delegated to one or more entities from outside the health center, and
- 3) authority to select or remove any health center governing board members by one or more entities from outside the health center.

Policy Clarification:

1. Composition of the Governing Board: In assessing the representativeness of the board relative to the community in general and the individuals served/to be served in particular, BPHC will determine whether or not the board meets the composition requirements stipulated in the health center authorizing legislation and regulations. In addition to the board as a whole,

BPHC is concerned about the composition of the Executive Committee (i.e., the officers of the board and chairpersons of the committees) since it typically has authority to act on behalf of the full board. The extent to which board members or other individuals selected by or representing any outside entity can fill leadership positions is expected to be limited. Specifically, the standard is that:

- a) the Chairman of the Board may not be selected by any other entity, and
- b) no other entity may select a majority of the members of the Executive Committee.

2. Authorities, Functions, or Responsibilities given to Others: Relative to any authority, function or responsibility which the law or regulations explicitly require of the health center board:

- a) no other entity may have an overriding approval authority,
- b) there can be no requirement for a majority of the affiliating entity's board to also exercise approval (i.e., a "dual majority" requirement), and
- c) no other entity may have veto power, including "super-majority" provisions which give another entity an effective veto power.

3. Method of Selection of Board Members: No other entity or entities may select a majority of the health center board members. In addition, it is not acceptable for any other entity or entities to select a majority of the non-user members. The only health center board members who can be removed by an outside entity are those permitted to be selected by the entity. Furthermore, no other entity or entities will be permitted to preclude the selection of, or require the dismissal of, health center board members who are not "endorsed" by that entity or those entities.

C. Management and Finance

In light of the management and finance requirements specified in

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the law and regulations, health centers considering an affiliation agreement should examine the proposed affiliation to assure that the governing board in particular and the health center in general will remain in compliance with all relevant management and finance provisions.

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This notice serves as an alert that BPHC, in reviewing affiliation agreements, will evaluate:

- 1) the role of the governing board, center staff, and any entity or entities from outside the health center, in determining the overall plan and budget for the center;
- 2) employment arrangements of key management staff of the health center, including the executive director, finance director and medical director;
- 3) role of the health center's governing board relative to personnel policies and procedures of the health center;
- 4) role of the health center's governing board relative to financial management of the health center;
- 5) role of the health center's governing board in evaluating center activities; and
- 6) the systems used by the health center for information, cost accounting, reporting and monitoring.

Policy Clarification:

1. Strategic and Operational Planning: The overall plan must be prepared under the direction of the health center governing board, and health center administrative and medical staff must be involved.
2. Budget Preparation and Approval: The budget must be prepared under the direction of the health center governing board, and health center administrative and medical staff must be involved.
3. Selection of Key Management Staff:
 - a) Executive Director: By law, the health center must select and directly employ an Executive Director (i.e., Chief Executive Officer). In some health centers, this position may be combined with that of Finance

Director or Medical Director. No other entity can have the authority to select or dismiss the Executive Director. The individual who fills the Executive Director position is expected to work full-time for the health center.

b) Finance Director: The BPHC recommends that the health center select and directly employ a Finance Director, and no other entity should have the authority to select or dismiss the Finance Director. In some health centers, this position may be combined with that of Executive Director.

c) Medical Director: The BPHC recommends that the health center select and directly employ a Medical Director, and no other entity should have the authority to select or dismiss the Medical Director. In some health centers, this position may be combined with that of Executive Director.

Temporary deviations from the above policy clarification regarding key management staff may be addressed, at the discretion of BPHC, within its authority under section 330(e)(1)(B) to make grants for a period not to exceed 2 years for entities that fail to meet certain requirements. In such cases, the BPHC may authorize a health center to have a "management services contract," preferably for not more than one budget period, for the provision of certain staff services.

4. Personnel Policies and Procedures: The establishment of personnel policies and procedures must remain under the control of the health center board. The exception, by law, is the governing board of a public center (i.e., a public entity is the grantee) with a co-applicant governing board that meets all health center board requirements except that it does not establish general policies for the center. Note: Co-applicant health center boards are only permitted in

the case of public centers.

5. Financial Management: The adoption of policy for financial management practices must remain under the control of the health center board. The exception, by law, is the governing board of a public center (i.e., a public entity is the grantee) with a co-applicant governing board that meets all health center board requirements except that it does not establish general policies for the center. Note: Co-applicant health center boards are only permitted in the case of public centers.

D. Health Services

In light of the health services requirements specified in the law and regulations, centers considering affiliation agreements should examine the proposed affiliation to assure that the governing board in particular and the health center in general will remain in compliance with all relevant health services provisions.

