

Health Resources and Services Administration

Shortage Designation Management System

OMB Control No. 0906-0029

Revision

Supporting Statement A

A. Justification

1. Circumstances Making the Collection of Information Necessary

This is a revised information collection request for Office of Management and Budget (OMB) continued approval of the Health Resources and Services Administration's (HRSA) Shortage Designation Management System (SDMS). This project is currently approved under OMB control number 0906-0029. The legislative authorities for shortage designation are Section 332 and Section 330(b)(3) of the Public Health Service (PHS) Act [see Attachments A and B respectively].

The need and purpose of this information collection is to obtain information via the Shortage Designation Management System (SDMS) for the submission and review of Health Professional Shortage Area (HPSA) and Medically Underserved Area/Population (MUA/P) applications.

Regarding revisions to this information collection request, previously State Primary Care Offices (PCOs) were required to provide HRSA with Census, ACS, and CDC data specific to the intended geographic area for designation known as a rational service area. PCOs are no longer required to provide this information as it is automatically populated in the system when they select the rational service area via the mapping tool in SDMS.

HPSA designations are geographic areas, population groups, and facilities that are experiencing a shortage of health professionals. The authorizing statute for the National Health Service Corps (NHSC) created HPSAs to fulfill the statutory requirement that NHSC personnel be directed to areas of greatest need (Sec.331-338H of PHS Act). To further differentiate areas of greatest need, HRSA calculates a score for each HPSA. There are three categories of HPSAs based on health discipline: primary care, dental health, and mental health. Scores range from 1 to 25 for primary care and mental health and from 1 to 26 for dental, with higher scores indicating greater need. They are used to prioritize applications for NHSC Loan Repayment

Program award funding, and determine service sites eligible to receive NHSC Scholarship and Students-to-Service participants.

MUA/P designations are geographic areas, or population groups within geographic areas, that are experiencing a shortage of primary care health care services based on the Index of Medical Underservice (IMU). MUAs are designated for the entire population of a particular geographic area. MUP designations are limited to particular subsets of the population within a geographic area. MUA/Ps are a prerequisite for eligibility for grant awards to plan, develop, and operate a HRSA-supported health center under Section 330 of the PHS Act.

Both designations were created to aid the federal government in identifying areas with healthcare workforce shortages. Several federal agencies use HPSAs and MUA/Ps by applying varying strategies to improve access to care. These programs include:

- Rural Health Clinic Program [Center for Medicare and Medicaid Services (CMS)]
- HPSA Physician Bonus Program [CMS]
- HPSA Surgical Incentive Payment Program [CMS]
- Indian Health Service Scholarship Program [Indian Health Service (IHS)]
- J1 Visa Exchange Visitor Program [HHS, Department of State (DoS), United States Citizenship and Immigration Services (USCIS)]
- Conrad 30 State Program [State governments, HHS, DoS, USCIS]

2. Purpose and Use of Information Collection

As part of HRSA's cooperative agreement with the State PCOs, the State PCOs conduct needs assessment in their states, determine what areas are eligible for designations, and submit designation applications for BHW review via the SDMS. Requests that come from other sources are referred to the PCOs for their review, concurrence, and submission via SDMS. In order to obtain a federal shortage designation for an area, population, or facility, PCOs must submit a shortage designation application through SDMS for review and approval by HRSA. Both the HPSA and MUA/P application require local, state, and national data on the population that is experiencing a shortage of health professionals and the number of health professionals relative to the population covered by the proposed designation. Previously, PCOs were required to provide HRSA with Census, ACS, and CDC data specific to the intended geographic area for designation known as a rational service area. With the development of the SDMS, PCOs are no longer required to provide this information as it is automatically populated in the system when they select the rational service area for designation. The application and supporting documentation capture information that is relevant to identify rational service areas with the greatest need for health care services and identification of qualifying shortages.

BHW reviews the HPSA applications submitted by the State PCOs. Applications are approved for shortage designations according to criteria required by Federal statute and regulation [see [Attachments A and C respectively](#)]. HPSAs are statutorily required to be annually reviewed and revised as necessary to ensure limited resources are appropriately targeted to communities based on current data. Currently, MUA/Ps do not have a statutorily mandated review period.

