STATE OF ALABAMA DEPARTMENT OF
PUBLIC HEALTH
Donald E. Williamson, MD
State Health Officer
June 5, 2015

HRSA Information Collection Clearance Officer
Room 10C-03, Parklawn Building
5600 Fishers Lane
Rockville, MD 20857

Dear Information Collection Clearance Officer:

RE: Response to Federal Register Notice (FRN) 80 FR 18240, Shortage Designation Management System (SDMS) OMB No. 0906-xxxx-New

In response to the FRN Paperwork Reduction Act notice, the Alabama Primary Care Office (PCO) submits the following comments regarding the burden statement as defined in the FRN as the "time expended by persons to generate, maintain, retain, disclose, or provide the information requested. This includes the time needed to review instructions; to develop, acquire, install and utilize technology and systems for the purpose of collecting, validating and verifying information, process and maintaining information, and disclosing and providing information; to train personnel and to be able to respond to a collection of information; to search data sources; to complete and review the collection of information; and to transmit or otherwise disclose the information." The total estimated annualized burden hours cited in the FRN are 4.25 average hours for Designation Planning and Preparation and 1.75 average hours for the SDMS Application, which total 6 hours for the entire process.

Alabama has over 4.5 million residents spread over 67 counties, each with a varying number of physicians that require surveying. Jefferson County has over 1,000 physicians that indicated 1 of the 5 primary care disciplines on their licensure renewal applications. This translates into an estimated 13 weeks, or 520 hours, to conduct a complete application starting with the survey process and preparing an application for submission. Seven counties have between 100 and 400 similar physicians, which require an estimated 6 weeks, or 240 hours, to conduct the survey and prepare the Health Professional Shortage Area (HPSA) application. An additional 59 counties have less than 100 physicians needing to be surveyed, which takes an average of 3 days, or 24 business hours, to collect data and complete a HPSA application for each county. The PCO estimates the time between initiating a primary care survey and completing a HPSA application in a range of 3 days to 13 weeks, a significant difference from the 6 hours cited in the FRN.

The FRN did not fully capture the extent of the process which includes time to survey the physicians, gather Medicaid claims data, update the physician data set, enter data into SDMS, verify geocoding changes, develop and attach documentation to the application, and review the application before submission. Given the emphasis on scoring and other programs that benefit from certain HPSA types, the PCO carefully analyzes each Rational Service Area (RSA) for eligibility and scoring potential for various HPSA types: Geographic, Geographic with High Needs, and Special Population. This thorough analysis of each RSA to maximize potential utilization of the designation on behalf of the community adds time and effort to the

process. It is a necessary step in order to properly represent the communities of Alabama through the HPSA designation application.

The FRN requests comments on "the necessity and utility of the proposed information collection for the proper performance of the agency's functions..." The proposed information collection process is inadequate for the proper performance of gathering data and preparing HPSA applications. Accurate data is necessary to determine areas qualified for HPSA designation, which is captured through a thorough data collection process completed by the PCO. SDMS has been developed using National Provider Identifier (NPI) data for physician information. NPI records are created at the time a physician applies for an NPI number. The Centers for Medicaid and Medicare Services does not require that providers update their NPI location information, which has led to a high rate of inaccurate provider locations in SDMS. The PCO is able to determine which physicians are working in a county based on annual licensing data provided by the Alabama Board of Medical Examiners, which is more current data than that of NPI. Furthermore, in SDMS, physician addresses outside of the state cannot be changed by the PCO. Only the PCO in the state where the physician is listed by NPI has the authority to update their provider data in SDMS.

Unlike other states, Alabama is not able to collect provider Full Time Equivalence (FTE) during the re-licensure process. Alabama's annual licensure process provides the location of physicians by address and county, but the FTE data must be collected by electronic surveys sent directly to physicians and telephoning those physicians not responding to the surveys. Alabama, like many states, has created a provider data management system with correct service addresses and FTE data. This data set is updated with information from subsequent HPSA application surveys. It would be most helpful if the Bureau for Healthcare Workforce would allow the PCO to upload this data into SDMS, saving time and preventing errors due to individual data entry for each provider in the state.

The SDMS Super User Group has collected a list of issues relating to the quality and accuracy of SDMS pre-populated data, as well as recommended solutions for many of those issues. The Alabama PCO has reviewed this list and concurs that the same issues affect the preparation and submission of accurate HPSA applications. At a time of reduced economic activity, decreased state and federal funding, and a decreased supply of providers, HPSAs are crucial to developing and supporting infrastructure at the community level. Accurate data is imperative for creating HPSA applications reflective of community needs. The HPSA application time burden and issues with the proposed information collection process need to be recognized in order for funding to accurately cover the staffing needed to perform this important task.

If you require additional information or details, please do not hesitate to call 334-206-5229 or email Carrie.Allison@adph.state.al.us.

Sincerely,

Carrie A. Allison

Carrie R. Allison
Alabama Office of Primary Care and Rural Health

CA/DR

From: Nagra, Baljinder@OSHPD [mailto:Baljinder.Nagra@oshpd.ca.gov]
Sent: Friday, April 10, 2015 1:16 PM
To: HRSA Paperwork
Subject: Agency Information Collection Activities: Proposed Collection: Public Comment Request

1) The data and information have had its issue, for starters the population count numbers are off. When determining a shortage of providers everything is based on a population to provider ratio, if the population numbers are incorrect, it impedes our ability to to move forward.

There have been data that has not been visible to PCO's, such as the demographic and socioeconomic information for contiguous areas. It would be greatly appreciated if this data were visible so we can verify and compare disparity numbers to ensure they are correct.

The provider management system should not interfere with our ability to create a map, since provider data defaults to 40 hrs. for all providers it shows the area as not meeting the population to provider threshold when trying to create a map. This is very problematic for us especially when trying to conduct a pre analysis.

2) ???

3) Honestly, stop trying to integrate provider data with mapping functions. The way the system is designed is flawed, SDMS wants provider data and information beforehand. It has been reiterated many times on numerous calls and stressed constantly to make sure provider data is accurate as possible. I agree that we should stress to get the provider data as accurate as possible, however why does it stop me from moving forward. This is what all the problems are boiling down to, at one point or another we don't have the ability to move forward with the application.

4) One can't move forward without inputting provider data first, which makes absolutely zero sense. If I want to analyze an area to determine if it might possibly qualify as a HPSA it makes no sense to gather data on providers if I am trying to conduct a pre analysis. Let us look at the map and rule out contiguous and get an idea of what areas need to be surveyed.

5) A lot of things are already automated, however a lot of it has not been accurate. For instance contiguous areas are being ruled out that shouldn't be, and when the automated test is being ran to rule out contiguous areas it stops when is passes and does not run the test all the way through. I would strongly advise that the test should be ran through fully and everything be visible that it can be seen, rather than simply saying passed.

OSHPD Office of Statewide Health Planning and Development

Healthcare Workforce Development Division
400 R Street, Suite 330
Sacramento, California 95811-6213
(916) 326-3700 Main Line
(916) 322-2588 Fax
www.oshpd.ca.gov

June 8, 2015

Information Collection Clearance Officer
Room 10C-03, Parklawn Building
5600 Fishers Lane
Rockville, MD 20857

RE: *Comments on Shortage Designation Management System OMB No. 0906-xxxx-New*

To whom it may concern:

The Shortage Designation Program (SDP) within the Office of Statewide Health Planning and Development (OSHPD) is the Primary Care Office (PCO) for the state of California. As the PCO, SDP is the point of contact and primary liaison to the Health Resources and Services Administration (HRSA) for all functions relating to Health Professional Shortage Areas (HPSA) and Medically Underserved Areas/Population (MUA/MUP) designations within the state of California. Below is SDP's response to HRSA's request for comments regarding '80 FR 18240.'

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

SDP agrees that it is necessary to collect accurate and up to date data related to HPSA and MUA/MUP designations. The current iteration of the Shortage Designation Management System (SDMS) includes data from the National Provider Identifier (NPI) and relevant U.S. census data; the PCO's data responsibility is to survey and input the Full Time Equivalent (FTE) data from clinics and other Primary Care providers located in the proposed rational service area and contiguous areas. The PCO is limited in the local and state data that can be inputted to SDMS, particularly entering providers into SDMS that are not in the NPI data. By limiting the PCO's ability to correct data within the SDMS system HRSA will be unable to properly perform the functions outlined within the federal rules and regulations for HPSAs and MUA/MUPs. SDP recommends SDMS allow PCO input into the provider data collection methods in addition to reviewing SDMS to ensure that it is following federal rules and regulations for HPSA and MUA/MUP designations.

2. *The accuracy of the estimated burden*

The estimated burden (6 hours) for designation planning, preparation, and application submission is underestimated based on SDP's experience surveying, analyzing, and submitting HPSA applications. California is the most populous state in the U.S. consisting of 542 Predefined Rational Service Areas (PRSA). On average, it takes SDP 60 hours to plan, research, and survey providers in PRSAs for proposed HPSA designations as well as the contiguous areas if necessary. The state has a full spectrum of PRSAs ranging from small frontier and rural areas to some of the most densely populated area in the country. The 60 hours is an average of all those areas with some frontier areas needing less time and some urban areas that can take nearly twice the average amount of time. In addition, it takes an average of 8 hours to enter the survey data into SDMS and correct any errors that may arise, and 1-4 hours to map out the proposed and contagious areas, depending on the population density of the area, as well as assign the nearest source of care and upload supplemental documents. The estimated burden does not take into account the time burden of the more populated states in the country as well as time required for those states to survey and build maps using SDMS.

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

The California PCO does not have access to provider FTE data through the various licensing boards. SDP staff is currently responsible for searching for providers through various resources and surveying providers in PRSAs and their contiguous areas for HPSA designations. In order to enhance the quality and accuracy of the data collected by SDMS the PCOs should be able to edit the provider data in SDMS and add and remove providers using the local data collected by the PCOs.

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

The current SDMS system does not have the capability for PCO's to upload provider data. PCO's are required to go into the system and update every record. It takes an average of 8 hours to update provider data for one PRSA in California. An additional function to upload provider data will make the process more efficient and less burdensome. SDP also recommends SDMS allow PCO's to add missing providers into the system. SDP does support automating collection techniques for the benefit of efficiency, however SDMS as it is designed now does not allow for inputting of new providers and inconsistencies in following HPSA and MUA/MUP rules and regulations in SDMS prevents PCOs from minimizing the collection burden. In SDP's experience, SDMS has had minimal to no positive impact on the time burden required for HPSA and MUA/MUP designations when compared to the previous

electronic shortage designation system used by HRSA, the Application Submission and Processing System (ASAPS).