This notice serves as an alert that BPHC, in reviewing affiliation agreements, will evaluate:

- 1) commitment to the medically underserved population(s) that are the basis for the grant or FQHC Look-Alike status;
- 2) the impact of the affiliation on availability, accessibility, continuity, and acceptability of health center services;
- 3) any limitations by an outside entity or entities on health center relationships (i.e., any limitations on other health center affiliation agreements); and
- 4) role of the health center's governing board relative to health care policies and procedures of the health center.

Policy Clarification:

1. Commitment to the Medically Underserved Population(s): The health center must be focused on the mission of providing care to the medically underserved.

2. Impact on Availability, Accessibility, Continuity and Acceptability of Services: For services to be available in a manner which assures continuity, the BPHC recommends that the health center directly employ a core staff of full-time primary care providers (i.e., in general, a majority of the health center providers).

3. Limitations on Health Center Relationships: By law, the health center must make reasonable efforts to establish and maintain collaborative relationships with other health providers in the service area. Furthermore, to the extent possible, center activities must be coordinated and integrated with the activities of other federally funded, as well as State and local, health services delivery projects and programs serving the same population. No other entity or entities should dictate, preclude or otherwise control health center relationships with other entities (i.e., affiliation agreements), except when the control delegated to the entity or entities is so limited that it does not preclude, or have the potential to preclude, the health center from complying with the statutory and regulatory provisions regarding health center relationships.

4. Health Care Policies and Procedures: An affiliation agreement will be considered unacceptable if it precludes the health center board from exercising its authority and fulfilling its responsibilities relative to evaluating service utilization patterns, productivity of the center, patient satisfaction, achievement of center objectives, development of a patient grievance process, and adopting health care policies which include scope and availability of services, location and hours of services, and quality of care audit procedures.

E. Considerations Beyond BPHC'S Purview

Centers are encouraged to seek legal advice from their own counsel in order to assure that organizational documents and contractual agreements accurately reflect the parties' affiliation objectives. In addition, legal advice about the proposed affiliation should be sought in the following areas:

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1. anti-kickback statutes, commonly referred to as the fraud and abuse provisions,
2. antitrust,
3. tax-exempt status of the health center,
4. Medicaid and Medicare reimbursement issues, and
5. State law.

Although it is beyond the scope of this notice to provide authoritative guidance on this topic, it is important that centers consider the provisions of the Medicare and Medicaid anti-kickback statute [42 U.S.C. 1320a-7b(b)]. This statute makes it a felony for a person or entity to knowingly and willfully offer, pay, solicit, or receive remuneration with the intent to induce a referral, or in return for a referral, under Medicare or a State health care program. Applicable State health care programs are Medicaid, the Maternal and Child Health Block Grant program, and the Social Services Block Grant program. Apart from the criminal penalties, a person or entity is also subject to exclusion from participation in the Medicare and State health care programs for a knowing and willful violation of the statute pursuant to 42 U.S.C. 1320a-7(b)(7).

The anti-kickback statute is very broad. Prohibited conduct covers not only remuneration intended to induce referrals of patients, but also remuneration intended to induce the purchasing, leasing, ordering, or arranging for any good, facility, service, or item paid for by Medicare or a State health care program. Illegal remuneration may be furnished directly or indirectly, overtly or covertly, in cash or in kind, and covers situations where there is no payment at all, but merely a discount or other reduction in price or the offering of free goods.

Under the authority in 42 U.S.C. 1320a-7b(b)(3), the Secretary of HHS has published regulations setting forth certain exceptions to the anti-kickback statute, commonly referred to as "safe harbors". These regulations are codified at 42 CFR 1001.952. Each of the safe harbors sets forth various requirements which must be met in order for a person or entity to be immune from

prosecution or exclusion for violation of the anti-kickback statute.

Centers are encouraged to seek legal advice from their own counsel about the implications of any proposed affiliation agreement under the fraud and abuse statutes, and in particular, under the anti-kickback provisions described above.

Centers are also encouraged to seek business advice from their own experts. In addition to providing financial advice, business experts can provide advice on such matters as permitting access to financial statements and/or to the books and records of the health center. In general, BPHC cautions health centers about permitting others to have access to such information. BPHC is especially concerned when access is permitted without confidentiality protections.

VI. BPHC REVIEW

The BPHC process for reviewing actual or proposed affiliation agreements is now and will continue to be overseen by headquarters staff in the BPHC, Division of Community and Migrant Health. The review process is currently being further refined, including work to incorporate affiliation reviews and documentation as appropriate into BPHC's standard documents and procedures (such as, Program Expectations, Pre-Application Guidance Letters; Single Grant Application; Regional Review Summary; Primary Care Effectiveness Review; and, Prevention, Problem Identification and Resolution).

