U.S. Department of Health and Human Services
HRSA BPHC Bureau of Primary Health Care
Health Resources and Services Administration

POLICY INFORMATION NOTICE

Policy Information Notice 2007-09

DOCUMENT NAME: Service Area Overlap: Policy and Process

DATE: MAR 1 2 2007

TO: Health Center Program Grantees
Federally Qualified Health Center Look-Alikes
Primary Care Associations
Primary Care Offices

This Policy Information Notice (PIN) describes the Health Resources and Services Administration's policies and processes for health center service area overlap. As the number of health center and Federally Qualified Health Center (FQHC) Look-Alike sites grows, so does the potential that service areas will overlap. Consequently, there are an increasing number of service area overlap-related issues emerging that involve federally funded health centers, FQHC Look-Alikes, and/or current applicants for Federal health center funding.

Please contact Shannon Dunne Faltens at 301-594-4060 for any questions regarding this PIN.

James Macrae
Associate Administrator

I. Purpose

The purpose of this PIN is to (1) define what constitutes "service area overlap" in the context of the Health Center and Federally Qualified Health Center (FQHC) Look-Alike Programs administered by the Health Resources and Services Administration's (HRSA) Bureau of Primary Health Care; (2) state HRSA's policies with respect to service area overlap; and (3) describe HRSA's process for determining whether to approve a pending application and/or change in scope request in a service area overlap situation.

II. Background

As the number of health center sites (including federally funded sites and FQHC Look-Alike sites) grows, so does the potential that service areas will overlap. In some places, such as areas with large and diverse underserved populations and significant unmet need, it may be appropriate and beneficial to both the community and the health centers involved to share all or part of the same service area. In other communities, however, service area overlap may undermine the stability of one or more of the health centers involved in serving the area. Moreover, HRSA has a responsibility to ensure that limited Federal grant dollars are used efficiently and effectively to provide access to as many underserved people as possible, and, in some instances, supporting multiple sites within the same service area may compromise this principle.

While overlapping service areas may not necessarily raise concerns, there are an increasing number of service area overlap-related issues that require analysis and resolution before HRSA may move forward in making a final decision on a health center's funding application, request for change in scope of project, or application for designation as a FQHC Look-Alike. This PIN describes and clarifies HRSA's policies and processes for resolving these issues, with the goal of improving the likelihood of early identification and timely resolution of service area overlap situations.

III. Definitions

A. Federally Funded Health Centers

For purposes of this guidance, the term "federally funded health centers" or "grantee health centers" includes all health centers funded under the Health Center Program authorized in section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b), as amended, specifically:

- Community Health Center (CHC) Programs, funded under section 330(e);
- Migrant Health Center (MHC) Programs, funded under section 330(g);

- Health Care for the Homeless (HCH) Programs, funded under section 330(h); and
- Public Housing Primary Care (PHPC) Programs, funded under section 330(i).

B. FQHC Look-Alike

FQHC Look-Alikes do not receive Federal funding under section 330 of the PHS Act; however, to receive the FQHC Look-Alike designation and the benefits of that designation, FQHC Look-Alikes must meet the same statutory, regulatory, and policy requirements as grantee health centers. Applicants for FQHC Look-Alike designation must meet the following requirements:

- be a public or a private nonprofit entity;
- serve, in whole or in part, a federally designated Medically Underserved Area (MUA) or Medically Underserved Population (MUP);
- meet the same statutory, regulatory, and policy requirements as grantees supported under section 330 of the PHS Act; and
- comply with section 1905(l)(2)(B) of the Social Security Act which states that an FQHC Look-Alike entity may not be owned, controlled, or operated by another entity.

When appropriate, this PI N will specifically reference FQHC Look-Alikes to emphasize the applicability of the PIN to these entities.

C. Health Centers

As used in this PIN, the term "health centers" includes both federally funded health centers and FQHC Look-Alikes.

D. Service Area

A service area, which is one element of a health center's scope of project, is comprised of several factors. Although, in general, the service area is the area in which the majority of the health center's patients reside, health centers may use other geographic or demographic characteristics to describe their service area.

1. Overview and Statutory Requirements

The concept of a "service" or "catchment" area has been part of the Health Center Program since its beginning. The Health Center Program's authorizing statute requires that each grantee periodically review its catchment area to:

i. ensure that the size of such area is such that the services to be provided through the center (including any satellite) are available and accessible to the residents of the area promptly and as appropriate;[1]
ii. ensure that the boundaries of such area conform, to the extent

[1] Primary health services of the center must also be provided "in a manner which assures continuity." (PHS Act section 330(k)(3)(A).)

practicable, to relevant boundaries of political subdivisions, school districts, and Federal and State health and social service programs; and

iii. ensure that the boundaries of such area eliminate, to the extent possible, barriers to access to the services of the center, including barriers resulting from the area's physical characteristics, its residential patterns, its economic and social grouping, and available transportation.