We appreciate the opportunity to comment. Should you have any additional questions, please feel free to contact me at (916) 326-3734 or via e-mail at hkhosrov@oshpd.ca.gov.

Sincerely,

Hovik Khosrovian
Manager, California Primary Care Office

Information Collection Request Title: Shortage Designation Management System OMB No. 0906-xxxx-New.

Document Citation: 80 FR 18240, Document Number: 2015-07673

In response to FR Doc. 2015-07673, filed on 4-2-2015 regarding *Information Collection Request Title: Shortage Designation Management System*

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

Information collection regarding the use of the National Provider Identifier

The National Provider Identifier (NPI) clinician registry is of little utility in the conduct of shortage designation needs assessment. According to the Centers for Medicare Medicaid Services:

> *All of the information collected by NPPES is self-reported and CMS attempts to verify only two things: (1) the provider's social security number and (2) that the provided business address is valid. CMS does not verify whether the provider actually works at the submitted business address, and CMS does not attempt to verify the provider's self reported specialty. Much of the supplied information, including the self-reported specialty taxonomy codes, is available in a searchable public database (National Plan & Provider Enumeration System, n.d.), and is available for research purposes from CMS through a data use agreement. Once a provider has an NPI, there are no scheduled requests for updated information; however, providers are instructed to update their information in NPPES within 30 days of a change of required data fields. The degree to which providers update their information is not fully known.*[1] *(underlining added)*

Because CMS policy regarding NPI does not "intend" to create a system to enumerate and track the practice location of clinicians, it cannot be expected serve as a meaningful workforce baseline for shortage designation analysis.

In Colorado's experience with NPI data, it was found that the NPI does not correspond to reliable and independently verified clinician data sets available for analysis. Our analysis has determined that NPI both *overstates* provider capacity with excess clinician records and *understates* provider capacity with missing clinician records.

In a sample of 60 Colorado service areas, the NPI data set reported an 87 percent excess of clinician capacity. The time needed to identify and "zero-out" non-pertinent data in the Shortage Designation Management System (SDMS) is estimated to be 224 hours (calculated at 3 minutes to identify and update per unneeded record).

---

1 Bindman, A. B. (2013). Using the national provider identifier for health care workforce evaluation. Medicare & medicaid research review, 3(3).

NPI also failed to capture 21 percent of clinicians working in this same sample of 60 service areas. In states less prepared to resolve the question of missing capacity in NPI, some service areas will likely receive a shortage designation when technically ineligible because of understated clinician capacity.

To remedy the problem of missing clinician data, current HRSA policy directs PCOs to contact the providers in question and request that the provider update his or her NPI record. The time needed to identify, notify, and follow up with clinicians without a current NPI record is estimated to be 182 hours for Colorado (calculated at 10 minutes to identify, contact, and verify update, per record). This estimate is conservative in that it is not known how much PCO effort will be needed to convince at least 1000 clinicians to update their NPI information. Furthermore, because we have no means of compelling providers to update practice information in NPI, it may not be possible to update all missing records.

A specific case example for a medium sized urban county

> The Colorado PCO conducted an analysis of Larimer County Colorado in the spring of 2015. The NPI data set indicated that there were 378 primary care physicians practicing in Larimer County. Our analysis found that only 273 clinicians were in fact practicing in the county. Of practicing physicians, 156 NPI records were found to report an accurate practice address. As a result, 222 NPI records had to be zeroed out or substantially modified. Furthermore, 48 physicians were found to be practicing in the community but were not represented in the NPI data set. An additional 38 physicians had two practice locations but SDMS does not currently accommodate reporting for clinical care in multiple locations by the same individual. To date, this one designation analysis has required 20 hours of survey effort and 20 hours of data correction and entry. This designation analysis is not yet complete.

The total estimate of 406 hours to revise and improve NPI data will only produce a dataset that is already available to Colorado from a license agreement with www.medicalquest.com. This proprietary database provides accurate and current physician practice data from which we have traditionally based HPSA survey analysis. As a result, the effort to improve NPI data will accrue no benefit to HPSA analysis above what is already available to Colorado without 406 hours of additional labor.

2. The accuracy of the estimated burden

The HRSA reported estimated burden on states to manage shortage designation applications in SDMS substantially understates the actual reporting burden states will experience. Colorado has traditionally allocated 832 hours per year to maintain HPSA designations. Approximately one third of Colorado's active designations were updated each year with this allocation of staff time.

In the new SDMS context, we estimate that it will require 15.4 hours per HPSA application. This assumes that the technical submission of applications in SDMS substantially improves with further programing development. Without technical improvements in SDMS, this per application burden estimate could be substantially higher.

The Colorado PCO collected data from other state PCOs on their process experience with SDMS. The results gathered from 51 of 54 state/territories as of June 1, 2015 are as follows:

	Submitted	Approved by HRSA
HPSA applications	45	0
MUA/P applications	15	6
Total	**60**	**6**

This application processing experience represents the total effort by PCOs working in SDMS since December of 2014. SDMS will have to accommodate a more than 100-fold increase in throughput to manage existing shortage designations on an annual update cycle.

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

Most state and territorial PCO's have a track record of high performance in data collection and analysis. A cooperative relationship with HRSA facilitates reliable needs assessment that results in efficient and fair allocation of public resources to workforce needs. State's that can demonstrate competence to produce accurate designation assessment should have a reasonable means to introduce that data into SDMS without inefficient and labor intensive per record user interfaces.

4. The use of automated collection techniques or other forms of information technology to minimize the information collection burden

The Colorado PCO supports the use of automated collection techniques or other forms of information technology to minimize the information collection burden. Automation collection techniques must, however, produce data that is accurate at the service area level. Automation that does not produce accuracy will substantially increase the information collection burden and result invalid service area level analysis.

Submitted by

Stephen Holloway
Branch Chief
Health Equity and Access Branch/Primary Care Office
P 303.692.2582 | C 303.246.5116
4300 Cherry Creek Drive South, Denver, CO 80246-1530
steve.holloway@state.co.us | www.coloradohealthservicecorps.org

DC Primary Care Bureau Comments on:
Information Collection Request Title: Shortage Designation Management System OMB No. 0906-xxxx-New.

Document Citation: 80 FR 18240, Document Number: 2015-07673

Link: https://federalregister.gov/a/2015-07673

The Primary Care Bureau of the District of Columbia Department of Health is the designated Primary Care Office for the District of Columbia and, in that capacity, is responsible for the District's HPSA and MUA/MUP designation process. As a "likely respondent" as defined in the cited Federal Register Notice (FRN), the Primary Care Bureau (PCB) within the DC Department of Health's Community Health Administration is pleased to have the opportunity to provide comments in response to *Information Collection Request Title: Shortage Designation Management System OMB No. 0906-xxxx-New.*

The FRN outlines four areas of inquiry on which the Health Resources and Services Administration (HRSA) is requesting comments: (1) the necessity and utility of the proposed information collection for the proper performance of the agency's functions, (2) the accuracy of the estimated burden, (3) ways to enhance the quality, utility, and clarity of the information to be collected, and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden. The PCB is limiting its comments to areas 2, 3, and 4.

2. **The accuracy of the estimated burden**
   The FRN includes average burden hour estimates for two key steps in the shortage designation process: "Designations Planning and Preparation" and preparation of an "SDMS Application". The PCB believes the estimates of 4.25 and 1.75 hours for Designations Planning and Preparation and Preparation of an SDMS Application, respectively, grossly underestimate the actual time required; the bulk of this section will focus on those hourly estimates.

   Prior to addressing the hourly estimates, however, the PCB would first like to propose that the "Number of Responses per Respondent" – also used in calculating the "Total Burden Hours" for each step are incorrect. For Designation Planning and Preparation, which would involve gathering and updating the provider data (among other tasks), HRSA posits that there is one (1) "Response per Respondent" (i.e. one dataset that must be developed to carry out the designations). However, since the PCO prepares applications for three disciplines (primary care, mental health, and dental) involving distinct provider types, there are in fact three (3) "Response[s] per Respondent" (i.e. provider datasets that the PCO must develop/refine) – one distinct dataset for each discipline. Similarly, the "Number of Responses per Respondent" estimated for the "SDMS Application" phase of the designations process, is 23 (i.e. each state would submit an average of 23 HPSA applications per year). However, by the PCOs' estimates, the average number of HPSA applications the

states submit should be closer to 75 – assuming 12,000 non-auto HPSA designations nationwide and a three (3) year renewal cycle. It is unclear from the FRN how the estimate of 23 was calculated.

Accordingly, solely on the basis of the "Number of Responses per Respondent" (i.e. without even revising the hourly burden estimates), the PCB proposes that the "Total Burden Hours" should be significantly higher than what was submitted in the FRN:

- Designation Planning and Preparation: **6,885** (i.e. 3*54*4.25) **instead of 229.5**, and
- SDMS Application: **7,087.5** (i.e. 75*54*1.75) **instead of 2,173.5**.

The PCB also finds the hourly burden estimates in the FRN for "Designations Planning and Preparation" and for preparation of an "SDMS Application" to be significantly lower than the actual hourly burden. Because each state approaches the designation process differently, DC's estimates may not be representative of the other 53 state and territorial "likely respondents". In particular, due to the fact that all of DC's HPSAs are currently on the same designation/renewal cycle and that DC's geographic footprint is small enough that virtually all of DC's census tracts must be considered in a designation as either part of a rational service area (RSA) or its contiguous areas, DC updates the data for all providers of a given discipline at once rather than on a county-by-county or HPSA-by-HPSA basis. This includes (according to data currently in the State Designation and Management System (SDMS)) 435 psychiatrists, 2,385 core mental health practitioners, 542 dentists, and 1,541 primary care physicians.

To ensure accurate data - and in particular: tour hours by location, verification of relevant services, and use of sliding-scale fees, the PCB relies on gathering and linking multiple discrete datasets, including, but not limited to:

- From the District's Health Regulation and Licensing Administration:
  - Licensure
  - Physician Workforce Surveys
  - Online Physician Profiles;
- From the State Medicaid Agency, Medicaid claims (Managed Care and Fee-for-Service);
- National Provider Identifier (NPI); and
- Direct surveys of health care facilities and/or individual health care practitioners.