These affiliation reviews can be characterized as BPHC compliance reviews for C/MHCs and FQHC Look-Alikes. The focus of these reviews is on Federal statutory and regulatory requirements and program expectations as clarified by this PIN. Whether the proposed affiliation is a sound business decision may be addressed to a limited extent, but centers should not rely solely on these reviews in that regard. Compliance with fraud and abuse requirements, antitrust, tax-exempt status, Medicaid and Medicare requirements, and State law is beyond the scope of assistance being offered under this notice. Thus, this review will not obviate the need for review by appropriate experts, including the center's own legal counsel and financial advisors.

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As the policy has been evolving, all potentially new FQHCs have been assessed based on our interpretation of the applicable requirements (i.e., FQHC Look-Alikes as well as applicants in head-to-head competition). In addition, we are currently preparing to assess the affiliation agreements of new start applicants and the affiliation agreements pertaining to proposed Integrated Delivery System Development Initiative projects. Now that the policy clarification is issued in writing, the affiliation agreements of all FQHCs (including both new and existing C/MHCs and FQHCs) must be in compliance and are subject to HRSA review for compliance at any time.

FQHCs will have a limited period to come into compliance with affiliation requirements. In accordance with section 330(e)(1)(B) of the Act, HRSA has the discretion to fund an entity which does not meet requirements for up to 2 years. Nonetheless, FQHCs are advised that BPHC is not inclined to exercise that authority if the affiliation agreement was made after the policy clarification was issued or if the FQHC was in violation of the policy clarification when it was issued and has chosen not to consult with BPHC about efforts to come into compliance.

Centers considering entering into affiliation agreements that may affect their compliance with Federal grant-related requirements should contact the appropriate Health Resources and Services Administration (HRSA) Field Office (see the list attached to this PIN) to initiate consultation, including discussion and review of all relevant documents, i.e., any document in which the terms of the relationship between the health center and the affiliate are stipulated, as early in the center's decision-making process as feasible. The relevant documents may include, but are not limited to, the proposed affiliation agreement, articles of incorporation of the center, by-laws of the center, management services agreement, successor-in-interest agreement, credit agreement, Memorandum of Agreement, Memorandum of Understanding, and/or other contract such as a lease. Headquarters staff in the Division of Community and Migrant Health will oversee review of the proposed affiliations and be responsible for ensuring consistency in the responses. The BPHC is aware of the need for timeliness of these reviews, and is enhancing its capacity to expedite the reviews.

In response to a request for review of a proposed affiliation,

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the BPHC will provide the health center with definitive guidance, to the extent that policy interpretations have already been made. The health center may also be advised of concerns regarding certain provisions relative to which we are considering issuing additional policy clarification or which we do not think are in the best interest of the health center.

Although the health center will be permitted to proceed with caution, if future policy clarification renders any provision unacceptable, BPHC has no intent to "grandfather in" any non-compliant affiliation agreement. However, a reasonable opportunity to come into compliance would be afforded.

VII. INFORMATION CONTACT

For further information contact:

Judy Rodgers or Jeanellen Kallevang
Division of Community and Migrant Health
Bureau of Primary Health Care
Health Resources and Services Administration
4350 East West Highway
Bethesda, Maryland 20814
Phone: (301) 594-4315 or 4300

Appendix: HRSA Field Office Contacts

Field Office I: Bruce Riegel, Acting Director
Division of Health Services Delivery
DHHS - Field Office I
Rm 1826, JFK Federal Building #1401
Boston, MA 02203

Field Office II: Ron Moss, Director
Division of Health Services Delivery
DHHS - Field Office II
Rm 3337, 26 Federal Plaza
New York, NY 10278

Field Office III: Bruce Riegel, Director
Division of Health Services Delivery
DHHS - Field Office III
Rm 10200, MS 14, 3535 Market Street
Philadelphia, PA 19104

Field Office IV: Marlene Lockwood, Director
Division of Health Services Delivery
DHHS - Field Office IV
101 Marietta Tower
Atlanta, GA 30323

Field Office V: Martin Bree, Acting Director
Division of Health Services Delivery
DHHS - Field Office V
105 West Adams Street
17th Floor
Chicago, IL 60603

Field Office VI: Frank Cantu, Director
Division of Health Services Delivery
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Rm 1800, 1200 Main Tower Bldg
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Field Office VII: Hollis Hensley, Acting Director
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DHHS - Field Office VII
Federal Office Building
601 East 12th Street
Kansas City, MO 64106

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