
E000909

Area Designation Requirements

I. Introduction

The National Health Planning and Resoruces Development Act of 1974 (P.L. 93-_____) sets forth certain requirements with respect to health service area designations. Within those requirements, Governors have considerable latitude and discretion in designating health service areas.

The purpose of this document (section) is to elaborate upon the explicit legislative requirements, especially those that are of a rather general as opposed to quite specific nature. Since Governors may request that the specific requirements with respect to (1) minimum population and/or (2) ~~XMSXX~~ Standard Metropolitan Service Areas be waived, it also enumerates the principal criteria or factors that will be employed by Federal officials in reviewing and acting upon waiver requests.

There is an a priori assumption for approving proposed health service area designations that meet the two most specific requirements relating to population and SMSAs (see Part II, items A & B) unless there is substantial evidence that the area proposed is an illogical or unworkable one and/or very significant opposition to it from within the proposed area itself and provider, consumer, and other groups in the State. Furthermore, the Act clearly provides that any area presently served by a Federally-funding areawide CHP agency which otherwise meets the legislatively mandated requirements must be approved unless a Governor finds that another area is more appropriate for effective health planning and resource development.

Any HEW Regional Office recommendation of non-approval of a proposed area that ostensibly meets the specific population and SMSA requirements, will be subject to review, and concurrence or override, by an ad hoc area designation review panel consisting of both regional office and headquarters program officials. Similarly, any requested waivers of the minimum population and/or SMSA requirements, also will be subject to the review of this panel in order to insure that the waiver criteria or factors are applied in a consistent and equitable manner.

II. REQUIREMENTS AND ELABORATION

Requirements	Elaboration
A. The area, upon its establishment, shall have a population of not less than 500,000 or more than 3,000,000, except that - 1. It may exceed 3,000,000 if the area includes an SMSA with a population of more than 3,000,000. 2. It may be less than 500,000 if the area encompasses an entire State with a population of less than 500,000.	This specific minimum-maximum population requirement was adopted from the House bill (H.R. 16204) by the Conferees. With respect to it, the House Committee Report stated that "The 500,000 people minimum reflects the experience that effective health planning can be conducted only with an adequate base of population and health resources to sustain a planning process." While waivers to the minimum 500,000 population requirement may be allowed, the Committee did not intend that "waivers in either 'unusual' or 'highly unusual' circumstances be used frequently." (See Part III for discussion of "Waivers" specifically. In that connection it should be noted that a request to establish a single, Statewide health service area in a State with a population of less than 500,000 does <u>not</u> constitute a waiver request, nor does an area encompassing an SMSA with a population in excess of 3 million.) Population for purposes of area designation is defined as being the 1973 Population Estimates prepared by the Bureau of Census which are available for all States and counties nationally.
B. Each standard metropolitan statistical area shall be entirely within the boundaries of one health service area, except that if the Governor of each State in which a standard metropolitan statistical area is located determines, with the approval of the Secretary, that in order to meet the other requirements of this subsection a health service area should contain only part of the standard metropolitan statistical area, then such statistical area shall not be required to be entirely within the boundaries of such health service area.	The House Committee Report states that "While health service areas should generally be larger than standard metropolitan statistical areas, the Committee has recognized SMSAs as useful delineations of our major metropolitan areas and feels very strongly that health service areas should not divide the SMSAs. Since SMSAs often cross State boundaries because metropolitan areas often do, the Committee intends that where a major metropolitan area straddles a State boundary its health service area will also cross the State boundary. While provision is made for waiving this requirement with the approval of the Secretary, it is anticipated that the waiver will be granted rarely . . . " (See Part III for discussion of "Waivers" specifically.)

Requirements

C. The area shall be a geographic region appropriate for the effective planning and development of health services, determined on the basis of factors including population and the availability of resources to provide all necessary health services for residents of the area.