To provide some context for the PCB's forthcoming estimates, below is a rough summary of the work required to get these data into a usable format:

1. Engage agency-owners of data;
2. Develop and refine queries of agencies' proprietary databases to ensure extraction of complete and appropriate data (e.g. all relevant providers);
3. Assess validity and reliability of queries;
4. Clean and standardize data elements to prepare for linkage;
5. Establish protocol for matching provider records and validating matches;

6. As necessary, manually triangulate data to calculate data points for which perfect data do not exist (e.g. tour hours) or for which there are conflicting data;
7. Identify and survey providers, as necessary, to gather missing data;
8. Create a clean provider data file with required data elements/Update provider records.

Steps 1-6 alone take on the order of weeks – rather than hours – to carry out. Common challenges that states face in carrying out these steps include: absence of common unique provider identifiers (e.g. NPI, license number, etc.) for matching, misspelled names, incorrect/varying and/or multiple addresses (including addresses in multiple states), duplicates, missing/incomplete data points, misclassification of providers, inconsistently formatted data, etc. The survey process (Step 7) requires drafting letters of introduction, surveys, and abbreviated surveys; mailings (electronic and paper); phone and email follow-up; and manual data entry. Depending on the number of providers to be surveyed, this step can also take weeks to complete.

The PCB therefore *conservatively* estimates the hourly burden to be between 160 and 400 hours for each discipline (primary medical, mental health, and dental).

And finally, Step 8: "Updating provider records", is a monumental task in SDMS. Whereas in ASAPS, the PCOs were able to prepare an Excel provider data file and submit it for upload into the system, SDMS requires that PCOs update their states' provider datasets record-by-record (i.e. provider-by-provider). At a minimum, assuming PCO staff facility with SDMS, the PCB estimates at least 3 minutes per record (i.e. 77 hours for Primary Care; 21.75 to 119.25 hours for psychiatrist-only and core Mental Health, respectively; and 27 hours for Dental).

In summary, the PCB's conservative estimate of the *average* hourly burden for the provider data portion of the Designations Planning and Preparation phase of the designation process is 341 hours – or 8.5 weeks - per discipline.

Please note, the above estimates are for preparing the provider data only, and do not include the time required to collect and update population data.

With regards to the SDMS Application phase of the designation process for which the FRN estimates a burden of 1.75 hours, the PCB has not yet prepared/submitted an application in SDMS so cannot provide a per-application burden estimate. However, in ASAPS, the PCB spent an average of 16 hours per application.

3. **Ways to enhance the quality, utility, and clarity of the information to be collected?**
The PCB recognizes HRSA's critical interest in ensuring the integrity of the data used for HPSA designations and therefore the impetus behind HRSA's decision to adopt the NPI data as the base provider data in SDMS for all states. However, given that the PCOs will – and must - carry out the same validation and auxiliary data collection activities (as was necessary with the American Medical Association (AMA) data in ASAPS) to ensure accurate

provider data, the PCB posits that once refined, the SDMS provider datasets will be as reflective of the variability in state data collection/analysis practices as they were in ASAPS. In effect, the only difference will be in the amount of hours required for PCOs to update the datasets record-by-record versus submitting a complete and updated dataset for upload into the system.

In the shared recognition that there is no singular dataset that can provide the specificity of information required for accurate HPSA designations and that, as a result, any such dataset (i.e. NPI) will need to be considerably refined prior to use, the PCB proposes that HRSA do a combination of the following to enhance the quality, utility, and clarity of the information to be collected:

- Provide formal guidance and training to PCOs regarding best practices for refining provider data; and/or
- Support the creation of a national-level organization representing PCOs to provide technical assistance and foster communities of learning;
- Increase funding to PCOs to enable offices to hire dedicated HPSA data analysts; and
- Collaborate with PCOs/states to facilitate the enactment of state-level; legislation/regulations that mandate the collection of data needed for shortage designations; and in the immediate:
- Create quality control standards for state-produced provider datasets that would allow them to be uploaded into SDMS; and
- Ensure regular updates to the NPI data in SDMS do not overwrite data/updates entered by the PCOs;
- Meaningfully engage the PCOs as both technical and policy experts/partners in the ongoing development and roll-out of SDMS.

4. **Use of automated collection techniques or other forms of information technology to minimize collection burden.**
   Allowing states to submit datasets for upload into SDMS would be the single-most effective way to minimize collection burden. Otherwise, HRSA should sponsor a multi-disciplinary/multi-sector workgroup to identify additional opportunities for utilizing information technology to improve the data collection process for designations.

DAVID Y. IGE
GOVERNOR OF HAWAII

KEITH YAMAMOTO
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
HEALTH RESOURCES ADMINISTRATION
FAMILY HEALTH SERVICES DIVISION
P.O. BOX 3378
HONOLULU, HAWAII 96801-3378

In reply, please refer to:
File:

June 2, 2015

HRSA Information Collection Clearance Officer
Room 10C-03
Parklawn Building
5600 Fishers Lane
Rockville, MD 20857

In response to HRSA's proposed collection of information for use in determining shortage designations, please find comments below.

1. **The necessity and utility of the proposed information collection for the proper performance of the agency's functions**.
The Hawaii Primary Care Office (PCO) concurs with the purpose and utility of collecting and analyzing data and information specific to the number of health professionals and services available to communities. The fact that Health Professional Shortage Area (HPSA) and Medically Underserved Area/Population (MUA/P) designations are utilized by multiple federal programs supports the importance of ensuring the data gathered and used is the most current and valid available.

   As described in this Federal Register notice, HPSA and MUA/P designations are requested to use and be based on local, state and national data. Often local and state data are more recent and accurate than national data.

2. **Accuracy of the estimated burden**.
The estimated burden developed by HRSA of 4.25 hours to plan and prepare a designation significantly under-estimates the amount of time the Hawaii PCO spends in planning and preparing a HPSA and/or MUA/P application. Developing an accurate list of clinics in the service and contiguous areas, reviewing and updating the National Provider Identifier (NPI) list (mandated for use by HRSA), creating a mailing list, preparing the survey, cover letter, envelopes and return self-addressed stamped envelopes, surveying all the providers in the service area and contiguous areas, contacting all providers who have not responded to the survey request (this may require at least 3 attempts), and entering the survey data in Shortage Designation Management System (SDMS) requires a minimum of 20 hours.

Similarly, the estimated burden of time reported in the Federal Register as 1.75 hours to submit an application is a gross under-estimation of time. December 2014, HRSA rolled out the new Shortage Designation Management System (SDMS) to be used to manage, apply and update existing designations. Many hours have and continue to be spent learning the new SDMS. More problematic are the on-going technical issues of the new system. When the system works, it takes on an average of 6 hours to develop application. Hawaii currently has a total of 19 designations (16 HPSAs and 13 MUA/Ps). Using the average time of 6 hours works out to a total of 114 hours versus 33.25 estimated hours at 1.75.

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

Before the launch of SDMS, Hawaii used established federal data, i.e. U.S. Census and/or the American Community Survey for the population data. Provider data and information for primary care, dental and behavioral health was collected from surveys, professional directories, and the State Licensing Board. Under the new system, all state PCOs must use NPI data. These data are not current as far as practice site, hours worked, and work status. Under the new policies, state PCOs are not permitted and the system cannot support, the addition of new providers. To enhance the quality and usefulness of the information, state PCOs need to be allowed to use their own established and validated provider databases and other local and state data to determine the FTE link to new and proposed service areas.

4. The use of automated collection techniques or other forms of information technology to minimize the information collection burden.

No comment.

Thank you for the opportunity to comment on this important matter.

Catherine Sorensen, Dr. P.H.
Hawaii Primary Care Office
Office of Primary Care and Rural Health
Hawaii Department of Health
3652 Kilauea Avenue
Honolulu, HI 96816
(808) 733-8364
Catherine.sorensen@doh.hawaii.gov

Primary Care Office
Comments on Paperwork Reduction Act
Federal Register April 3, 2015
Comments due: June 3, 2015
Send comments to: Paperwork@hrsa.gov

Total Estimated Annualized burden hours:

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	1	54	4.25	229.50
SDMS Application	54	23	1,242	1.75	2,173.50
Total	54	—	1,296	—	2,403.00

HRSA specifically requests comments on

(1) the necessity and utility of the proposed information collection for the proper performance of the agency's functions,

The collection of provider data is still local agency specific!

The collection of the U.S. Census Data accurately worked from paper to automated applications. When the data was collected to load into the Application Submission And Processing System, ASAPS, the first automated system, it standardized the population data across the board for all applications and improved the accuracy of the applications submitted. I believe that this is a viable method for standardization as long as it is kept up to date and the possibility of different local data could be a discussion point if need be.

It has been my experience that the collection of provider data has been more accurate when completed at the state and local levels. The standardization of the provider data is extremely difficult as the providers themselves have problems reporting to federal agencies to update their records.

(2) the accuracy of the estimated burden,

The Iowa Primary Care Office has 1 FTE, 1,960 hours, to perform the 3,120 hours work!

As the Interim Primary Care Officer, I concur that by automating the application system preparation was reduced; however, I now spend more hours waiting for local data than processing that data. The collection of the provider data, by state and local offices/clinics, takes time for each review, some longer than others. An average time estimate per review, just for the collection of provider's face to face patient time to establish an accurate Full-Time Equivalent, FTE, hours can be made. For Iowa it takes approximately 20 hours per review to connect, educate, review, survey and follow up with each clinic coordinator or individual provider. With 63 Primary Health Care, 70 Dental Health Care and 23 Mental Health Care related Catchment Areas may take as much as 3,120 hours.

The Shortage Designation Management System, SDMS, has been an enigma since its launch in December 2014. As with most programs there is beta testing, checking, rewriting and the cycle starts over after each period of testing. It has been a challenge that has been taken on by a super users group, the programming team and the management team. At this time I do not know how I can estimate how long it will take to do an application, update the providers and create a map. I do know by how the update is progressing that the end result will be very useful. I do not believe the stated 1.75 hours per application is accurate.

(3) ways to enhance the quality, utility, and clarity of the information to be collected,

Collection of provider data by third party organization is not cost sustainable!

The University of Iowa, Office of Statewide Education Program, OSCEP tracks and surveys the Doctor of Medicine, MD and Doctor of Osteopathic Medicine, DO professions throughout the state. The dataset is a very good base collection for us to have the work place address, telephone number, profession, age and other. The FTE hours is 40 for full time and 20 for part time and does not report the hours spent in "face-to-face" patient time or Medicaid & Sliding Fee patient counts. The Iowa Medical Licensure Board does not collect this information either. That leaves me to call each clinic point of contact listed in the data set to request the appropriate data for the designation. – *Process is extremely time consuming.*

The collection of the additional data required for shortage designation by at least two sources already collecting some of the data would be ideal. The main problem in the past has been sustained financing to make the changes and then to maintain the data set.

