
E000904

AREA DESIGNATION GUIDELINES

The National Health Planning and Resources Development Act of 1974 provides for the designation of health service areas which cover the entire country (the 50 States, Puerto Rico, and the District of Columbia). Section 1511(b) of the Act gives the authority for the designation of health service areas to State Governors. The Secretary of HEW, however, may intervene and designate areas, but only if (1) the requirements in Section 1511(a) of the Act are not met; (2) a Governor requests a waiver of one of the requirements where exceptions are expressly permitted by the Act; or (3) a Governor fails to include all or part of his State in any designated health service area.

The purpose of these Guidelines is to provide Governors, their designees, and others with (1) an elaboration of the legislative requirements; (2) the format and instructions for submission of proposed health service area designations; and (3) a brief description of the procedures to be followed at the Federal level in reviewing and approving their proposed designations.

I. Area Designation Requirements

The requirements with respect to the designation of health service areas by Governors are set forth in Section 1511(a) of the Act. Within those requirements, Governors have considerable latitude and discretion in designating health service areas.

This Section elaborates 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) Standard Metropolitan Service Areas be waived, it also enumerates the principal criteria 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 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, Section 1511(c) of the Act clearly provides that any area presently served by a Federally-funding areawide CHP agency which otherwise meets the 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 Federal 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.

A. Requirements & Elaboration

- *The area, upon its establishment, shall have a population of not less than five hundred thousand or more than three million; except that--*

  (A) the population of an area may be more than three million if the area includes a standard metropolitan statistical area (as determined by the Office of Management and Budget) with a population of more than three million, and

(B) *the population of an area may--*

(i) be less than five hundred thousand if the area comprises an entire State which has a population of less than five hundred thousand, or

(ii) be less than--

(I) five hundred thousand (but not less than two hundred thousand) in unusual circumstances (as determined by the Secretary), or

(II) two hundred thousand in highly unusual circumstances (as determined by the Secretary), if the Governor of each State in which the area is located determines, with the approval of the Secretary, that the area meets the other requirements of this subsection.

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 I.B 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 not 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.

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 when 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 I.B for discussion of "Waivers" specifically.)

- *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.*

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.

4. SMSA boundaries.

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, optometry, 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 transplantation) be available <u>within</u> the area itself.

> *The boundaries of a health service area shall be established so that, in the planning and development of health services to be offered within the health service area, any economic or geographic barrier to the receipt of such services in nonmetropolitan areas is taken into account. The boundaries of health service areas shall be established so as to recognize the differences in health planning and health services development needs between nonmetropolitan and metropolitan areas.*

This has the effect of moderating the requirements with respect to the availability of resources within the area, including a center for the provision of highly specialized services, where the area proposed is essentially nonmetropolitan (or rural) in character and population.

> *To the extent practicable, the area shall include at least one center for the provision of highly specialized health 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.
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.

. *To the maximum extent feasible, the boundaries of the area shall be appropriately coordinated with the boundaries of areas designated under section 1152 of the Social Security Act for Professional Standards Review Organizations, existing regional planning areas, and State planning and administrative areas. (Underscoring supplied.)*

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).

. *Each State's Governor shall in the development of boundaries for health service areas consult with and solicit the views of the chief executive officer or agency of the political subdivisions within the State, the State agency which administers or supervises the administration of the State's health planning functions under a State plan approved under section 314(a), each entity within the State which has developed a comprehensive regional, metropolitan, or other local area plan or plans referred to in section 314(b), and each regional medical program established in the State under title IX.*

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:

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 organizations be obtained to the tentative proposed designations prior to their submission as well as in their preliminary development.

B. Waivers

Requested waivers for areas with populations of less than 500,000 will be reviewed in terms of the following criteria or factors:

1. Its geography, including size, natural isolation, and adverse climatic conditions.
2. Population, including rate of growth in recent years, density, and community of interest.
3. Whether it essentially is a self-contained economic trade area.
4. How well the area is linked together (or separated from other areas) by transportation and communication networks.
5. Whether the health facilities, manpower, resources, and services within the area constitute a sufficiently critical mass to generally meet the needs of its residents.
6. Whether it encompasses one or more SMSAs.