Elaboration

A number of factors or considerations are relevant to this general requirement. They include:

1. Geographic barriers or natural isolation.

2. Major transportation arteries.

3. Economic trade areas. (The most authoritative definition of ETAs is that of the Department of Commerce.)

4. SMSA boundaries per B above.

5. State boundaries and those of local political subdivisions. Many funding and other decisions of State and local general-purpose governments are highly relevant to health planning, resource development, and regulatory activities. Moreover, such governments frequently provide services and operate facilities as well as paying for care.

6. Health services utilization and referral patterns.

7. Availability of data. Many kinds of data relevant for health planning and decision-making are not disaggregated below the county level.

8. Special population characteristics that have a distinct areal dimension (e.g., reservation-dwelling Indians, preponderance of Spanish-speaking people in parts of certain Southwestern States).

The area should, moreover, have sufficient health facilities, manpower, and other resources needed to satisfy its population's primary care (e.g., pediatrics, optemetry, ob/gyn, outpatient mental health, diagnostic radiology, dentistry) and secondary care needs, those which require a certain degree of specialized services that are provided mainly by community hospitals (e.g., pathology, general surgery, emergency, dermatology). It is desirable but not required in all instances that highly specialized tertiary care services (e.g., burn care, cardiac surgery, kidney [illegible]) be available within the area itself.

Requirements	Elaboration
D. The boundaries of a health service area shall be established so that, in the planning and development of services to be offered within it, any economic or geographic barriers to the receipt of such services in nonmetropolitan (or rural) areas is taken into account. They shall be established so as to recognize the differences in health planning and health services development needs between non-metropolitan and metropolitan areas.	This has the effect of moderating the requirements with respect to the availability of resources within the area (C above), including a center for the provision of highly specialized services (E below), where the area proposed is essentially nonmetropolitan (or rural) in character and population.
E. To the extent practicable, it shall include at least one center for the provision of highly specialized services. (Underscoring supplied.)	The House Committee Report noted that this requirement "reflects the desire that the health service areas provide a self-contained, comprehensive and complete range of health services such that an individual residing in the area would rarely if ever have to leave it in order to obtain needed medical care. The presence of a medical school, university health science center, and/or affiliated teaching or other major hospital(s) offering specialized services for patients with cancer, heart disease, kidney disease, and stroke, accident victims, premature births, and the like, generally would be considered to satisfy this requirement, would in effect constitute a surrogate measure. It is not required, however, that each area necessarily have available all of the highly specialized and most sophisticated services (e.g., kidney transplantation, open-heart surgery) or facilities (e.g., burn and trauma centers). Moreover, it is recognized that some areas will not include a medical school and/or major teaching hospital. The following are among the considerations or factors to be taken into account in those instances. 1. The number and range of residency programs offered by the hospitals in the area.

Requirements

F. To the maximum extent practicable, the boundaries of the area should be appropriately coordinated with boundaries of areas designated for -

1. Professional Standards Review Organizations

2. Existing regional planning areas, and

3. State planning and administrative areas.

(Underscoring supplied.)

Elaboration

2. The distances separating, the wide dispersion of major medical centers and/or other highly specialized facilities. If these are great (e.g., 100-200 miles), requiring considerable travel time and cost, this would be a mitigating factor.

3. The existence of long-standing, well-established referral patterns or formalized linkages with one or more major medical centers outside the area.

The House Committee Report recognized "that the boundaries of areas defined for different purposes cannot all be identical, the criteria for designation of health service areas do not require that their boundaries be identical with those for PSRO areas, regional planning areas, or State planning and administrative areas.

In order to insure close coordination between the health service areas and local Health Systems Agencies being established by this legislation and other State, regional, and local health and health-related planning and administrative areas and agencies, it is important that insofar as possible the former -

1. Be congruent with one or several State planning and development districts as defined for A-95 purposes.

2. In the case of the PSROs (a) either a single health service area encompass one or more PSRO areas in their entirety, or (b) that several health service areas collectively encompass a single PSRO area.

