Office of Strategic Health Initiatives

Rural Health Research and Policy Center

July 16, 2025

HRSA Information Collection Clearance Officer
Room 14NWH04
5600 Fishers Lane
Rockville, MD 20857

Sent Via: paperwork@hrsa.gov

RE: Request for Information, Shortage Designation Management System, OMB No. 0906-0029 Extension, Documentation Citation 90 FR 21318, Document Number 2025-08819

Dear HRSA Information Collection Clearance Officer,

Thank you for the opportunity to provide input on the Shortage Designation Management System, OMB No. 0906-0029 Extension, Documentation Citation 90 FR 21318, Document Number 2025-08819. We hope that our input will provide information on proposed data collection projects of the Paperwork Reduction Act of 1995, regarding the burden estimate, any other aspect of the Information Collection Request (ICR), and the importance of the State's Primary Care Office (PCO).

The University of Hawai'i (UH) Rural Health Research and Policy Center (RHRPC) was established in 2022 and seeks to translate community health needs into actionable, evidence-based policy solutions. With a focus on improving the quality, affordability, and accessibility of healthcare in Hawai'i, RHRPC provides policy analysis and strategy to support community members' efforts to enact structural changes through policy. Our work to date has focused on the adequacy of Medicare Geographic Practice Cost Index (GPCI) and Health Professional Shortage Area (HPSA) methodologies in Hawai'i as well as transportation access in rural communities across our state. While not providing direct care, we are intimately involved with community providers, patients, and residents – especially those in rural communities.

Our comments are below:

1. **The necessity and utility of the proposed information collection for the proper performance of the agency's functions**

   The proposed information collection by the Hawai'i PCO coordinator is necessary and useful for the proper performance of the HRSA Bureau of Health Workforce (BHW) Shortage Designation process. Without the Hawai'i PCO coordinator

collecting data, the Shortage Designation process for Health Professional Shortage Areas (HPSAs) could not be executed.

The State of Hawai‘i and many other states do not have state laws requiring healthcare workforce data collection when health care providers apply or reapply for a state license. Therefore, other methods are used to determine where a healthcare provider is currently licensed and providing in person care. These methods include state licensure data, surveys (which providers can easily opt out of because no penalties can be imposed), and health insurance claims data. Healthcare providers are often licensed in multiple states, which then requires PCOs to cross-reference the healthcare provider survey results.

Given the current formula to calculate a HPSA score (which can be found at https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation/scoring), the population-to-provider ratio is the only metric within the formula that PCOs can gather data on and report to the Shortage Designation Management System (SDMS). The iterative Shortage Designation process requires a HPSA score, regardless of whether the HPSA score demonstrates enough of a shortage to qualify for scholarship or loan repayment award or not.

Therefore, it is in the interest of the public to identify, test, and gradually implement improved PCO information collection and reporting to the HRSA BHW Shortage Designation Branch.

2. **The accuracy of the estimated burden**

    a. **Average burden per response** - The effort to collect and process the data needed to prepare designations is greater than the estimated burden of 8 hours for designation planning, preparation and for entering the application into the SDMS.

        The effort for the required full-state provider updates is not included in the estimate of 8 hours provided by HRSA BHW. Our state PCO must ensure that the state provider updates are complete and accurate for designated or proposed designated areas and cover undesignated areas. This effort is not included in the 8-hour count stated in the RFI. The current processing of data has a high missing “Level of Effort” (LOE) that the PCO must identify, acquire, clean, analyze, and format for SDMS uploads and processing of data files (such as, licensure, survey, claims, and other supplemental data).

    b. **Provider status** - There is no clear, standard data set that tells PCOs when the provider has left the state. The current method often utilized is

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for state PCOs to share current provider location/status information with other states to identify duplicate data.

3. **Ways to enhance the quality, utility, and clarity of the information to be collected**

   In conversation with our state PCO, the following recommendations were obtained:

   a. **Supplemental data** – It would be immensely beneficial if BHW were to include applicable, nationally available, supplemental data, such as National Survey on Drug Use and Health (NSDUH) and U.S. Centers for Disease Control and Prevention (CDC) fluoridation data pertinent to facility and area service areas/designations, where available, rather than having the state PCOs acquire and upload that information.

   b. **Update stamp** – The 'tagging' of each piece of information within the SDMS that is editable by PCOs would also ease the burden for the state PCO, as this 'tagging' would quickly identify *specific changes*, as well as noting who made the change, the date, and time of the change. We recommend that the detailed changes be provided as a separate downloadable file for the state PCOs.

   c. **Geocoding** – We recommend that the geocoder tool settings be expanded to allow street range address matches, after not finding an exact match. This change would reduce the number of entries that the PCO needs to manually geocode.

   d. **Contiguous areas** - Contiguous areas of Statewide Rational Service Areas (SRSAs) are still required for HPSA applications. Efficiency could be introduced by eliminating this requirement when an HPSA selection is based on the approved SRSA's.

   e. **Service areas, especially non-contiguous areas** - It is important to recognize that patient populations in small, disadvantaged areas' are not similar to the population residing in larger, nearby areas. Such differences are exacerbated in non-contiguous areas. Caution is warranted and combining such areas should be avoided, as these areas are distinct disadvantaged areas and should be highlighted. It would, therefore, be helpful to continue to provide the PCO with the ability to adjust SRSAs to account for socioeconomic differences, such as areas that are non-contiguous.