7. Extent to which the area is consistent with other official districts (e.g., A-95 sub-State planning and PSRO areas) and political boundaries (e.g., State, counties).

8. Evidence that it provides a reasonably adequate dollar base for supporting an HSA; that the area would be able to obtain sufficient matching and/or other funds to support a minimum required professional staff of five (5), that the Federal grant of $.50 per capita and other funds would equal or exceed $200,000 annually.

9. Degree to which it has a demonstrated health planning capacity and experience.

10. Degree of community support for the area proposed by local governments, providers, general population and others.

Waiver requests proposing an area that would split or <u>divide</u> <u>an SMSA</u> would be reviewed against the following criteria or factors:

1. In the case of inter-State SMSAs, degree to which its population is overwhelmingly in one State; or conversely, where only a small fraction of its population is in one State or another.

2. Also in the case of inter-State SMSAs, extent of cooperation (or noncooperation) in other endeavors or efforts in recent years.

3. In the case of intra-State SMSAs, extent to which it is coterminous with existing PSRO areas.

4. Extent to which it is coterminous with: (a) existing health planning areas (e.g., CHP, EHSDS, RMP) and/or (b) Department of Commerce defined economic trade areas.

5. High degree of acceptability to local elected officials, health providers, consumer groups, and others in the area proposed.

It should be noted that, the legislation contemplated that waivers would seldom be granted. Thus, it is anticipated that only those waivers requests that can meet a large number of the above criteria have a reasonable chance of favorable action.

II. Area Designation Plan

This section explains and describes what each State must submit in the way of its proposed health service area designations, its Area Designation Plan. The instructions and format specified, and the maps, information, and data supplied in response thereto, are closely tied to the substantive area designation requirements as set forth in the legislation, as elaborated upon above.

A. General

Each State's Area Designation Plan should be submitted to the appropriate HEW Regional Office at one time as a complete package. It should include all materials, information, and justifications required by these instructions.

Submissions must include a covering letter signed by the Governor or his designee. That letter should explicitly state that the material submitted constitutes the Governor's official designation of health service areas for the State pursuant to the legislation. The deadline for submission is May 3, 1975, with 25 copies required.

As noted above, all materials which States are requested to submit in connection with their health service area designations are either specifically required by the legislation or are directly related to determining that the areas proposed meet those requirements. Those materials (e.g., data, information, maps) will be grouped as they relate to (1) the overall or Statewide aspects of the plan, (2) each of the individual areas proposed, and (3)

any waivers requested. Provision also is made for (4) appendices, including copies of comments received.

B. Overall

The following maps, information, data and other materials are required for the State as a whole.

1. Maps of designated areas: A legible map or maps showing the boundaries of each health service area proposed to be included in whole or in part within the State. The map or maps should, in addition, show:

   a. areas served by existing Federally-funded areawide CHP agencies that meet the area designation requirements as they relate to population and SMSAs;

   b. the counties or equivalent political subdivisions included in each area;

   c. SMSAs;

   d. PSRO areas; and

   e. sub-State planning areas designated by Governors under OMB Circular A-95.

2. A brief narrative description or discussion of the major premises, factors, and the like underlying, serving as the foundation for the State's overall plan for its health service areas. (This might include factors like existing

facilities and services, patient flow, and interstate service patterns, the supporting data for which should be included as appendices.)

3. Consultation: A summary description of the process and procedures followed in obtaining consultation on proposed health service areas; State and local groups, interests, and organizations generally consulted; substance of the comments received including a resume of actions taken with respect thereto; and the location of files where all comments received are filed and available for inspection. (Submission of copies of the actual comments received from CHP agencies, EHSDS projects, and RMPs, are required; see II E below.)

4. Special justification where any of the health service areas proposed:

   a. are not well coordinated with PSRO areas; or

   b. do not include a center for highly specialized services.