3. Not divide locally established, functioning, and recognized COG areas.

4. Follow the boundaries of local political subdivisions of general-purpose governments (e.g., counties, incorporated cities, parishes in Louisiana, townships in New England).

Requirements

5. Each State's Governor shall in the development of boundaries for health service areas consult with and solicit the views of -

   1. the chief executive officer or agency of the political subdivisions within the State,

   2. The State CHP agency,

   3. Each areawide CHP agency, and

   4. Each RMP established in the State.

Elaboration

Consultations with chief executive officers of political subdivisions should as a minimum include:

1. The chief elected officials (e.g., mayor, chairman of county board of supervisors), or their representatives of the principal and more populous cities and counties in the State.

2. Representatives of State associations of counties, municipal officials, and the like.

Consultation with State and areawide CHP agencies and RMP shall include each Federally-funded CHP and RMP serving all or a portion of the State.

In addition to the mandatory consultation prescribed above, it would be highly desirable for Governors, or their representatives, to consult with other agencies, groups, and organizations in their States, including:

1. Various State health and related agencies (e.g., health and mental health departments, Hill-Burton agencies, vocational, rehabilitation agencies).

2. PSROs.

3. Major health provider groups (e.g., State medical society, hospital association).

4. Any EHSDS site(s) within the State.

5. Voluntary health organizations (e.g., State heart association, mental retardation chapter).

6. Appropriate consumer or public interest groups.

While the form or method of consultation will be left to the discretion of Governors, States are encouraged to hold some public forums, hearings, and meetings. Other acceptable forms of consultation include:

Elaboration

1. Written or oral statements or positions by agencies or their representatives.

2. Meetings with agency representatives, individually or severally, for the specific purpose of obtaining their views.

3. Formal resolutions by legislative bodies or position statements by the chief elected officials.

It is particularly desirable that consultation be sought, the views, reactions, and comments of groups, interests, and comments of groups, interests, and organizations be obtained to the tentative proposed designations prior to their submission as well as in their preliminary development.

III. WAIVERS

Waiver requests will be subject to particularly careful scrutiny and searching review by a small ad hoc review panel composed of both Federal regional office and headquarters officials. Approval (or denial) of waiver requests will be made by the Administrator of HRA based upon the review and recommendations of that panel.

A. Population:

Waiver requests proposing health service areas of less than 500,000 or 200,000 population will be reviewed and assessed against the following criteria or factors.

1. Rate of population growth in recent years.
2. Low population density over a large area.
3. Geographic barriers or natural isolation (See II-C 1 above.)
4. Extent to which it is largely a nonmetropolitan (or rural) area. (See II-D above.)
5. The adequacy of its health facilities, manpower, resources, and services to the needs of the area. (See II-C above.)
6. Health services utilization and referral patterns within the area. (See II-C 6 above)
7. Special population characteristics (See II-C 8 above.)
8. Demonstrated ability or reasonable evidence thereof that it will be able to obtain sufficient matching and/or other funds to support a minimum professional staff of five (5), that guaranteed Federal grant (i.e., 50¢ per capita) and other funds will equal or exceed $200,000 annually.

B. SMSAs:

The following are among the criteria or factors against which waiver requests that would divide an SMSA will be assessed:

1. In the case of inter-State SMSAs, degree to which its population overwhelmingly (e.g., 80% or more) in one State.
2. Also in the case of inter-State SMSAs, whether a single, Statewide health service area is proposed by one or more of the States affected.
3. Extent of cooperation (or non-cooperation) in other endeavors or efforts in recent years (e.g., metropolitan airport or transit authority, joint emergency medical services planning.)
4. Extent to which they are coterminous with existing PSRO areas and State planning and development districts.
5. Extent to which they are coterminous with existing areawide CHP and other health planning areas.
6. Degree of acceptability to local elected officials, health providers, consumer groups, and others in the area proposed.