WPHCA
Wisconsin Primary Health Care Association

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

Re: *Information Collection Request Title:* Shortage Designation Management System OMB 0906-0029-Extension https://www.federalregister.gov/d/2025-08819

To Whom It May Concern:

The Wisconsin Primary Health Care Association (WPHCA) is an association of Wisconsin's 17 Community Health Centers funded under section 330 of the Public Health Services Act and 2 Health Center Program Look-Alikes. In addition, WPHCA serves as a contractor for the Wisconsin Primary Care Office (WI PCO) and is responsible for completing all functions related to the preparation, analysis, and submission of shortage designations for the state of Wisconsin. With this experience, WPHCA is uniquely situated to provide HRSA with comments regarding the burden statement published in volume 90, number 95, page 21318 in the Federal Register on May 19, 2025. These comments are organized into 5 sections: the first 4 sections answer the questions requested by the Health and Resources Services Administration (HRSA) and the last section has other general comments.

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

There are several data points required to submit a Health Professional Shortage Area (HPSA), Medically Underserved Area (MUA), or Medically Underserved Population (MUP) designation application, such as resident civilian population, provider Full Time Equivalency (FTE), poverty status, status of water fluoridation, and drug and alcohol abuse. Maintaining accuracy of this data is important to properly determine if an area has a shortage of primary care physicians, psychiatrists, or dentists. This is particularly important as significant federal and state resources, for example Medicare and Medicaid bonus payments and loan repayments, are allocated based on an area's shortage designation status and score. Most of this data can be collected from existing sources such as the US Census. The provider FTE per location data, however, is not currently available in any existing sources, such as the National Provider Identifier (NPI) data. Thus, the provider FTE per location data must be

collected by the Primary Care Office and its contractor (WPHCA), which is a time-intensive process. The provider FTE per location data is particularly important as it determines the population-to-provider ratio and this ratio determines if an area can be designated and what the base HPSA score for that area will be.

2. The accuracy of the estimated burden

The estimated burden of 38,644 hours split across 54 Primary Care Offices (PCOs) equals 716 hours per PCO. It is an accepted principle that 1 FTE is equivalent to 2080 hours annually (40 hours per week multiplied by 52 weeks = 2080 hours), inclusive of vacation and holidays. The estimated burden of 716 hours per PCO is thus equivalent to 0.34 FTE (716/2080 = 0.34). The Shortage Designation Management System (SDMS) for Wisconsin currently has 9,067 unique provider location combinations for primary care physicians, certified nurse midwives, dentists, and psychiatrists with the status of eligible, meaning the hours for each of these counts for HPSA determination purposes. Wisconsin is an average size state with a population of about 6 million people. Between Wisconsin's PCO and WPHCA, approximately 1.5 FTE are devoted to collecting, submitting, and analyzing data for HPSA and MUA/P designations, putting the burden estimate at 4.4 times that which is estimated in this federal register notice (FRN). WPHCA can attest that at 1.5 FTE devoted to this work, there is a lot of prioritization that needs to happen. It is unreasonable to collect accurate data on 9,067 unique provider location combinations annually with 1.5 FTE. In Wisconsin, providers can choose, but are not required, to provide FTE data for up to three locations they work at as part of the license renewal application. Between 30 and 60% of providers choose to do so; however, formatting these data, matching state license numbers to federal NPI numbers, and importing the data into SDMS takes significant time. The Medicaid office provides WPHCA and the WI PCO with Medicaid Claims data to import into SDMS. Providers' work locations and specialty in the Medicaid Claims data often differs from what the provider voluntarily reported as part of their license renewal. It takes time to review and rectify these differences. WPHCA also surveys clinics to gather data needed for HPSA applications, which can take significant time in back-and-forth communications. In addition, providers are automatically added to SDMS based on data they submit to the National Plan and Provider Enumeration System (NPPES). The addition of these providers can result in providers showing up in SDMS with more than 1 FTE, which is in opposition to HPSA regulations that limit a provider to 1 FTE, thus reviewing providers with more than 1 FTE in SDMS is also required. Finally, all this work, plus the work of creating and submitting HPSA applications takes place in a system that often runs

slowly and periodically crashes, often creating a need to re-do lost work. In summary, the estimated burden of 38,644 hours split across 54 Primary Care Offices (PCOs), which is the equivalent of .34 FTE, is a woeful undercount of the burden of this work.