(4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

Keeping up with the technology, or not!

Over the years the data revolution has evolved, however as technology moves forward the users should adapt new attitudes on how to grow, share and communicate with each other through compatible programs and data sets and use common data to eliminate additional steps to improve the work and workforce. These ideals have to be in place before a viable solution can be made.

The CMS NPI Data used to back load the SDMS is a locked system that has to have additional steps added to it as "work arounds" and creates a heavier load of work rather than an improved process.

I do not have any suggestions that will not create more work at this time!

Other Comments:

I commend the Leadership and the programmers for their effort in creating a business compatible program with automatic updates to the common data used for the designation program, seeking a common provider data set that might work, and listening to the needs of the actual users, we the Primary Care Officers and State representatives for your programs.

Respectfully Submitted,
Name: Lloyd Burnside
Title: Program Planner 2, Interim Primary Care Officer
State: Iowa

Information Collection Request Title: Shortage Designation Management System OMB No. 0906-xxxx-New http://www.gpo.gov/fdsys/pkg/FR-2015-04-03/pdf/2015-07673.pdf

Illinois Primary Care Office Comments
Federal Register Notice: April 3, 2015
Comments due: June 8, 2015
Send comments to: Paperwork@hrsa.gov

The Center for Rural Health (CRH) was formed in 1989 in response to a recommendation by the Governor's Rural Health Task Force. A division of the Illinois Department of Public Health (IDPH), the CRH was mandated and funded by legislative action to enhance the health status of rural residents. The CRH has served as the Primary Care Office (PCO) grantee in Illinois since October 1990. In this capacity, the Illinois PCO is pleased to provide HRSA with comments regarding '80 FR 18240'.

The Illinois PCO comments:

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

The Illinois PCO recognizes that current demographic data as well as specific full-time equivalent (FTE) data on health care providers is necessary to prepare HPSA and MUA/P applications that accurately represent the available healthcare services in our State.

Health Professional Shortage Area (HPSA) and Medically Underserved Area/Populations (MUA/P) designations are integral to the utilization of recruitment and retention incentive programs on which our providers and primary care sites depend. Illinois currently has 90 J-1 Visa Waiver placements and nearly 650 obligated health professional placements (NHSC 430, State Scholarships 208) providing medical services to the underserved residents of the state.

(2) the accuracy of the estimated burden,

Illinois has over 300 HPSAs that require re-evaluation every three years. There are 121 Primary Care, 80 Dental Care and 38 Mental Health Care HPSAs that are geographic or population groups HPSAs and 64 facility/state correctional facility HPSAs.

With respect to the time estimates for HPSA processing as stated in '80 FR 18240', designation and planning, the average burden per response is grossly understated.

Designation planning and preparation now requires extensive review of relevant data outside the SDMS system to evaluate the area with respect which type of HPSA may

be appropriate (Geographic, Geographic High Needs, or Population Group). As stated in response # 4 below, the functionality of pre-application HPSA analysis within the federal HPSA processing system has been lost with SDMS.

About half of the HPSA processing in Illinois is in urban areas, where there are more residents and therefore, more medical providers. Provider data must be obtained through surveys and data analysis from several sources. Then the NPI provider records must be updated with accurate addresses, verifying tour hours, and removing or zeroing out providers who do not meet the HPSA requirements for a variety of reasons. As stated in #4 below, updates to provider records in SDMS are performed manually, one record at a time.

The Illinois PCO estimates 15 hours for urban HPSA preparation and 5 hours for rural HPSA Designation Planning and Preparation. Thus the 'average burden per response' should be at least 10 hours rather than the 4.25 hours as listed in '80 FR 18240'.

It is difficult to determine the average burden per response for the SDMS application, because Illinois has not been able to successfully process an application in SDMS due to system problems. Taking into consideration the system error corrections and proposed enhancements, Illinois PCO estimates an average of at least 4 hours to process a HPSA application (RSA and CA creation, NND analysis, etc.)

(3) ways to enhance the quality, utility, and clarity of the information to be collected,

The PCO has access to relevant information relating to the RSA (Rational Service Area) and CAs (Contiguous Areas) that is more current and accurate than the Census or other federal data in SDMS, i.e. substance abuse, resident civilian population. SDMS allows for some changes to demographic data on a HPSA application if it is accompanied by an upload with supporting documentation. This is a good feature of SDMS.

Accurate Provider data in SDMS for HPSA processing is complex and time consuming. The importance of accurate FTE ratio to provider services determines the Population-to-Provider (P2P) ratio, a key component in determining HPSA/MUA/P eligibility. Further, the P2P ratio and the accurate data about providers from surrounding CAs can affect up to 10 points on the scale of 1-26 in HPSA score methodology. NHSC program provider incentives are awarded to the providers in areas of the greatest need, which is determined by a higher HPSA score. If the FTE data is not correct, it causes discrepancies and inaccuracies in the HPSA point score which will adversely affect the utilization of these provider placement incentives and ultimate access to services for Illinois residents in shortage areas.

Auto processing of HPSAs using default provider data (FTE of 1.0) will result in a loss of HPSA designated shortage areas due to inaccurate P2P ratios. Currently, the SDMS

system has been loaded with provider data from NPI. Much of the NPI data is based on license or medical practice status and practice addresses that are not accurate. There is no utility built into SDMS for the PCO staff to add providers who are not listed. The NPI data in the SDMS system assigns provider records with default FTE of 1.0 resulting in faulty data.

(4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

Prior to the determination of the NPI data source, Illinois had executed a Data Use Agreement with the Illinois Department of Professional Regulation (IDFPR) to obtain current licensing data by specialty semi-annually. This data was intended to be used with Medicaid data obtained from the Illinois Healthcare and Family Services (HFS), the agency responsible for the Medicaid program in Illinois. The PCO had anticipated developing a good base point for provider data using these resources, however, they cannot replace provider surveys conducted by the PCO in determining WHO is providing HOW MANY HOURS of services to Illinois residents. This is the only way to obtain an accurate P2P ratio for HPSA designations.

<u>The ability to upload a file with current provider records into SDMS would allow for substantial time savings</u> in updating provider records, when compared to the manual update of individual provider records in SDMS at this time. Note: the prior HPSA processing system (ASAPs) allowed for provider data uploads, coordinated through the Shortage Designation Branch (SDB).

The functionality of pre-application HPSA analysis with the HPSA processing system in the states has been lost with SDMS. In order to evaluate any geographic area that overlaps (even with one census tract) an existing HPSA, the PCO must initiate a request for withdrawal of the existing HPSA before the data can be called up for review and analysis. This is a significant step backward for the PCOs and the residents we serve.

Other Comments:

Respectfully Submitted,

Name: **Dianne Roberts**
Title: **Primary Care Office Administrator/HPSA Analyst**
State: **Illinois**

IPHCA
Illinois Primary Health Care Association

Bruce A. Johnson
President & Chief Executive Officer

Submitted via email paperwork@hrsa.gov

HRSA Information Collection Clearance Officer
Room 10C-03
Parklawn Building
5600 Fishers Lane
Rockville, MD 20857

Re: ***Information Collection Request Title:***
Shortage Designation Management System OMB No. 0906-xxx-New

Document Citation: 80 FR 18240, Document Number: 2015-07673
Link: https://federalregister.gov/a/2015-07673

To Whom It May Concern:

The Illinois Primary Health Care Association (IPHCA) appreciates the opportunity to comment on the burden estimate of the Information Collection Request (ICR) that the Health Resources and Services Administration (HRSA) plans to submit.

Established in 1982, IPHCA is the state Primary Care Association (PCA) that serves Illinois' 42 Section 330 Federally Qualified Health Center (FQHC) grantees, one Urban Indian FQHC grantee, one Look Alike, two Iowa 330 grantees, and one Missouri 330 grantee that operate nearly 400 sites, serving more than 1.2 million patients each year. These federally-supported health centers are entities that are directly impacted by the shortage designations awarded.

IPHCA works as part of a cooperative agreement with Illinois' Primary Care Office (PCO) to prepare shortage designations for review and submission.

Comments:

1. *The necessity and utility of the proposed information collection for the proper performance of the agency's functions.*
The collection of accurate full-time equivalent (FTE) data about health care providers is extremely important. It impacts the designation of Health Professional Shortage Areas (HPSA) and Medically Underserved Areas/Population (MUA/P), National Health Service Corps (NHSC) resource allocation of loan repayment and scholar awards and FQHC New Access Point grant awards. The actual FTE data on provider services and populations served determines the Population to Provider ratio, a key component in determining the distribution of these limited funds that impact the provision of healthcare to the most vulnerable citizens in our nation. Unfortunately, HRSA's new Shortage Designation Management System (SDMS) falls short in its ability to accurately collect this information.

2. *The accuracy of the estimated burden.*
Illinois contains 102 counties of which 81 are designated as a county medical shortage area which accounts for only 33% of the designations. As we understand, the data points reported in the burden sample included in the federal register

were county or rural designations which in general are more straightforward. However, Illinois contains two major metro areas and many more urban areas where the designations are more appropriately a smaller rational service area. The average burden hours are therefore underestimated for any of the those urban areas and vastly underestimated for the work required in both the greater Chicago area spanning six counties and the St. Louis metro area spanning three counties. Illinois' PCO estimates 15 hours for an average urban designation based on the Automatic Scoring And Processing System (ASAPS) functionality, HRSA's system prior to SDMS. Those metro areas require work not only in the rational service area but all surrounding contiguous areas which multiplies the provider research needed when multiple hospitals and teaching organizations are also included in the metro and urban areas. Under SDMS, we estimate that it will be much more burdensome given the inability of the software to retain changes made by the PCO as discussed in detail throughout this letter.

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

IPHCA appreciates the HRSA's desire to use National Provider Identifier (NPI) data instead of American Medical Association as did the former ASAPS system. However, comparing NPI data to Illinois' professional licensing database shows that using NPIs would greatly decrease the quality of designations. For instance, a sample analysis showed a 50% error rate due to a combination of inaccurate provider practice addresses, hours of operation, license numbers and whether a provider is no longer practicing. This may largely be due to the fact that physicians have little reason to update the NPI database once they register. Illinois has 34,000 primary care physicians so this relates to approximately 17,000 physicians needing to be manually updated. Also, as we understand it, these updates are not maintained in the system, so with each NPI update, provider data would have to be researched again and reentered causing an even greater burden over time. ASAPS maintained changes made by state PCOs.