In terms of the information collection, general forms include the SDMS Application and Supporting Documents [see [Attachment D](#)]. The Supporting Documents are created and provided by the applicant and are only required as necessary to explain or enhance information included in the application. These documents may include:

- Rational Service Area Validity Justification,
- Age/Sex Adjustment,
- Fluoridation Rate Justification,
- Alcohol Abuse Justification,
- Substance Abuse Justification,
- Population Center Justification,
- Transportation Type Justification,
- Contiguous Area Validity Justification,
- Contiguous Area Analysis Justification,
- Nearest Source of Non-Designated Care Justification,
- Nearest Source of Non-Designated Care Travel Time/Distance Justification, and
- Other optional documents.

In addition to the general application, applicants also utilize the SDMS Mapping Tool and the SDMS Provider Management Tool to plan and prepare shortage designation applications [see [Attachments E and F respectively](#)]. All forms, tools, and documents are completed by the PCO submitting the application.

3. Use of Improved Information Technology and Burden Reduction

This information collection activity is web-based. The link to the online application and instructions are available at <https://programportal.hrsa.gov/> for PCOs [see [Attachment G](#)].

HRSA previously used another online application system, the Application Submission and Processing System (ASAPS), to create, review, and make determinations on HPSA and MUA/P applications. ASAPS was built on the manual business process and HPSA methodology defined in the 1970s. While ASAPS had major advantages over the all-paper process that preceded it, the HPSA and MUA/P application process in ASAPS involved the creation of paper files for each application for every rational service area in every state and U.S. territory. Between 2013-2015, this process led to the printing of over 33,000 pieces of paper.

In August 2013, HRSA launched an initiative to review the shortage designation process. By the following year, SDMS was created, allowing HRSA to retire the previous system in August of 2014. SDMS is a single, automated system that simplifies the designation process with improved data standardization and data integrity, a new and improved user-interface, improved external communication functionality, and enhanced system support. The new system has eliminated the need to print, process, and store over 16,000 pieces of paper annually and has brought transparency to the shortage designation process. This initiative also resulted in the digitization of over 380,000 pages of legacy application documents that had accumulated over the years of the previous application system. SDMS continues to improve with the addition of new and enhanced functionality focused on eliminating the need to mail out review findings to agencies and applicants.

4. Efforts to Identify Duplication and Use of Similar Information

The SDMS does not duplicate any other application and is unique to HPSA and MUA/P designations. These applications are the only known mechanism for collecting geographic, population, provider, and facility specific information that can be used to designate HPSAs and MUA/Ps.

5. Impact on Small Businesses or Other Small Entities

The information collection will not have a significant impact on small entities.

6. Consequences of Collecting the Information Less Frequently

The information collected in the SDMS applications is used to determine which geographic areas, population groups, and facilities have critical shortages of health professionals. The online SDMS application, Mapping Tool, and Provider Management Tool are necessary for the designation of HPSAs and MUA/Ps. MUA/Ps are not required to be updated on a regular basis once designated.

However, if the information in the SDMS applications were collected less frequently, the Secretary of HHS would not be able to meet the statutory requirement to annually designate, review and, as necessary, revise HPSA designations. This would affect several different programs, including:

- **NHSC Program [HRSA]:** The National Health Service Corps builds healthy communities by supporting qualified health care providers dedicated to working in areas of the United States with limited access to care. The NHSC provides funding support to encourage selected primary health care professionals to practice in HPSAs. HPSAs were specifically created to target placement of NHSC providers in areas with the highest

need for health professionals. If new HPSA applications were collected and existing HPSAs reviewed less frequently, there would be no guarantee that NHSC providers could be placed in areas of greatest need. The pool of eligible service areas would be limited to existing HPSAs, and the pool may become smaller as some existing HPSAs lose their designation.