Public Health Service Act sec. 330(k)(3)(J)

Health centers receiving grants under section 330(e) of the PHS Act are statutorily obligated to make services available to all residents of the service area, to the extent that they are able, using available resources. Grantees receiving funding only under section 330(g), (h), and/or (i) of the PHS Act, which are targeted respectively to migrant and seasonal, homeless, or public housing populations (i.e., the grantee receives no section 330(e) funds), are not subject to the requirement to serve all residents of the service area (see section F. below).

2. Assessing and Identifying Service Areas

Each health center should periodically assess its declared service area to ensure that the description adequately reflects the health center's current activities. Routine patient origin analysis (for example, using the zip codes of the patient records on file) will help to ensure that the reported service area is accurate and can help determine updated service area boundaries by indicating the areas from which the health center draws the majority of its patients. While health centers may be called upon to serve patients from outside their service area, the service area should include, at a minimum, the area from which the vast majority of patients reside.

The service area should, to the extent practicable, be identifiable by county and by census tracts within county. Describing service areas by census tracts is typically necessary to enable analysis of service area demographics. Service areas may also be described by other political or geographic subdivisions (e.g., county, township, zip codes as appropriate). The service area must be federally designated as a MUA in full or in part or contain a federally designated MUP.

Starting with calendar year (CY) 2005 Uniform Data System (UDS) data, grantees now annually report information on the aggregate geographic area in which its patients reside. This will enable HRSA to better identify overall health center service areas.

3. Service Area Establishment and Expansion

Applicants for funding under section 330 of the PHS Act initially document their service area in the New Access Point (NAP) or Service Area

Competition (SAC) funding application. The funded NAP or SAC application is the basis for determining a grantee's initial service area. Similarly, FQHC Look-Alikes initially document their service area in the designation application. Once established, health centers should incorporate periodic service area assessments into the annual grant application (competing or non-competing) or FQHC Look-Alike annual re-certification application.

A grantee or FQHC Look-Alike that wishes to expand its service area by opening a new site may submit a change in scope request at any time. For grantees, they must demonstrate that this expansion will not require additional grant funds. Grantees may also expand their service area through a funded NAP application which requests additional grant support to add a new service delivery location to the approved scope of project. (See PIN 2002-07, "Scope of Project Policy," for information on change in scope requests.)

E. Health Center Service Site

For purposes of determining which sites are included within a health center's scope of project, a service site is any place where a health center, either directly or through a subrecipient[2] or contract arrangement, provides required primary health services and/or approved additional services to a defined service area or population. Service sites are defined as locations where all of the following conditions are met:[3]

- health center encounters are generated by documenting in the medical record face-to-face contacts between patients and providers;
- providers exercise independent judgment in the provision of services to the patient;
- services are provided directly by or on behalf of the grantee, whose governing board retains control and authority over the provision of the services at the location; and
- services are provided on a regularly scheduled basis (e.g., daily, weekly, first Thursday of every month).[4] However, there is no minimum number of hours per week that services must be available at an individual site/location.

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[2] For purposes of Medicaid and Medicare FQHC reimbursement, a subrecipient is an organization that: (1) receives funding from a section 330 grant through a contract with the recipient of such a grant and (2) is compliant with all of the requirements of section 330 of the PHS Act (see §1861(aa)(4) and §1905(l)(2)(B) of the Social Security Act).

[3] Service sites are a critical component of a health center's scope of project. Other programs, (e.g., FTCA, 340B, and FQHC) have their own standards to determine eligibility for the benefits available through these programs. Each of these programs has a specific application process and a comprehensive set of requirements, of which service site is only one. In other words, identification as a service site within a scope of project is necessary, but not sufficient to ensure participation in the other programs. To participate, all of the requirements of the other programs must be met and coordination with these programs is required.

[4] Again, note the statutory requirement in section 330(k)(3) of the PHS Act that "primary health services of the center will be available and accessible in the catchment area of the center promptly, as appropriate, and in a manner which assures continuity." In addition, note the regulatory requirement for community and migrant health center grantees that such centers "must be operated in a manner calculated to . . .

Administrative offices or locations that do not provide direct health care services are not service sites.

F. Target Population

The target population is the population to be served by the health center. It is usually a subset of the entire service area population, but in some cases, may include all residents of the service area.