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

The default FTE for a provider in a Population Group – Low Income HPSA is zero. It is the responsibility of each PCO to gather data on the amount of time each provider spends serving patients insured by Medicaid and patients that are uninsured using a sliding fee scale. Based on this data, the default FTE of zero is adjusted upward. The current structure can inadvertently undercount low-income physician FTE when a state does not have adequate resources to collect this data, thus artificially increasing the Population Group – Low Income HPSA scores in that state. BHW should calculate and use the national average in SDMS for the percentage of patients using Medicaid or on a Sliding Fee Scale. Alternatively, BHW can look for other national data sources such as the American Medical Association (AMA.) Using approaches such as these will ensure a more even playing field for HPSA designations across states.

To determine if an area is a Medically Underserved Area (MUA) or a Medically Underserved Population (MUP) the area is analyzed across 4 factors, providers per 1,000 population, percent of the population living at or below 100% of the federal poverty level, percent of the population age 65 and over, and the infant mortality rate. Per BHW's website "MUAs have a shortage of primary care health services within geographic areas such as: A whole county…" and "MUPs have a shortage of primary care health services for a specific population subset within a geographic area." Currently BHW only looks at the population subset when determining the number of providers per 1,000 population. To enhance the quality of the MUP data BHW should calculate the percentage of the population 65 years of age and older from the subset of people living at or below 200% of the federal poverty level. This can be done using the census table B17024: Age by Ratio of Income to Poverty Level in the Past 12 Months. Similarly, the infant mortality rate should be calculated based on the subset of infants born to women living at or below 200% of the federal poverty level, if that data is known.

4. Use of automated collection techniques or other forms of information technology to minimize collection burden.

SDMS is currently pre-filled with National Plan and Provider Enumeration System (NPPES) data. If HRSA could partner with CMS to ensure providers are keeping NPPES up to date

and add FTE by location to NPPES, that would minimize the burden of collecting this data directly by the PCO.

Currently, the speed and responsiveness of SDMS is slow, requiring the user to sit idle for some second or minutes while the database catches up. Whereas SDMS maybe has a few hundred users actively working in the system at any given time, other software such as Google likely has billions of users at any given time and responds almost instantaneously. WPHCA and the WI PCO encourage BHW to invest in the technology necessary to ensure that SDMS is similarly responsive to the relatively small group of users that rely on it to create and submit HPSA and MUA/P designations. This technological improvement will help decrease the collection burden.

5. General comments

The inaugural Congressional Justification of the Administration for a Healthy America (AHA) request for the Fiscal Year (FY) 2026 Budget states "AHA will work to ensure that Health Center Program grantees are continuing to serve as a safety net for low-income and medically underserved populations…" It is not yet known how AHA will accomplish this, however, a Paragon Health Institute report titled "Where Are Provider Shortages? Reassessing Outdated Methodologies" recommends updating the list of medically underserved areas (MUAs) and medically underserved populations (MUPs) using existing methodologies. If this recommendation were to move forward, it would increase the burden hours to collect relevant data and would be a significant, time-intensive exercise with for PCOs and their contractors, who are operating on limited budgets. As noted in section 2 "The accuracy of the estimated burden" of this commentary, even with the 1.5 FTE devoted to this work at WPHCA and the WI PCO there is substantial prioritization that needs to happen.

Another recommendation from the Paragon report is to add Nurse Practitioners and Physician Assistants to the provider count for HPSAs and MUA/Ps. Should HRSA accept this recommendation, counting these providers will substantially increase the data collection and analysis burden, and should only be undertaken if the requirement comes with commensurate funding. In addition, should this change take place, the scoring rubric for the population to provider ratio for HPSAs and MUA/Ps would require updating, as societal expectations since the 1960's when the HPSA regulations were written and a ratio of 3,500 people for every one provider was considered a shortage.

More importantly, it is our sincere hope that HHS see each existing Health Center as a commitment to the community they serve and as such HHS interpret MUA/Ps as a tool for

determining where to fund new Health Centers and not a tool to determine where to defund existing Health Centers. For PCOs to be effective in enumerating the primary care staffing needs of our states, we need both adequate funding and sufficient timelines. As stated above, the current work is already extensive, and the burden undercounted. Many in the Community Health Center and Public Health worlds are open to collaboration and have ideas on how to improve these systems and would be interested in exploring ways to engage in Negotiated Rulemaking to provide enhancements to the current designations.

Thank you for the opportunity to respond to the burden statement. Please feel free to contact Aleksandr Kladnitsky (akladnitsky@wphca.org or 608-571-6017) of my staff if you have any questions or comments.

Sincerely,

Scott Stewart, MPA
Chief Executive Officer
Wisconsin Primary Health Care Association