- **Health Center Program [HRSA]:** Health centers are non-profit private or public entities that serve designated MUA/Ps or special MUPs comprised of migrant and seasonal farmworkers, the homeless or residents of public housing. MUA/Ps are a prerequisite for eligibility for grant awards to plan, develop, and operate a HRSA-supported health center under Section 330 of the PHS Act. If MUA/P applications were collected less frequently, the Health Center Program would not be able to award new access points efficiently.
- **Medicare HPSA Physician Bonus Program [CMS]:** Section 1833(m) of the Social Security Act provides bonus payments to physicians who furnish Medicare Part B services in areas that are designated by HRSA as primary care geographic HPSAs under section 332 (a)(1)(A) of the PHS Act. In addition, psychiatrists furnishing services in mental health HPSAs are also eligible to receive bonus payments. If HPSA applications were collected less frequently, there would be no guarantee that bonus payments would be given to providers serving in areas of greatest need.
- **HPSA Surgical Incentive Payment Program [CMS]:** The Affordable Care Act of 2010, Section 5501(b)(4), expanded bonus payments for general surgeons in HPSAs. Effective January 1, 2011 through December 31, 2015, physicians serving in designated primary care geographic HPSAs will receive both a HPSA bonus payment and an additional 10% bonus for major surgical procedures with a 10 or 90 day global period. This additional payment, referred to as the HPSA Surgical Incentive Payment (HSIP), will be combined with the original HPSA payment and will be paid on a quarterly basis. If HPSA applications were collected less frequently, there would be no guarantee that bonus payments would be given to providers serving in areas of greatest need.
- **Rural Health Clinic Program [CMS]:** The Rural Health Clinic (RHC) program is intended to increase access to primary care services for Medicaid and Medicare patients in rural communities. RHCs can be public, nonprofit, or for-profit healthcare facilities, however, they must be located in rural, underserved areas. The site must be in a U.S. Census non-urbanized area, and in an area designated as a shortage area within the last four years. If designation applications were collected less frequently, any clinic that is located in an area that was not newly designated or updated as an existing designation within the last four years would not be certified as an RHC.
- **Indian Health Service Scholarship Program [IHS]:** The IHS Scholarship Program (IHS SP) provides qualified American Indian and Alaska Native health professions students an

opportunity to establish an educational foundation for each stage of their pre-professional careers. IHS SP service commitment can be fulfilled at a/an: IHS facility, Tribal facility (contracted under the Indian Self-Determination Act [P.L. 93-638]), Urban Indian program (assisted under Title V, Health Services for Urban Indians, of the IHCA [P.L. 94-437]), or a private practice located in a designated HPSA that serves a patient base of which at least 75 percent of the patients are documented members or descendants of federally or state-recognized Tribes. If HPSA applications were collected less frequently, there would be no guarantee that IHS providers pursuing private practice could serve in areas of greatest need. The pool of eligible service areas would be limited to existing HPSAs, and the pool may become smaller as some existing HPSAs lose their designation.

- **J-1 Visa Exchange Visitor Program [HHS, DoS, USCIS]:** The J-1 Visa is an exchange visitor non-immigrant visa that can be used by students of 17 different types of programs to promote cultural exchange. International medical graduates pursuing residency and fellowship training in the United States often have J-1 Visas. The J-1 visa allows holders to remain in the U.S. until their studies are completed or up to 7 years. At the completion of their studies, they are expected to return to their home countries for two years before applying to re-enter the United States. A J-1 Visa Waiver waives the two-year home residency requirement and allows a physician to stay in the country to practice in a federally designated Health Professional Shortage Area (HPSA) or Medically Underserved Area (MUA) if recommended by an interested federal government agency. State government agencies may also recommend J-1 physician waiver requests through the Conrad State 30 program. If designation applications were collected less frequently, there would be no guarantee that J-1 Visa waiver physicians could serve in areas of greatest need. The pool of eligible service areas would be limited to existing designations, and the pool may become smaller as some existing HPSAs lose their designation.
- **Conrad 30 State Program [State governments, HHS, DoS, USCIS]:** The Conrad 30 Waiver program allows medical doctors who hold a J-1 visa to apply for a waiver for the 2-year residence requirement upon completion of the J-1 exchange visitor program. The program addresses the shortage of qualified doctors in medically underserved areas. Although each state has developed its own application rules and guidelines for the Conrad 30 Waiver program, the following program requirements apply to all J-1 medical doctors. The J-1 medical doctor must:
 - o Agree to be employed full-time in H-1B nonimmigrant status at a health care facility located in an area designated by HHS as a HPSA, MUA, or MUP,
 - o Obtain a contract from the health care facility located in an area designated by HHS as a HPSA, MUA, or MUP,