Section 330(e) grantees and FQHC Look-Alikes are required to serve all residents of the center's service area, regardless of the individual's ability to pay. Centers are also free to extend services to those residing outside the service area. However, HRSA recognizes that health centers must operate in a manner consistent with sound business practices. As such, health centers are not expected to extend services to additional patients residing inside or outside of the service area if (1) the demand for services exceeds available resources, and/or (2) doing so would jeopardize the center's financial stability. However, grantee health centers and FQHC Look-Alikes should address the acute care needs of all who present for service, regardless of residence.

Some health center programs receive funding to target special populations: specifically, migrant and seasonal farmworkers and their families, persons who are homeless, and residents of public housing. Health centers receiving such funding (i.e., grants under section 330(g), (h), or (i) of the PHS Act) are not subject to the requirement to serve all residents of the service area; however, they should make services available to all members of the special population targeted, and, as stated above, address the acute care needs of all who present for service.

G. Health Center Patient

For purposes of the HRSA UDS reporting, a patient is an individual who has at least one clinical encounter at one of the health center's service sites in a given calendar year. For purposes of serving on a health center's governing board, a consumer board member should utilize the health center as his/her principle source of care and, at a minimum, should have used the health center's services within the last 2 years (see HRSA PIN 98-23, section III(B)(2)).[5]

H. Unmet Need

In communities with high levels of unmet need among the underserved population(s), service area overlap may be appropriate and provide critical additional access. This is particularly true in areas with high numbers of underserved people and limited providers serving this population or in areas with specific sub-groups of the population who may need special approaches to ensure

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maximize . . . effective utilization of services." (See 42 CFR 51c.303(m) and 42 CFR 56.603(k).)

[5] Health centers receiving funding only under section 330(g), (h), and/or (i) of the PHS Act (i.e., the center receives no section 330(e) funds) may apply for a waiver of this and other governing board requirements.

access (e.g., non-English speaking groups, people who are homeless, or newly arrived immigrants/refugees). In order to determine whether overlapping service areas could benefit the community without threatening the stability of existing health centers, some assessment of the degree and type of unmet need in the service area is necessary. The process for assessing unmet need in situations of service area overlap is explained further, below.

I. Collaboration

In order to maximize limited resources and access to care for their patients, health centers should coordinate and collaborate with other section 330 grantees, FQHC Look-Alikes, State and local health services delivery projects, and programs in the same or adjacent service areas serving underserved populations to create a community-wide service delivery system. Section 330 of the PHS Act specifically requires that applicants for health center funding have made "and will continue to make every reasonable effort to establish and maintain collaborative relationships with other health care providers in the catchment area of the center" (PHS Act section 330(k)(3)(B)). As stated in section V. of this PIN, "HRSA Policy," the goal of collaboration is to utilize the strengths of all involved organizations to best meet the overall health care needs of the area's underserved population. In addition, continued collaboration among providers will help to ensure that organizations are aware of and, where possible, maximize the benefits of, existing or potential service area overlaps.

IV. Identifying Service Area Overlap

HRSA examines issues of overlap in the context of the service area definition in section III of this PIN. As stated above, service areas are primarily defined by patient origin and identified by census tracts or other political or geographic subdivisions (e.g., zip codes). Issues of service area overlap are raised primarily in five types of situations, listed below:

1. an existing grantee health center, new entity, or FQHC Look-Alike applies for NAP or other funding to serve an area which includes all or part of the service area of another existing grantee health center;
2. an existing grantee health center or FQHC Look-Alike requests a "Change in Scope" to open a new health center service site to serve all or part of the service area of another health center, or to provide new services to all or part of the service area of another health center;
3. an existing grantee health center, non-grantee health center, or FQHC Look-Alike applies for NAP funding, other section 330 funding, or requests a Change in Scope at the same time as another grantee health center, non-grantee health center, or FQHC Look-Alike proposes to serve an area which, at the time of the application, is not served by either organization;
4. an existing grantee health center or FQHC Look-Alike relocates an existing clinic to an area served by another health center; or

5. an organization applies for FQHC Look-Alike status to serve an area or population already served by an existing grantee health center.

Potential overlaps are typically identified through a number of sources (e.g., HRSA staff reviews, health center grantees, applicants, FQHC Look-Alikes, and/or Primary Care Associations (PCAs)). All applications for grant funding, FQHC Look-Alike designation/recertification, and changes in scope are examined for potential service area overlap. Applications that present possible service area overlaps are flagged for additional review, if necessary.