Allowing PCOs to upload multiple provider updates from state professional licensing and Medicaid claims databases to the designation software as was available through ASAPS would be preferable. However, at a minimum, it is critical that SDMS be reconfigured to allow PCOs to change the provider practice address and FTEs and also add the physician license number based on provider surveys, state Medicaid claims and state licensing data without being overwritten by NPI file updates. Many NPIs are based on the provider's billing address which may only represent a fraction of the practice locations which greatly impacts accurate provider data. In Illinois alone, FQHCs operate an average of eight locations per organizational billing address. Plus the idea that a provider has an NPI does not guarantee they are practicing. The ease of update tools in SDMS is essential to establishing accurate designations, particularly in metro areas which contain multiple hospitals and schools where physicians only practice a fraction of the time on outpatient primary care if at all.

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

Most of the population data used for designations can be taken from the US Census data and state community health data coordinated for public health departments in Illinois. However, provider data needs to be updated locally to reflect patient population trends, provider movement, and practice changes. The ability to link the NPI data with state licensing and Medicaid claims data would assist with data updates as well as the ability to add multiple practice locations to a provider's practice site. Also, the ability to modify the current automated update of NPI so that it leaves the FTE and practice site location information input by the PCO untouched is critical. The SDMS NPI system updates were causing duplication of effort by overwriting updated provider information. A SDMS software change was released 6/6/2015. Unfortunately, we have not had an opportunity to analyze the updates made on Saturday so we have no personal knowledge of the impact on the functionality or the estimated burden. The newest update notes suggest that NPI updates may not overwrite PCO-updated records but may actually create duplicate provider records which would create an entirely new set of issues and added workload. Another technology component that would greatly reduce the information collection burden would be to have the automated designation system allow changing the designation from

geographic to population with a toggle switch to calculate and evaluate the designation by either method rather than having to manually input data for both designations separately.

Thank you for the opportunity to comment on the Shortage Designation Management System ICR. If you require any clarification on these comments, please contact me at kcarter@iphca.org.

Sincerely,

Kelly Carter

Kelly Carter
Chief Operating Officer
Illinois Primary Health Care Association

Cc Bruce Johnson
Julie Casper
Jim Macrae

Description of issue	Link to relevant Regulation	Area of System
The population data being used in the SDMS system is wrong. All data is based on the Total Population instead of the 'Resident Civilian" population. As a result the % Low Income and poverty is calculating incorrectly, the ratios reported are incorrect, and other factors, such as the % elderly and the % minority race/ethnicity are all incorrect. The total population includes Institutional and Group Quarters populations that include prisons, dorms, military barracks, etc		Non-Provider Data
Pop to Provider Ratio – System on General Information tab is reflecting the total population instead of low income population for P2P calculation for population based designation		Non-Provider Data
Please walk the PCOs through two of the data reports, so that we know where the data came from, what the columns mean, how this data is used, and will be used going forward. (1 NPI Provider Data Reports and 2 Designation Demographic and Health Data Export)		Non-Provider Data
SDMS Contains incorrect data on the "Designation Demographic and Health Data Export" report. The "Last Approved Designation Date" has an error and is loading the same data as the "Initial Designation Date."		Non-Provider Data
Can't open "details" and "history" links in "ASAPS Archive Designations Report"		Non-Provider Data
HRSA is considering updating all HPSAs based on data in SDMS in 2016. Many states do not have capacity to survey all of the HPSAs and CAs for all three disciplines. Areas that are not surveyed and entered into SDMS will likely see some impact, whether it is losing their HPSA designations or a decrease in scores. This is a result of the assumption that each provider in the area is a full time provider. (High Priority because this determines PCO workload and can negatively impact communities within 1.5 years.)	42 CFR Ch 1, Appendix A to Part 5, Part I Geographic Areas, B. Methodology, 3. Counting of Primary Care Practitioners	Policy
Unclear what policy will be regarding overwriting of PCO data with NPI updates and what PCO will need to do in response to new NPI providers being added with periodic updates		Policy
Requiring PCO's to address the NPI providers in the area based on HRSA selected taxonomy will cause many extraneous providers to be addressed (0'ed out) while preventing valid providers from being included.		Policy
Maximum population size for RSAs in Mental Health designations		Policy
ASAPS sent an email automatically to select parties notifying them of the application submission. This triggered the 30-day comment period. SDMS does not have this functionality. The current setup requires the PCO to distribute notification to the select parties even though sending a copy of the application to those parties is not an option at this time.		Policy

For MUP - system is using service area instead of population group for "Population 65 Years of Age and Older" percentage. HRSA website states “The weighted values for percent of population age 65 and over (V2) and the infant mortality rate (V3) would be those for the requested segment of the population in the area of residence, if available and statistically significant.”	1. Public Law 93-222 Dec. 29, 1973 states “Sec. 5 Within three months of the date of the enactment of this Act, the Secretary of Health, Education, and Welfare shall report to the Congress the criteria used by him in the designation of medically underserved areas and population groups for the purposes of section 1302(7) of the Public Health Service Act.” a. Source: http://www.gpo.gov/fdsys/pkg/STATUTE-87/pdf/STATUTE-87-Pg914.pdf 2. Section 1302(7) of the Public Health Service Act states “The term “Medically underserved population” means the population of an urban or rural area designated by the Secretary as an area with a shortage of personal health services or a population group designated by the Secretary as having a shortage of such services.” a. Source: http://legcounsel.house.gov/Comps/PHSA_CMD.pdf 3. Neither of these regulations define specifically how the four values for the Index of Medical Underservice (IMU) should be calculated differently for MUAs versus MUPs. This includes the calculation used for counting physician FTEs. 4. However, via HRSA’s website the Secretary has defined the difference between how the four values for IMU should be calculated for MUAs versus MUPS. The website states: “The weighted value for poverty (V1) is to be based on the percent of population with incomes at or below 100 percent of the poverty level in the area of residence for the population group. The weighted values for percent of population age 65 and over (V2) and the infant mortality rate (V3) would be those for the requested	Policy
Minimum populations for primary care, dental and mental HPSA designations		Policy
At an earlier hypercare session, HRSA stated that they could not ensure that state data would not be lost after a massive update to the SDMS system. Will HRSA maintain a backup of the data set before the new/updated data is uploaded? (As a precautionary measure.)		Providers
Providers not able to be geocoded by SDMS have lat/long available but are not tied to MCD, CT, or County. True for original NPI and for newly added addresses		Providers

Newly geocoded address says "omitted" under "included in FTE Calculations."		Providers
Providers reported in the Providers section of SDMS, when compared to the NPI Providers report on the opening page of the portal, do not coincide. The difference is many records are reported in the Providers section that are not in the downloadable report. Is there a reason for the discrepancy?		Providers
There is no place to indicate that the provider is a J1 Visa Waiver. There is a place to indicate that the provider is a J1 Visa Holder. J1 Visa Holders are counted as .5FTE because they are interns. J1 Visa Waivers are counted as 0 FTE based on regulations. Also there is already a place to indicate that the provider is an intern and there is no need to seperate J1 Visa Holders from the rest of the interns.	Part 5, App. A, Part I, B, (a), (ii) Graduates of foreign medical schools who are not citizens or lawful permanent residents of the United States will be excluded from physician counts. (iii) Those graduates of foreign schools who are citizens or lawful permanent residents of the United States, and practice in certain settings, but do not have unrestricted licenses to practice, will be counted on a full-time-equivalency basis up to a maximum of 0.5 FTE. (Primary Care & Mental Health) (Also found here: Part 5, App. C, Part I, B, 3, (f), (i) and (ii): (ii) Graduates of foreign schools who are not citizens or lawful permanent residents of the United States will be excluded from counts. (iii) Those graduates of foreign schools who are citizens or lawful permanent residents of the United States, and practice in certain settings, but do not have unrestricted licenses to practice, will be counted on a full-time-equivalency basis up to a maximum of 0.5 FTE.	Providers
Core Mental Health Providers are assumed as 40 hours per week the only way to exclude them from the HPSA FTEs is by entering a reason code for each provider. This is an unreasonable request given the staffing levels of PCOs.		Providers
NPI – Several categories of providers currently cannot be accessed. This includes out-of-state providers and in-state providers that were not included in the SMDS (for whatever reason). Out of state providers cannot be easily located in other states except by name, which can be ambiguous for common names	HIPAA Administrative Simplification Regulation Text 45 CFR Parts 160, 162, and 164 (Unofficial Version, as amended through March 26, 2013 § 162.410 Implementation specifications: Health care providers. (a)A covered entity that is a covered health care	Providers
NPI Taxonomies are including unnecessary specialties. Two examples are dental hygienists and physical therapists.		Providers

States that border foreign countries cannot complete HPSA applications for RSAs that have part of the polygon go into the foreign country, SDMS does not have a function to select and remove foreign Contiguous Area. Therefore the HPSA application cannot complete the Contiguous Area analysis because of the polygon entering a the foreign country		Providers
Modify reason code to allow "other" or replace with an open text field for states who need the information.		Providers
There is no place in SDMS to enter hospital hours separately from outpatient hours. And the primary care provider page does not have the Hospital Hours included question and the Hospital Privileges question	Part 5, App. A, Part I, B, 3, (b) Practitioners who are semi-retired, who operate a reduced practice due to infirmity or other limiting conditions, or who provide patient care services to the residents of the area only on a part-time basis will be discounted through the use of full-time equivalency figures. A 40-hour work week will be used as the standard for determining full-time equivalents in these cases. For practitioners working less than a 40-hour week, every four (4) hours (or 1/2 day) spent providing patient care, in either ambulatory or inpatient settings, will be counted as 0.1 FTE (with numbers obtained for FTE's rounded to the nearest 0.1 FTE), and each physician providing patient care 40 or more hours a week will be counted as 1.0 FTE physician. (For cases where data are available only for the number of hours providing patient care in office settings, equivalencies will be provided in guidelines.)	Providers
Responsiveness and Stability: System is slow at pulling up provider search results list, pulling up designation search results list, and saving between mapping steps. Also system is down frequently		Providers
No way to check which providers are being counted as in the RSA and their associated FTE value.		Providers
High Needs and Insufficient Capacity parameters that are asked via provider surveys are entered as aggregate data. This is a concern because some PCOs do not manage their data externally and most PCOs will have this data per providers. This could lead to further issues if RSA shapes may change after the provider data has been collected and entered.		Providers
The ability to upload provider data to SDMS in order to update primary care, dental or mental health with ease, in comparison to the time lag being caused by entering individual providers.		Providers
Locations added to a provider do not allow for Direct Tour Hours to be corrected/changed after the address is submitted.		Providers