- o Obtain a “no objection” letter from his or her home country if the home government funded his or her exchange program, and
- o Agree to begin employment at the health care facility within 90 days of receipt of the waiver, not the date his or her J-1 visa expires.

If designation applications were collected less frequently, there would be no guarantee that Conrad 30 physicians pursuing waivers could serve in areas of greatest need. The pool of eligible service areas would be limited to existing designations, and the pool may become smaller as some existing HPSAs lose their designation. There are no legal obstacles to reduce the burden.

7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5

The request fully complies with the regulation.

8. Comments in Response to the Federal Register Notice/Outside Consultation

Section 8A

A 60-day Federal Register Notice was published in the Federal Register on February 26, 2020, vol. 85, No. 38; pp. 11094-11095 [see Attachment H]. Public comments were received from the Colorado Department of Public Health and Environment.

The commenter agreed that the proposed information collection is a critical and necessary tool to identify areas that require assistance in recruiting and retaining primary care providers for the NHSC. Commenters also agree that it is critical to collect accurate and timely provider data for the purpose of shortage designation applications.

The primary concern raised about the proposed information collection was that the estimated burden hours included in the SDMS 60-day Federal Register Notice for designation planning and preparation when submitting an SDMS application is underestimated because it does not take into account collection of provider data. The commenter provided a wide-range of estimates in their designation application process and indicates that they complete provider updates once a year for each discipline. Specifically, the commenters indicated that they submit 113 applications annually, thus exceeding HRSA’s estimation of 83 designations submissions annually.

HRSA recognizes the commenter’s objections to the accuracy of the original burden estimates and recognizes that the exact number of designation submitted by each state will vary. SDMS reports indicate that in FY2019 4,482 designations applications were submitted by the PCOs with an average rational service area development time of 4 hours.

HRSA will continue to work with PCOs as SDMS is developed and will continue to review feedback and suggestions to improve SDMS as appropriate.

Section 8B

There were no recent efforts to consult with persons outside the agency to obtain their views on the availability of data, frequency of collection, the clarity of instructions and record keeping, disclosure, or reporting format (if any), and on the data elements to be recorded, disclosed, or reported, because the information is still relevant and there were no major changes since the last submission to OMB.

9. Explanation of any Payment/Gift to Respondents

Respondents will not receive any payment or gifts besides the grant funding from the HRSA for the State Primary Care Offices Program [Attachment I].

10. Assurance of Confidentiality Provided to Respondents

Data will be kept private to the extent allowed by law.

11. Justification for Sensitive Questions

There are no questions of a sensitive nature.

12. Estimates of Annualized Hour and Cost Burden

Section 12A - Estimated Annualized Burden Hours

Original Burden Estimate:

Form Name	Number of Respondents	Number of Responses per Respondent	Total Responses	Average Burden per Response (in hours)	Total Burden Hours
Designation Planning and Preparation	54	48	2,592	8	20,736
SDMS Application	54	83	4,482	4	17,928
Total	54	----	7,074	----	38,664

There are 54 PCOs that are funded through the Primary Care Services Resource Coordination and Development Program cooperative agreement. Each PCO is responsible for submitting shortage designation applications on behalf of their state or territory. HRSA expects to receive approximately 5,000 applications per year; this estimate is based on the average number of geographic, population, and facility HPSA applications received during the cycles from FY 2015 to FY 2019.

Before creating SDMS applications, PCOs undergo designation planning and preparation to map out which designation applications they wish to submit to HRSA for approval. It is estimated that it will take an average of 8 hours to plan and gather information from health provider surveys, state data sets, and other health and demographic data to submit with the online SDMS application. (54 applicants x (48 responses x 8 hours/response per application) = 20,736 total burden hours).

