E000922

Area Designation Requirements

I. GENERAL

The legislation mandates a limited number of general and specific requirements with respect to health service area designations. Within those Governors (as opposed to Federal officials) have great latitude and discretion in designating areas.

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 C & E) and the process requirement with respect to consultation (Part II, item F) unless there is considerable evidence that the area proposed is an illogical or unworkable one and/or very substantial opposition to it from within the area itself and provider, consumer, and other groups in the State.

Therefore any 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 the joint regional office-headquarters review panel.

Similarly, any requested waivers of the minimum population and/or SMSA requirements, also will be subject to the review of this panel. The severity of that panel's review and actions in that regard will in significant measure be a function of the number of waivers requested, since the "ideal" sought is approximately 200 health services areas.

Requirements	Elaboration
	9. Existing CHP, EHSDS, and RMP areas (or boundaries). While the "logic" of these existing health planning areas is hardly overwhelming in all instances, many do reflect or have demonstrated that they are highly suitable planning areas.
	10. 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).
B. To the extent practicable, it shall include at least one center for the provision of highly specialized services.	The House Committee Report notes 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 major 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.
	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 or more), this certainly would be a mitigating factor.

Requirements	Elaboration
	3. The existence of long-standing, well-established referral patterns or formalized linkages with one or more major medical centers outside the area (e.g., Bingham Associates program between Tufts and many Maine hospitals, the University of Iowa's Medical Center Statewide "network".)
C. 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.	The House Committee Report states 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.) Population for purposes of area designation is defined as being the most recent Current Population Estimate prepared by the Bureau of the Census which is available for all States.
D. To the maximum extent practicable, the boundaries of the area should be appropriately coordinated with boundaries of areas designated...for -	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 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 areas -

I. ELABORATION OF SPECIFIC REQUIREMENTS

Requirements	Elaboration
A. The area should be	A number of more specific factors or considerations are relevant to this multi-faceted, general requirement. They include:
1. A rational geographic region	1. Geographic barriers or isolation (e.g., Rocky Mountains which separate eastern and western Colorado, panhandle of Alaska, upper peninsula of Michigan).
2. Within which there are available a comprehensive range of health services,	2. Transportation arteries (e.g., the principal road and railroad networks in the Dakotas and Montana run essentially east-west rather than north-south).
3. And which is of a character suitable for the effective planning and development of health services.	3. Economic trade areas. (The most authoritative definition of ETAs is that of the Department of Commerce.)
	4. SMSA boundaries. (There is of course a separate and distinct SMSA requirement; see item E below.)
	5. State boundaries and those of local political subdivisions. (Also see item D below.) 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 facilities, manpower, resources, and services available in the area. (There is of course a separate and distinct requirement in this regard; see item B below.)
	7. Health services utilization and referral patterns.
	8. Availability of data. Many kinds of data relevant for health planning and decision-making are not disaggregated below the county level.

Requirements	Elaboration
1. Professional Standards Review Organizations	1. In the case of the PSROs a. either a single health service area encompass one or more PSRO areas in their entirety, b. or that several health service areas collectively encompass a single PSRO area.
2. Existing regional planning areas, and	2. Be approximately congruent with one or several State planning and development districts as defined for A-95 purposes.
3. State planning and administrative areas.	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).
E. 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, perhaps in such situations as the Norfolk, Va., SMSA which includes one county in northeast North Carolina." (See Part III for discussion of "Waivers" specifically.)
F. Each State's Governor shall in the development of boundaries for health service areas consult with and solicit the views of	Consultations with chief executive officers of political subdivisions shall as a minimum include:

Requirements

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

1. The chief elected official (e.g., mayor, chairman of county board of supervisors) or his or her representative, of each incorporated city, county, or similar local political subdivision with 50,000 or more population.
2. Elected officials broadly representative of all counties and incorporated places with less than 50,000 population.

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, vocational, rehabilitation agencies).
2. Any EHSDS site(s) within the State.
3. Major health provider groups (e.g., State medical society, hospital association).
4. PSROs.
5. Voluntary health organizations (e.g., State heart association, mental retardation chapter).
6. Appropriate consumer groups.

The form or method of consultation will be left to the discretion of the Governors, but must be requested in writing. It may include:

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

Requirements	Elaboration
	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 chief elected officials.
	4. Public hearings.
	5. A combination of these.

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. Approvals (or denial) of waiver requests will be made by the Administrator of HRA based upon the review and recommendations of that panel.

A. Population

Set forth below are the factors that will be looked at particularly as regards waiver requests proposing health service areas of less than 500,000 or 200,000 population. Since all waiver requests will be carefully scrutinized, it is important that hard data and information be supplied relating to the factor(s) used to justify waivers.

1. Rate of population growth in recent years.
2. How population density (e.g., 10-20 persons per square mile) over a large area (e.g., 100,000 square miles or more).
3. Geographic barriers or isolation; A.1 above.
4. Availability of health facilities, manpower, resources, and services; A.6 and B above.
5. Health services utilization and referral patterns; A.7 above.
6. Self-contained economic trade area.
7. Special population characteristics; A10 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 factors that will be looked at particularly as regards waiver requests proposing health service areas that would divide an SMSA:

1. In the case of inter-State SMSAs, degree to which its population is overwhelmingly (e.g., 80% or more) in one State.
2. Also in the case of inter-State SMSAs, extent of cooperation (or non-cooperation) in other endeavors or efforts in recent years.
3. In the case of intra-State SMSA, extent to which they are coterminous with existing PSRO areas and State planning and development districts.
4. Extent to which they are coterminous with existing areawide CHP and other health planning areas.
5. Degree of acceptability to local elected officials, health providers, consumer groups, and others in the area proposed.