5. A description of how the differences between the needs of non-metropolitan and metropolitan areas have been recognized.

6. Whether areas that meet the population and SMSA requirements which are currently served by areawide CHP agencies are to be new health service areas or, as an alternative, whether other areas are more appropriate.

C. Individual Health Service Areas

Each area proposed should have a numerical designation and name with an indication of same on the map(s) submitted. The following information or data should be supplied for each health service area designated.

1. Population and area: (a) 1973 population; (b) U.S. Census Bureau estimate of population projection for 1980; (c) 1970-73 population change; and (d) total area in square miles. (All current population figures are to be based on the U.S. Bureau of Census Population Estimates for 1973, which are the most recent figures available nationally by county.)

2. SMSAs: Any SMSAs included in whole or in part.

3. Centers of highly specialized services: Name and location of (a) medical schools, (b) academic health centers, (c) major speciality familities, and (d) major hospitals. (Since the legislation only requires a center "to the extent practicable," failure of an area to have such a center does not require a waiver. Where a center is absent, however, an explanation of how the people residing within this area do or in the future will receive such highly specialized services must be included.)

4. Health facilities and manpower: Summary data as to (a) the number of non-Federal, short-term hospitals and hospital beds; (b) physicians; and (c) nurses.

5. Relationship to other areas: Specifically (a) State planning and development districts; (b) COGs; (c) PSROs. (The legislation only requires that health service areas be "appropriately coordinated . . . to the maximum extent feasible" with certain other specified areas. If they are not, an explanation of the reasons therefore must be included, but it does not require a waiver request.)

6. Interstate areas: For interstate areas which do not contain an interstate SMSA, evidence that the other Governor(s) concur in the designation.

D. Waiver Requests

Additional information and justification must be supplied for any area proposed for which a waiver is requested; that is, any area (1) with a current population of less than 500,000 except if it is one encompassing an entire State with a lesser population and/or (2) that splits or divides an SMSA. This must be supplied for each area for which a waiver is requested.

The basis for each waiver request must be explicit in terms of the specific waiver criteria set forth in I.B above. Thus germane and specific information and data appropriate to each criterion used to justify and support the waiver request, must be supplied.

E. Appendices

States are encouraged to place high-volume, "marginal" kinds of supporting data, information, and materials in an appendix to their Area Designation Plan. In addition, though, several items would be prescribed for inclusion therein.

1. Comments: A listing, by name, of all the groups, interests, and organizations from whom comments had been solicited. Also, the copies of (a) all comments from CHP agencies and RMPs, and (b) those specifically relevant or addressed to waiver requests.

2. Interstate areas: Documentary or supporting evidence or certification (e.g., exchange of letters, formal interstate agreements) that the Governors involved or their designees have consulted and agreed on any interstate area that does not encompass an interstate SMSA.

III. Review and Final Designation

HEW's Regional Offices will have the principal responsibility for reviewing proposed health service area designations submitted by Governors, and making recommendations with respect thereto. However, as noted above all waiver requests will also be reviewed by an ad hoc review panel composed of both regional office and headquarters program officials in order to insure national consistency in the application of the criteria against which those requests will be assessed.

It is anticipated this Federal review, to determine that proposed area designations meet the requirements of the Act, will be completed within 60 days of the submission deadline, or by early July. Official establishment of health service areas will be by publication of their boundaries in the Federal Register. Section 1511(b)(3) of the Act requires that this be done within 210 days of its enactment, or by August 1, 1975.

Appendices

1. Section 1511, "Health Service Areas", of P.L. 93-641.

2. Copy of the letter sent to Governors officially notifying them of the initiation of the area designation process.

3. Listing, by State, of those State and area-wide CHP agencies and RMPs that must be consulted.

4. Listing, by State, of those areas presently served by area-wide CHP agencies that meet the requirements of Section 1511(c) of the Act.

5. List of HEW Regional Offices, including their addresses and the names of the Regional Directors and Regional Health Administrators.