V. HRSA Policy

HRSA's foremost concern is to utilize its limited Federal grant dollars to provide access to high quality primary care services to as many underserved people as possible, as efficiently as possible. As such, grant dollars should be targeted to entities in areas of high need that demonstrate that the Federal investment will be efficiently and effectively applied to those needs.

To achieve this, HRSA will be guided by the following overarching principles listed below when assessing individual situations of service area overlap:

1. Meeting the health care needs of the community and target population is paramount in decisions related to service area overlap;
2. Federal grant dollars should be distributed in such a way as to minimize the potential for unnecessary duplication and/or overlap in services, sites, or programs;
3. HRSA recognizes the advantage of using existing resources with proven capabilities to maintain effective and efficient delivery of health care within communities;
4. When a newly identified group of underserved people within a community already served by a health center is proposed to be served by a new site (e.g., homeless people within the service area), this potentially unmet need in the community will be considered when reviewed for service area overlap. If the health care needs of the relevant medically underserved population group within a service area are not being met, geographic service area boundaries will not serve as a barrier to the approval of the application, even where the service area does in fact overlap with that of an existing grantee health center or FQHC Look-Alike;
5. HRSA encourages openness and collaboration among providers.[6] The goal of collaboration is to utilize the strengths of all involved organizations to best meet the overall needs of the area's underserved population; and
6. HRSA has a responsibility to ensure the efficient distribution of Federal resources. Therefore, when the potential exists for patients to be drawn from an existing health center to a new organization or proposed site, HRSA will consider the financial impact on the existing health center. In doing so, HRSA

[6] See also section III.H., above.

may examine the past performance of the existing health center and its historical and current ability to meet the needs of the community.

VI. Process for Resolving Potential Service Area Overlap

HRSA's approach to resolving potential situations of service area overlap is based on: 1) early identification of potential overlap; 2) utilization of standard data to define service area and unmet need whenever possible; and/or 3) conducting site visits as appropriate. The actual steps may differ slightly depending on the individual circumstances and the data available.

The following list of steps outlines the process that will be undertaken by HRSA to resolve identified service area overlap issues:

1. Map the service area in question and its census tracts and/or zip codes;
2. Gather data (for example, current patient origin studies) in coordination with the relevant parties.[7] Considerations such as community and financial support, current capacity, utilization rate, existing and proposed partnerships, and unmet need may be assessed; and/or
3. A site visit may be conducted.

VII. Data Sources

In order to analyze service area overlap, HRSA may request data from relevant parties to describe the service area, provider/population ratio, target population, and current patient population (for operational grantee health centers and FQHC Look-Alikes) or projected patient populations (for new grantee health centers or newly designated FQHC Look-Alikes). These data will be requested, as necessary and appropriate, from all organizations that are impacted by the service area overlap. The data requested may augment and/or substantiate data already on file at HRSA from the grant applications, change of scope requests, and/or UDS reports. Data submitted should be verifiable and site-specific.

A. Currently Reported Data

Grantee health centers define their service area and target population as part of their competing or non-competing section 330 grant application. Currently (as of fiscal year 2006), the NAP, SAC, and Budget Period Renewal (BPR) applications require applicants to list the census tracts and zip codes covered by the entire program (Form1-Part A: General Information) while Form 5-Part B: Service Sites asks applicants to list the census tracts served by each site within their Scope of Project. The instructions ask applicants to define their target population and provide demographics for both the service area and target population in the narrative and on Form 4: Community/Target Population Characteristics.

[7] Coordination with relevant parties will be consistent with HHS grants law, regulations, and policy.

Beginning with the collection of CY 2005 UDS data, grantee health centers report patient origin by zip code.

FQHC Look-Alikes define their service area and target population as part of their designation/recertification application. FQHC Look-Alike applicants are not required to submit UDS data. Rather, these organizations complete the FQHC Look-Alike tables and forms, describe their service area, and describe their target and patient populations as part of their initial designation and subsequent recertification applications.

B. Data Sources to Document Service Area Overlap

In order to accurately document the extent of a potential service area overlap, and to determine whether there is unmet need in that area, it is critical that the grantee, FQHC Look-Alike, or applicant provide information that is as detailed as possible. HRSA may request the organization's assistance in providing data such as:

1. Service Area and Target Population:

   - **Census data** as applicable: including median income level, percent of population below poverty and/or below 200 percent of poverty level, number of uninsured, ethnicity, and/or language.
   - **Other State or Federal reports:** for example, reports on school English as a Second Language program enrollment or State surveys of the area in question.
   - **Other Providers:** In order to accurately document the extent and implication of a potential service area overlap, health centers and FQHC Look-Alikes are expected to describe the other providers serving the underserved population in the area. At a minimum, they should identify the other safety net providers available (FQHCs, public hospital/health department primary care clinics, Critical Access Hospitals with primary care capacity, and Rural Health Clinics), if any. They should also describe the extent to which private sector providers in the area serve Medicaid beneficiaries, the uninsured, and other underserved populations. If the health center is not able to document the support of other local providers for its application, it should provide an explanation for the lack of support.