Search tools do not allow you to search by County or MCD name - requiring user to know geographic identifiers.		Providers
Added columns are not "remembered" by system in the provider search		Providers
For some providers the second address line does not contain the name of the clinic they work for. It is useful for us to track the name of the clinic the provider works for.		Providers
The providers' State license number is not provided within SDMS except by downloading data. Also, multiple license numbers may exist in the taxonomies		Providers
The reason code "Only Reporting Psychiatrists" does not 'stick'		Providers
In Mental Health designations in SDMS, when attempting a Geographic with High Needs designation the system will not allow you to continue with a designation if the area doesn't meet the 20% of 100% poverty even if the RSA meets the Alcohol/Substance Abuse prevalence. SDMS doesn't allow for us to select alcohol/substance abuse prevalence as the reason for High Needs designation. The option to select alcohol/substance abuse isn't until later in the application after the RSA has been validated and created. But SDMS only looks at poverty rate, and youth/elderly ratio for high needs indicators during the RSA creation.		Designations
There is no function in place to print an application. This is important for those who receive requests from the public to conduct a review and the findings indicate the area does not qualify. The printed application serves as documentation of the review, the findings, and a way to communicate those findings to the public.		Designations
"RSA Provider Report" opens an Excel spreadsheet with no information		Designations
SDMS performs an automatic Contiguous Area analysis in a specific order. When the PCO processes a Low-income HPSA application there are six steps in Contiguous Area analysis, the first three steps rules are: a current HPSA, Over Utilized, and Excessively Distant. If those three rules are not met it continues to the fourth step of Inaccessible Economic Access. If the contiguous area has greater than 20% poverty and no Medicaid providers then this rule is met and the contiguous area passes and is ruled out with the remaining 2 steps not run. However, if the PCO knows that a contiguous area has a demographic disparity hence there is no need survey the contiguous area because it is ruled out SDMS does not recognize the contiguous area as having a demographic disparity because it stops at the Inaccessible Economic Access rule. The contiguous area may have medicaid providers but a survey was not done for it because there is a disparity. SDMS is incorrectly passing a contiguous area using this rule.		Designations
Cannot search by type (auto HPSA, MUA, geographic...)		Designations
Designation search not showing as many results as it says there are after an application has been deleted		Designations

Some HPSAs are missing from HPSAFind; HPSAFind should be usable by the public as a reliable source for designation status. ALSO some HPSAs are showing up as being redesignated a few years after they were actually redesignated. (or should this be a separate issue?) BMISS may be root of the issue.		Designations
Dates of approval in HPSA Find are incorrect		Designations
When trying to view an uploaded document to an inquiry screen the result is an "access denied" screen.		Inquiries
In the message box in inquiries it is prepopulating with what was typed in the previous inquiry		Inquiries
User cannot tell what inquiry ID they are viewing		Inquiries
System does not currently allow for a user to continue an application if RSA does not qualify. This also creates an inability to determine what Contiguous Areas will be required to survey prior to completing the designation.		Mapping Tool
No way to override overlap even when it is innacurate.		Mapping Tool
System does not let the user choose between the ratios allowed in the HPSA legislation to be used in a mental health designation. States should be able to analyze all options prior to submitting an application. Also, being able to analyze the CMHP options may lead to more states surveying for CMHP data.	Part 5, App. C, Part I, B, 3, (i) Core mental health professionals or core professionals includes those psychiatrists, clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists who meet the definitions below.; Part 5, App. C, Part I, C. Determination of degree of shortage. Designated areas will be assigned to degree-of-shortage groups according to the following table, depending on the ratio (RC) of population to number of FTE core-mental-health-service providers (FTEC); the ratio (RP) of population to number of FTE psychiatrists (FTEP); and the presence or absence of high needs	Mapping Tool
No warning when SDMS is about to time out. When a user opens the mapping application in a second tab, the first tab (designations) will time out even though the user is continuously using the mapping application.		Mapping Tool
Can't see logic for the contiguous area exclusions and the numbers that are being used by the system		Mapping Tool

When updating a designation by selecting Copy or Update the Mapping Tool does not load the original RSA map, the census tracts that create the RSA are scattered throughout the state, country and in some instances throughout the world. This makes it difficult for the PCO to select the correct census tracts for the RSA and frequently the mapping tool will show incorrect overlaps and deny the RSA because tracts are scattered everywhere.		Mapping Tool
We are finding it difficult to deselect components when creating an RSA because we can't remember where each specific component is located geographically.		Mapping Tool
There is no easy way to label counties or MCDs in the mapping tool - the zoom level set for seeing this is not optimal.		Mapping Tool
NND – It appears that coordinates are needed in order to move the system default – it would be more accurate to be able to enter a physical address instead of dragging the point to the coordinate location.		Mapping Tool
States need hands on training to maneuver the SDMS system and to see in real time how a real application and provider data is entered into the system.		Mapping Tool
When copying an existing HPSA and clicking save RSA the application doesn't let you continue and all the buttons are unclickable. Even to go back and try clicking save RSA again.		Mapping Tool

STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
Larry Hogan, Governor - Boyd Rutherford, Lt. Governor - Van Mitchell, Secretary

Re: *Information Collection Request Title:* Shortage Designation Management System OMB No. 0906-xxxx-New, Document Citation: 80 FR 18240, Document Number: 2015-07673
Link: https://federalregister.gov/a/2015-07673

The Maryland Primary Care Office (Maryland PCO) has been granted a cooperative grant to work directly with HRSA's Bureau of Health Workforce (BHW) while utilizing the Shortage Designation Management System (SDMS) database for the determination of Health Professional Shortage Areas, Medically Underserved Areas, and Medically Underserved Populations (shortage areas). In this capacity the Maryland PCO is pleased to provide HRSA with comments regarding "80 FR 18240". We have organized our comments below in four sections. The sections answer the specific areas HRSA has requested comment on.

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

BHW is charged with improving the health of the nation's underserved communities and vulnerable populations by developing, implementing, evaluating, and refining programs that strengthen the nation's health workforce through shortage designations. The Maryland PCO agrees that it is necessary for BHW to have a mechanism for information collection for proper performance. However, the Maryland PCO also believes that the information collected should be valid and true to the federal policy in which shortage designations are established.

The current SDMS database does not contain valid provider or non-provider data. It also does not follow current federal policy found in the 42 CFR. Shortage designations are tied to over 30 federal programs (including National Health Service Corps, Rural Health Clinics, Medicare Bonus Payments, Federally Qualified Health Center and Look-Alike eligibility, Area Health Education Centers, Mental Health Clinical Grants, AIDS Service Related Training Grants, Residency and Graduate Training, and many more). Maryland also uses shortage designations for the State Loan Repayment Program, the Maryland Loan Assistance Repayment Program, and the J-1 Visa Waiver Program. Distribution of state and federally funded programs should be based on a valid system.

Please see attachment for a list of concerns found within the SDMS database by the PCO Super Users Workgroup. The PCO SuperUsers Workgroup was formed by the PCOs to collect concerns and speak on behalf of all PCOs as a technical team regarding the SDMS database.

2. The accuracy of the estimated burden.

The estimated burden of 4.25 hours that each PCO (54 total, includes Washington DC, Puerto Rico, Guam and Virgin Islands) will spend in planning and preparation for HPSA updates is greatly understated in "80 FR 18240".

Planning and preparation for the Maryland PCO includes the following steps: (1) requesting new data from licensing boards; (2) reviewing new data; (3) geocoding and creating boundaries for new data based on county and neighborhood jurisdictions; (3) Speaking with healthcare leaders (Hospitals, Federally Qualified Health Centers, Local Health Departments, etc.) regarding losing/gaining shortage areas in case surveying of providers is warranted due to initial analysis of data; and (4) uploading new data into the federal database system to begin formal submission process. Each time Maryland receives new data, the whole state is tested for eligibility to ensure access to healthcare is constantly being checked. Each PCO not only has to update the eligibility for existing HPSAs, they must also test their state for new areas/new requests for eligibility for shortage designations. This type of intensive testing can take up to five months prior to any updating of existing shortage areas. That is an average of 800 hours just for planning and preparation.

Once planning and preparation is completed, it takes an additional 40 hours per HPSA for formal submission. Twelve hours to enter the collected data into SDMS and correct NPI data that SDMS comes prefilled with, and twelve hours to draw an appropriate Rational Service Area and Contiguous Areas as well as assign the nearest source of care and upload appropriate documentation. Another sixteen hours is needed to test various HPSA type scenarios.

Total Hours Needed to Complete an Average HPSA:
40 hours x 93 HPSAs = 3,720 hours + 800 hours planning and prep = 4,520 hours
4,520 hours / 93 HPSAs = 48.6 hours to complete an average HPSA

HRSA has estimated that EACH STATE has a total of 23 HPSA and MUA/MUP designations. According to the HRSA Data Warehouse on 6/5/15 at http://datawarehouse.hrsa.gov/topics/shortageAreas.aspx, the U.S. and its territories contains 15,369 Geographic and Population HPSAs, and 4,197 MUA/MUPs which would average 362 per state, not 23. Maryland has a total of 151 shortage designations (93 HPSAs and 58 MUAs/MUPs) in total.

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

SDMS is currently pre-filled with NPI data. Much of the NPI data has not been updated by providers since 2007. The result is that most providers do not work at the location listed in NPI and the PCO has to utilize limited staff and resources identifying the appropriate reason code for why the provider is no longer working at the location listed in NPI. Most PCOs have a mechanism already in place via legislation, surveying or a state contract to collect valid provider data. Maryland has a Memorandum of Understanding with the Maryland Board of Physicians. When physicians renew their

license, they also go through a series of questions that includes a shortage designation survey. The Maryland PCO receives new data every other year from the Board of Physicians, but can receive it on an annual basis if needed. Maryland PCO also receives Medicaid claims data for primary care, dental and mental health which is also not included with NPI data and has to be entered manually per provider.

There is no mechanism to simply upload this valid data into SDMS through a file or spreadsheet. Each provider must be typed in separately and only providers with matching NPI IDs can be addressed. This leaves providers not listed within SDMS to be undercounted if not added into the system by the PCO. The Maryland PCO suggests that local data again be accepted for shortage designations to ensure accurate analyses of providers for utilization of state and federal resource distribution.

According to 42 CFR, regulations in which shortage designations are based; HRSA is to use data available to the Department from national, state, and local sources. It appears forcing PCOs to use only NPI data without considering valid local data is not only inefficient, but against federal regulations as well.

For further suggestions on improving the SDMS system, the Maryland PCO recommends BHW to address the concerns of the PCOs that have been collected through the Super Users Workgroup (please see attachment).