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4. **<u>The use of automated collection techniques or other forms of information technology to minimize the information collection burden</u>**

    a. **Acquisition of data** - Although there may be a federal 'sister' agency data acquisition procedure to consider, there would be a reduction of LOE at the state level if the federal government could access the data directly and provide the data to the state PCOs. Specifically, we recommend that the BHW work with the Centers for Medicare & Medicaid Services (CMS) directly to obtain Medicaid claims data. This change would <u>significantly</u> reduce the burden of effort if integrated directly by BHW. The state PCOs would not need to request the data from the state Medicaid department or rely on other agencies/partners to provide the outputs if BHW could aggregate the claims and give this information directly to the PCOs.

    We recognize that there would have to be some policy development on how to process the data. For example, how should organizational claims be dealt with? However, once these policies were developed, the time saved for the state PCOs as well as the federal agencies would be massive. Data accuracy would also likely be improved.

    b. **Matching addresses** – We recommend amending the system to allow PCOs to compare various data sets (such as claims data and various survey data sets) that contain addresses against the BHW address locator - using a consistent location identification (ID) that PCOs can replicate and easily match.

    c. **Provider imports** - There are currently no reoccurring data checks to the National Plan and Provider Enumeration System (NPPES) provider imports. For example, if addresses were removed/deactivated/marked as inappropriate during provider inputs at a BHW system level, i.e., by military bases or Veterans Affairs (VA), the hours spent by the state PCOs having to manually update the data would be reduced significantly.

    d. **Address duplications** - Duplication of practice addresses with identical data persists in the system, which causes added effort for the state PCO to review the records and mark providers as "inactive." We recommend that BHW implement a review for duplication of this type on a routine basis.

    We recognize that for the changes noted above, several steps would be needed:

    - Development of a policy and guidance would be needed for data processing (i.e., Medicaid claims) at a federal level;

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- Development of a policy to address individual National Provider Identifier (NPI) applied to a servicing/rendering provider with Medicaid claims would be needed; and
- An update of the NPPES NPI Registry requirements would be necessary to include current, practice information, along with a requirement for providers to update the registry or for CMS to require an update schedule (if this does not yet exist).

However, the burden savings would likely be significant, as well as likely improving data accuracy.

5. **<u>The critical importance of the state PCO</u>**

In addition to the critical role the state PCO performs with the SDMS and identification of required shortage designations, the state PCO performs many tasks that are linked to communication, data accuracy, advancement of workforce programs, and healthcare access in general. Some specific tasks include, but are not limited to:

- Direct promotion of the National Health Service Corps and Nurse Corps scholarship and loan repayment programs to potentially eligible applicants through email and in person events throughout the year.

- Notification of various health professional schools about the application cycles for scholarship and loan repayment programs. In-person events include high school career fairs, health workforce conferences, and other events where healthcare professional students are convened.

- Because the Hawai‘i State Department of Health currently does not have a statewide oral health program, the state PCO contracts the Hawai‘i Oral Health Coalition to build and support coalition activities. The state PCO volunteers on the Hawai‘i Oral Health Coalition Workforce Committee and promotes engagement activities (e.g. outreach to the public high schools to promote recruitment to the dental professions).

- Provision of ongoing technical support to the Rural Health Clinics (RHCs) as there are no other organizations in Hawai‘i performing this necessary service. RHC technical support includes contracting with consultants to conduct webinars and speak at an annual conference on a variety of topics such as billing, revenue, disaster preparedness, quality metrics, current RHC policies and guidance from CMS, and operations.

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- When funds are available, the state PCO partners with other nonprofit entities, such as the Hawai‘i/Pacific Basin Area Health Education Center (AHEC), Hawai‘i State Rural Health Association, University of Hawai‘i Rural Health Research and Policy Center, 3RNET, Hawai‘i Primary Care Association, Hawai‘i Department of Health Executive Office on Aging, and other organizations who share similar goals.

6. The critical importance of the shortage designation system for rural health access

The shortage designation system is critical to ensuring adequate health care services and access for especially rural and remote populations – especially due to the non-contiguous nature of our state. The SDMS role in provision of federal funding to areas and populations that experience significant healthcare workforce shortages is a key to unlocking our ability to successfully address chronic illnesses. Without consistent and adequate federal funding, rural health access will significantly decrease, as there are a wide variety of federal programs that are dependent on the shortage designation system, as can be seen in the chart below:

Federal Program Dependencies

	Shortage Designation Type	National Health Service Corps (NHSC)	NURSE Corps	Health Center Program	CMS Medicare Incentive Payment	CMS Rural Health Clinic Program	J-1 Visa Waiver Program
HPSA	**HPSA Disciplines**						
	Primary Care HPSA	X	X		X	X	X
	Maternity Care Target Area (MCTA)						
	Dental Care HPSA	X					
	Mental Health HPSA	X	X		X		X
	HPSA Categories						
	Geographic HPSA	X	X		X	X	X
	Population HPSA	X	X			X	X
	Facility HPSA	X	X				X
MUA/MUP	**MUA/P Types**						
	Exceptional MUP			X			X
	Medically Underserved Area (MUA)			X		X	X
	Medically Underserved Pop (MUP)			X			X
GDSC	**Other Designation Type**						
	State Governor's Designated Secretary-Certified Shortage Area (GDSC)					X	

RHRPC greatly appreciates the opportunity to provide input, ensuring our commitment to accuracy of data and reduced burden in data preparation, while also ensuring affordable access to care and medicines for all patients, especially those who reside in remote, rural communities. For questions or more information, please

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reach out to Diana M V Shaw, PhD, MPH, MBA, FACMPE, Rural Health Policy Advisor, at dmshaw@hawaii.edu.

Sincerely,

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