2. Patient Population:

   The most recent UDS report is a major source of information on current grantees' patient population in terms of total numbers as well as income, ethnicity, and language preference. Some grantee health centers may be asked to supplement their UDS data with more detail (e.g., if the center serves a specific ethnic group that is not distinctly reported on the UDS).

3. Relationship of Patients to Service Area:

   The purpose of collecting service area, target population, and patient origin data is to determine the extent to which an existing health center serves the area and population and whether there is sufficient remaining unmet need or a distinct underserved population in the area to justify approving a grant application of change in scope request.

VIII. Conclusion

While individual circumstances will affect the specific process used to resolve service area overlap issues, this PIN describes the overarching principles that will inform decisions related to service area overlap and providing examples of the types of data that may be requested. HRSA will make every effort to reach positive and timely resolutions of service area overlap issues.

Attachment

ATTACHMENT
Relevant Statutory and Regulatory Provisions

Public Health Service (PHS) Act Section 330(a)

(1) In general

For purposes of this section, the term "health center" means an entity that serves a population that is medically underserved, or a special medically underserved population comprised of migratory and seasonal agricultural workers, the homeless, and residents of public housing, by providing, either through the staff and supporting resources of the center or through contracts or cooperative arrangements--

(A) required primary health services (as defined in subsection (b)(1) of this section); and

(B) as may be appropriate for particular centers, additional health services (as defined in subsection (b)(2) of this section) necessary for the adequate support of the primary health services required under subparagraph (A);

for all residents of the area served by the center (hereafter referred to in this section as the "catchment area").

(2) Limitation

The requirement in paragraph (1) to provide services for all residents within a catchment area shall not apply in the case of a health center receiving a grant only under subsection (g), (h), or (i) of this section (emphasis added)

PHS Act Section 330(k)(2)

An application for a grant under subparagraph (A) or (B) of subsection (e)(1) of this section for a health center shall include--

(A) a description of the need for health services in the catchment area of the center;

(B) a demonstration by the applicant that the area or the population group to be served by the applicant has a shortage of personal health services; and

(C) a demonstration that the center will be located so that it will provide services to the greatest number of individuals residing in the catchment area or included in such population group.

PHS Act Section 330(k)(3)(B)

"The Secretary may not approve an application for a grant . . . unless the Secretary determines that the entity . . . has made and will continue to make every reasonable effort to establish and maintain collaborative relationships with other health care providers in the catchment area of the center."

PHS Act Section 330(k)(3)(J)

The center will review periodically its catchment area to--

(i) ensure that the size of such area is such that the services to be provided through the center (including any satellite) are available and accessible to the residents of the area promptly and as appropriate;

(ii) ensure that the boundaries of such area conform, to the extent practicable, to relevant boundaries of political subdivisions, school districts, and Federal and State health and social service programs; and

(iii) ensure that the boundaries of such area eliminate, to the extent possible, barriers to access to the services of the center, including barriers resulting from the area's physical characteristics, its residential patterns, its economic and social grouping, and available transportation;

Section 330/Community Health Center Program implementing regulations

42 CFR 51c.102(b) "Catchment area means the area served by a project funded under section 330 of the Act."

42 CFR 51c.104(b) "Applications must include . . . the precise boundaries of the catchment area to be served by the applicant, including an identification of the [MUPs] within the catchment area. In addition, the application shall include information sufficient to enable the Secretary to determine that the applicant's catchment area meets the following criteria:

> (i) The size of such area is such that the services to be provided by the applicant are available and accessible to the residents of the area promptly and as appropriate;
> (ii) The boundaries of such area conform, to the extent practicable, to relevant boundaries of political subdivisions, school districts, and areas served by Federal and State health and social service programs; and
> (iii) The boundaries of such area eliminate, to the extent possible, barriers resulting from the area's physical characteristics, its residential patterns, its economic and social groupings, and available transportation."

42 CFR 51c.305 "The Secretary may award grants under this subpart to applicants . . . taking into consideration . . .

(h) Whether the center's catchment area is exclusive of the area served by another center;
(i) The de gree to which the applicant intends to integrate services supported by a grant under this subpart with health services provided under other Federally assisted health services or reimbursement programs or projects."