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

The current SDMS system does not allow states to utilize current technology for importing provider, Medicaid or health data. Uploading data into SDMS would help save time, prevent data entry errors, and be a better utilization of resources.

The Maryland PCO provider and Medicaid data is geocoded and contains an NPI ID for each provider. This data should be allowed to be uploaded into the SDMS database through the matching of an identifier, such as the NPI ID. However, the SDMS is causing additional burden through requiring the PCO to update an outdated provider source which has to be addressed per provider.

Also there are many technical problems (55 concerns total) associated with SDMS that must also be addressed before PCOs can truly use it for submission of shortage designation applications. Please refer to the attachment for a list of concerns.

The Maryland PCO is committed to its cooperative agreement with the BHW and would like to work in partnership to assist in the development of a proper mechanism for shortage designation data collection and submission.

Sincerely,

Elizabeth Vaidya

Elizabeth Vaidya, Director
Maryland Primary Care Office

Michigan Primary Care Association Comments on:

Information Collection Request Title: Shortage Designation Management System OMB No. 0906-xxxx-New.

Document Citation: 80 FR 18240, Document Number: 2015-07673

Link: https://federalregister.gov/a/2015-07673

The Michigan Primary Care Association (MPCA) has a contract with the Michigan Primary Care Office (PCO) to complete all functions related to shortage designation in the state of Michigan. In this capacity MPCA is pleased to provide HRSA with comments regarding '80 FR 18240'. We have organized our comments below in 4 sections to answer the specific areas HRSA has requested comment.

Total Estimated Annualized burden hours:

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	1	54	4.25	229.50
SDMS Application	54	23	1,242	1.75	2,173.50
Total	54	—	1,296	—	2,403.00

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

MPCA believes that it is critical to the integrity of shortage designations to collect accurate FTE data from clinics located in areas proposed for shortage designation as well as contiguous areas. The population of the service area or population group should be obtained from the census and then divided by the number of FTE serving that population in order to obtain an accurate population to provider ratio which is the heart of the current shortage designation regulations. MPCA has spent considerable time educating state legislators on health workforce related issues, including Health Professional Shortage Areas. As state legislators become increasingly educated about Health Professional Shortage Areas, other uses for HPSAs are beginning to be discussed, including emerging discussions around need-based approaches to funding graduate medical education and other health workforce related policies.

2. The accuracy of the estimated burden

Based on MPCA's experience completing HPSA applications the estimated burden appears highly conservative in '80 FR 18240'. MPCA estimates that an average HPSA takes 32 hours to complete. It takes on average 6 hours to determine an accurate list of clinics in the service area and contiguous areas, 15 hours to survey these clinics, 6 hours to enter the collected data into SDMS and correct NPI data that SDMS comes prefilled with, and 5 hours to draw an appropriate Rational Service Area and Contiguous Areas as well as assign the nearest source of care and upload appropriate documentation. In essence, time needed to plan and prepare Geographic and Population HPSA designation would be approximately 27 hours, and the average time to complete the SDMS application estimate at 5 hours per application. For facility designations, the burden time is considerably less at an estimated time of 5 hours on average for both planning/preparation and SDMS application, with an average of 2 hours spent on the actual SDMS application.

According to the HRSA Data Warehouse, Michigan currently has 800 Health Professional Shortage Areas (inclusive of All Facility, Geographic, Population, and Geographic with High Needs HPSA designations). In order to accurately estimate the burden to execute the process of updating of every designation in the state in the SDMS application phase, the estimates should be broken down to highlight the difference between burden time for facility designations and all others (Geographic and Population). In Michigan, there are 194 Geographic or Population HPSAs. MPCA estimates time expended to update would total approximately 970 work hours (194 designations x 5 hours per application = 970 hours). In addition to the Geographic and Population HPSA, Michigan has 606 Facility HPSA designations. To update all facility designations, the estimated total burden hours would equal 1,212 work hours (606 facility designations x 2 hours per application = 1,212).

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

Many pieces of data go into a shortage designation application such as resident civilian population, provider FTE, race, ethnicity, poverty status, status of water fluoridation, and drug and alcohol abuse. Most of this data can be collected from existing sources such as the US Census. The provider FTE however cannot be collected from existing sources. In some states this data is collected during the re-licensure process. Currently, Michigan does not collect provider FTE during the re-licensure process and thus the burden lies on MPCA via our contract with the PCO to survey clinics for this data.

SDMS is currently pre-filled with NPI data. Much of the NPI data has not been updated by providers since 2007. As of 5/26/2015, Michigan has a total of 15,722 Primary Care NPIs, 6,028 Dental NPIs, and 17,229 Mental Health NPIs. With much information originally input to the NPI data in 2007, the result is that most providers do not work at the location listed in NPI and MPCA has to spend time identifying the appropriate reason code for why the provider is no longer working at the location listed in NPI. If NPIs are to be the required standard used for federal designation purposes, it should also be required that holders of NPIs update their information periodically (e.g. every three years to be aligned with data validity for shortage designation purposes).

SDMS also features a downloadable NPI Provider Data Report on the Primary Care Office Portal main page in the BHW Program Portal. Due to the formatting of the default NPI Provider Data Report spreadsheet that is exported from SDMS, the data/spreadsheet requires additional re-formatting to be able to be used by PCOs when creating provider lists, most often done on a county-level basis in Michigan. MPCA suggests that HRSA develop a more functional export option that allows for customizable exports of the provider list in the provider management section of SDMS to decrease time spent on compiling accurate provider lists.

A SDMS Super User Group was created by PCO staff to address the many technical issues faced by PCOs in the SDMS transition. The SDMS Super User Group has done considerable work to offer suggested improvements and enhancements to SDMS. For further suggestions on improving the SDMS system MPCA recommends HRSA review the recommendations of the SDMS Super User group.

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

Since both NPI and state licensing database can have disparate data, the ability to link SDMS to the state licensing system would assist in identifying providers that need personal information updated, such as address of practice. Additionally, the current SDMS system does not allow states to import provider FTE data. Uploading provider FTE data into SDMS would help save time and prevent data entry errors.

We appreciate the opportunity to comment.

Respectfully submitted,

Name: Ryan Grinnell
Title: Policy and Workforce Development Manager, Michigan Primary Care Association
State: Michigan

Montana Primary Care Office Comments on:

Information Collection Request Title: Shortage Designation Management System OMB No. 0906-xxxx-New.

Document Citation: 80 FR 18240, Document Number: 2015-07673

Link: https://federalregister.gov/a/2015-07673

The Montana Primary Health Care Office (MT PCO) works with other state agencies and associations to complete all functions related to shortage designation in Montana. In this capacity the MT PCO is pleased to provide HRSA with comments regarding '80 FR 18240'. We have organized our comments below in 5 sections. The first 4 sections answer the specific areas HRSA has requested comment on 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***

The MT PCO believes that it is necessary to collect accurate FTE data from clinics located in areas proposed for shortage designation as well as contiguous areas. The population of the service area or population group should be obtained from the census and then divided by the number of FTE serving that population in order to obtain an accurate population to provider ratio which is the heart of the current shortage designation regulations.

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

Based on MT PCO's experience completing HPSA applications the estimated burden is grossly understated in '80 FR 18240'. Montana does not have a mandatory reporting requirement for providers, so it takes more time to survey than for states where data are required. The MT PCO contracted with the MT Medical Association (MMA) to conduct surveys on all primary care providers in Montana, including those who are not members of MMA. For every 10 providers it is estimated that the survey work takes approximately 3 hrs, after a connection has been made. This does not include all the time it takes to do follow-up calls, and this does not include the extra survey time required if a provider has more than one practice location. Additionally, for every 10 providers, it is estimated that it takes approximately 2 hours to figure out discrepancies between Shortage Designation Management System (SDMS) and our survey lists, correct the NPI/SDMS data, and to enter the MMA survey data results into SDMS. **Only then is the SDMS data accurate.**

SDMS is currently pre-filled with NPI data. Much of the NPI data has not been updated by providers since 2007. The result is that most providers do not work at the location listed in NPI. This error requires the MT PCO to spend time identifying the appropriate reason code for why the provider is no longer working at the location listed in NPI. Again, this takes approximately 2 hours per 10 providers to locate numbers, make calls to verify, zero out hours and provide a reason code in the SDMS.

The MT PCO has not yet been able to complete a HPSA designation application or update in SDMS. Rather, the MT PCO has begun the process of cross-referencing the primary care providers' NPI data

in the SDMS with the MMA primary care providers' survey data results. To illustrate the data discrepancies, the MT PCO determined:

- Example One, Beaverhead County: There were 9 primary care providers located in Beaverhead County in SDMS; 6 primary care providers matched between SDMS and the MMA database; 4 providers were in MMA and not in SDMS; and 3 that were in SDMS were not in MMA. Of the 3 providers in SDMS, but not in MMA: 2 moved and 1 is PRN only. This is a total of 7 inconsistencies for this county that only has 9 providers. (Note: there is currently no way for the PCO to enter the 4 provider, identified by MMA, into SDMS.)
- Example Two, Lewis and Clark County: There are 74 primary care providers located in Lewis and Clark County in SMDS; only 24 providers are in both SDMS and MMA; 25 providers were in MMA and not in SDMS; and 50 providers were in SDMS, but not MMA. This is a total of 75 inconsistencies for this county that has 74 providers.
    - Of the 50 providers in SDMS and not in MMA: 7 providers are federal employees that work at the VA, 2 have different addresses in the same county, 7 moved out of the county, 4 retired, 2 are PRN only, 2 are physician assistants, and 9 we were unable to locate.
    - Of the providers not in SDMS, we were able to locate 6 of them: 1 was in CO, 2 were in a different Montana county, and 3 were listed as mental health providers. We have 7 providers that do not have an NPI number. We are still trying to figure out why. The remaining 12 we cannot find in SDMS. (Note: there is currently no way for the PCO to enter these providers into the system.)

These are just two of the 56 counties that have SDMS errors for primary care providers. The MT PCO has just begun the process of surveying the dental health and mental health care professionals so as to complete the cross referencing task with the SDMS data and the survey results data. If the error rates for these two disciplines are similar to those for the primary care providers, the amount of time to update the SDMS requires 554.8 hours. The total amount to do the survey work AND to update SDMS is 1,387 hours.

We recognize that Montana has a small number of providers in comparison to many states. Our hour estimates are based on 2,774 providers in SDMS. Recently we learned that California has more than 200,000 providers. If it takes CA the same amount of time, that would mean 42,000 hours to ensure accurate SDMS data, and this does not include survey work. This is equivalent to 20 FTE employees.