HRSA estimates that each PCO will plan for an average of 48 designation applications for approval. The current application requests that applicants:

- Create a Rational Service Area (RSA) by selecting the RSA boundaries via the mapping tool,
- Create Contiguous Areas (CAs) by selecting the boundaries via the mapping tool, and,
- Review the Nearest Source of Care provider selected by the system.

It is estimated that it will take an average of 4 hours to make the selections within the system, review the system data for the RSA, and upload the necessary documents to the online SDMS application. (54 applicants x (83 applications x 4 hours/response per application) = 38,664 total burden hours).

HRSA received one comment containing hourly estimates from the Colorado Department of Public Health and Environment. The commenter indicated on average they submit 113 SDMS applications per year and agreed with the average time of four hours for SDMS input.

HRSA's original burden estimate is reflective of standard processing, staffing, and system knowledge. Modifications were not made to HRSA's original burden estimate as the information received from the commenter was specific to their processes and staffing limitations.

Section 12B

Estimated Annualized Burden Costs

Type of Respondent	Total Burden Hours	Hourly Wage Rate ¹	Total Respondent Costs
PCO	38,664	\$\$64.56	\$2,496,177.84
Total	38,664		\$2,496,177.84

13. Estimates of other Total Annual Cost Burden to Respondents or Recordkeepers/Capital Costs

Other than their time, there is no cost to respondents.

14. Annualized Cost to Federal Government

The average annual costs to the government for implementing the on-line application and processing are as follows:

Federal Employee Costs:

Instrument	GS-Level/Base Pay Rate	Project Time per FTE	Number of FTEs	Total Annual Cost
SDMS Application Review	\$86,335 (GS-12, Step 1)	.50	13	\$561,177.50
Total				\$561,177.50

All SDMS applications are reviewed and processed internally by 13 HRSA staff with an average pay rate of \$86,335 (equivalent to a GS-12, Step 1 at 2015 pay rate level). It is estimated that the annualized total cost to the government will be \$561,177.50.

Contractor costs:

¹ Per Bureau of Labor and Statistics 2019 Median Pay for Community Service Managers was \$67,150 per year/\$32.28 per hour. For the purposes of the supporting document hourly wage has been duplicated to account for fringe benefits and overhead <https://www.bls.gov/ooh/management/social-and-community-service-managers.htm>

Contract costs for the on-line application system include, development, modernization, enhancement, and hosting services associated with the operations and maintenance of American Community Survey (ACS), Centers for Disease Control and Prevention (CDC), Census, and ESRI (mapping software) data used by respondents in the development and submission of Health Professional Shortage Area designation.

Period of Performance (representative of ongoing costs)	Type	Amount
6/1/2018 to 5/31/2019	Operations & Maintenance (O&M) (includes improvements & production support)	\$3,279,000
6/1/2018 to 5/31/2019	Development, Modernization & Enhancement (DME)	\$3,573,000
6/1/2018 to 5/31/2019	Hosting Services	\$540,000

The total annualized cost to the Federal Government is \$7,953,177.50.

15. Explanation for Program Changes or Adjustments

The current burden inventory is 106,899 hours while this request is for 38,664 hours. Previously, PCOs were required to provide HRSA with Census, ACS, and CDC data specific to the intended geographic area for designation known as a rational service area. With the development of the SDMS, PCOs are no longer required to provide this information as it is automatically populated in the system when they select the rational service area via the mapping tool in SDMS.

16. Plans for Tabulation, Publication, and Project Time Schedule

The HPSA statute requires that the lists of designated HPSAs are annually published in the Federal Register by July 1 [see Attachment J, K, and L respectively]. In addition, lists of designated HPSAs and MUA/Ps are updated on the HRSA Data Warehouse Website, <https://data.hrsa.gov/tools/shortage-area> so that interested parties can access the information in real time.

17. Reason(s) Display of OMB Expiration Date is Inappropriate

The OMB number and Expiration date will be displayed on every page of every form/instrument.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.