The MT PCO is not the only state who has discovered the inconsistencies between the SDMS data and the real data. The MT PCO has provided feedback to the SDMS Super User Group which was formed with the goal to provide workable suggestions on improving the SDMS system. The MT PCO recommends HRSA review the recommendations of the SDMS Super User group.

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

Many pieces of data go into a shortage designation application such as resident civilian population, provider FTE, race, ethnicity, poverty status, status of water fluoridation, and drug and alcohol

abuse. Most of this data can be collected from existing sources such as the US Census. The provider FTE however cannot be collected from existing sources. In some states this data is collected during the re-licensure process. Currently, Montana does not collect provider FTE during the re-licensure process and thus the burden lies on the MTPCO and their contractors to gather these data.

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

The current SDMS system does not allow states to import or export provider FTE data. Uploading provider FTE data into SDMS would help save time and prevent data entry errors.

5. ***General comments***

The MT PCO appreciates the opportunity to offer our comments. Accurate HPSA scores are an important method to ensure that all Montanans have access to primary care, dental, and mental health care professionals. At this time it is apparent that additional analysis of the generalizability of the total estimated annualized burden of hours to all states is warranted because the SDMS errors for the two counties outlined in #2 above requires resources and time beyond what the current grant funds.

It is conceivable that this error rate could increase given the Federal Bureau's plan to import NPI data weekly; whereby Primary Care Offices will then have to verify the new data, while simultaneously verifying the existing data. Again, the amount of work required to continually correct errors will require additional resources to match the task.

The MT PCO also supports the comments from the Wisconsin Primary Health Care Association (WPHCA) which are included below.

"The "Total Estimated Annualized Burden hours" table indicates that the "Number of respondents" is 54 for both "Designation Planning and Preparation" and "SDMS Application". WPHCA originally interpreted this to mean that 54 PCOs had given data to BHW and based on these responses the "Average burden per response (in hours)" was calculated. **However, WPHCA learned from e-mailing paperwork@hrsa.gov that only 4 states were surveyed.** WPHCA then reached out to each of those four states to find out if any caveats were provided with the data supplied to BHW.

WPHCA learned that New Mexico had given BHW data regarding an atypical designation that had no providers that needed to be surveyed, thus their response should not have been used to calculate the average. In fact, in the e-mail forwarded to WPHCA from New Mexico BHW stated "Although you mentioned that this wasn't a typical designation, I'll keep this response so we have a sense of how long an atypical designation would take."

WPHCA learned from South Dakota that the designation that they had used to provide time estimates to BHW had only one healthcare facility and that facility had requested the designation thus almost eliminating the need to survey. Again, this was not a typical application and should not have been used to calculate an average.

WPHCA learned that Virginia receives provider FTE data from their licensure board and thus does not need to take the time that other states do to survey providers.

WPHCA learned that Arkansas was the only state out of the four used that stood behind the numbers supplied to BHW. In the case of Arkansas the person completing the HPSA designations has been doing this work for 16 years and has developed relationships with many of the clinics that help him receive survey data much quicker than in other states. In addition the HPSA reported to HRSA was a rural HPSA which tend to have less clinics that need to be surveyed."

Thank you again for the opportunity to comment.

North Dakota Primary Care Office Comments on:

Information Collection Request Title: Shortage Designation Management System OMB No. 0906-xxxx-New.

Document Citation: 80 FR 18240, Document Number: 2015-07673
Link: https://federalregister.gov/a/2015-07673

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

With North Dakota being a frontier state, many of its providers practice at more than one site making it necessary to obtain accurate Full Time Equivalent (FTE) data from clinics and practices in areas that are proposed for shortage designation as well as the contiguous areas. As a Health Professional Shortage Area (HPSA) designation relies on the population to provider, ratio accurate FTE data is very important. Many of the clinics rely heavily on the designations for recruitment of providers and Medicare Bonus Payments in addition to grant eligibility etc. North Dakota PCO has always used the census data for population data, however with the influx of population in the Western part of the State due to development of the Bakken Oil Field, the census data is underestimated to actual population in the area.

(2) The accuracy of the estimated burden.

The estimated burden of hours is definitely understated in the '80 FR 18240'. The North Dakota Primary Care Office (NDPCO) needs to survey all provider practices to determine accurate FTE data which takes significant time compared to a state that is able to obtain FTE data from their licensure board such as Virginia. Currently, this is being completed through telephone surveys on an as needed basis for updates and proposed designations with hopes to convert to a Qualtrics survey once email addresses are obtained making it easier for a state-wide survey to be completed. With the anticipation that designations will need to be updated on an annual basis, a state-wide survey will need to be completed for all three disciplines rather than designation by designation. As an estimate, it takes approximately ten hours per designation request which includes five hours for planning and surveying the proposed rational service area and contiguous areas, two hours updating Shortage Designation Management System (SDMS) provider data within those areas, three hours to map the rational service area, contiguous areas, nearest source of care and upload supporting documentation when SDMS is functioning without issues. In North Dakota, there are currently 92 population group and area designations which require updates. In addition, 67 designations are automatic and/or facility designations. Approximately 10% require survey's for updates as they are not automatic designations.

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

Utilizing as much data as possible from a federally approved source such as, the U.S. Census data, is desired for consistency among states. However, the National Practitioner Identifier (NPI) data does not provide the most accurate data for each State in that many providers do not update their NPI data once they register. It is necessary to get accurate FTE data as a significant

number of primary care providers, dentists and mental health providers actually practice in multiple locations in multiple counties and states. Some state licensure boards, including North Dakota's, currently do not collect provider FTE. Therefore, the responsibility is that of the NDPCO to complete surveys to obtain provider FTE and other practice characteristics utilized for designations. Also in instances where federally approved data is inaccurate, there needs to be a mechanism to allow for adjustment utilizing supported local data. An example of this would be population estimates for the Western North Dakota that are underestimated due to the significant population influx related to the Bakken Oil Field.

(4) The use of automated collection techniques or other forms of information technology to minimize the information collection burden.

One suggestion for minimizing the information collection burden would be to have all licensure boards collect FTE and practice data during their licensure process, share the data with the PCO, and be able to upload the data into SDMS in addition to providing a mechanism whereby border states are able to access data on providers practicing in more than one state.

Title: Shortage Designation Management System OMB No. 0906–xxxx–New
Sent to: paperwork@hrsa.gov
Date: 06/05/2015
Prepared by: Thomas Rauner, Director, Nebraska Primary Care Office

The estimated average processing time to complete an application using the Shortage Designation Management System currently is 10 hours (planning and prep 6 hrs, SDMS application 4 hours), hopefully it will be reduced once updating provider information is limited to only addressing migration changes. Unfortunately the Shortage Designation Management System has only been able to completely process and approve one application out of three submitted. The one approved application took four months from application to approval. The other two applications have been pending for an average of greater than four months.

The data collection for preparing and updating federal health professional shortage areas and medically underserved areas/populations using the Shortage Designation Management System is desirable but as of yet not fully developed. There are several areas of concern which will impact the data collection process and timeline necessary to prepare an application for submission.

There are several components with the process which have been automated and standardized to ensure the most accurate and complete data available (i.e. census, road systems, health indicators…). One of the most significant variables in the designation process is accurate information on health care providers and their work status. This variable is currently being populated using the National Practitioner Information database maintained by CMS. This database is fine for maintaining an NPI number as it was designed to do, but there is no rational method to address updating NPI information which is being pulled into the Shortage Designation Management System. **The reliance on weekly data pulls from the NPI will not correct the issues of providers being properly identified regarding their practice location(s). This will prevent applications from being completed and approved.**

Many if not most states have more updated information on provider locations than what resides in the National Practitioner Information database. **It is recommended that a process be created within the Shortage Designation Management System to allow states to update information on provider locations for those actively practicing in their state and should be incorporated as soon as possible.**

Without the use of the most accurately available information being utilized in the Shortage Designation Management System, the overall credibility and functionality of the software will be jeopardized.

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

29 HAZEN DRIVE, CONCORD, NH 03301-6503
603-271-4612 1-800-852-3345 Ext. 4612
Fax: 603-271-4827 TDD Access: 1-800-735-2964

NH DIVISION OF Public Health Services
Improving health, preventing disease, reducing costs for all

Nicholas A. Toumpas
Commissioner

Marcella Jordan Bobinsky
Acting Director

New Hampshire Department of Health and Human Services
Rural Health and Primary Care Section
Comments on:

Information Collection Request Title: Shortage Designation Management System OMB No. 0906-xxxx-New.
Document Citation: 80 FR 18240, Document Number: 2015-07673

Link: https://federalregister.gov/a/2015-07673

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

   The information collected is extremely necessary and useful for both HRSA and for the State of New Hampshire. Its collection is not a burden as long as the HRSA process and our state process match. It is the only consistent way to accurately assess the capacity and availability of primary care for the population statewide. In addition, it allows us to:

   - Anchor support for local, regional and state resources related to health workforce issues including the National Health Service Corps, the J-1 Visa Waiver Program, and the NH State Loan Repayment Program
   - Provide timely data for statewide health care workforce assessment and provide the ability to anticipate health workforce shortages before crisis
   - Provide an understanding of the changing health system and how those changes intersect with existing education and regulatory systems

2. The accuracy of the estimated burden

Based on the New Hampshire (NH) Primary Care Office's (PCO's) experience completing HPSA applications, the estimated burden is grossly understated in '*80 FR 18240, Document Number: 2015-07673*'. As illustrated in Table 1 below, NH estimates that an average HPSA designation currently takes 80 hours to complete. This estimate includes the time of the three to four staff engaged in the specific application effort. The staff who work on each application have expertise in data analysis, survey implementation, interfacing with local stakeholders, the designation requirements, and the software system (now SDMS) to enter and submit the designation information. The estimate is comprised of the time, per application, for planning and preparation (52 hours) and for designation processing into the BHW SDMS online application system (28 hours), for a total of 80 hours.

Table 1: Total Estimated Burden Hours

Task	Total Hours (Average)
Designation Planning and Preparation	52
SDMS Application	28
Total	**80**

* Estimates are an average, across all disciplines per application

It should be noted that this aggregate estimate of effort masks a great deal of variability in the level of effort required for any given application. Variables include the type of designation being sought, the number of providers and practices involved, the need to assess population-level (low income) access, assessment of high need / insufficient capacity parameters, and contiguous area considerations - often crossing in to neighboring states. Most notably, these estimates take into account a newly implemented system that has, and continues to, experience significant implementation issues, making it difficult to determine the ultimate level of effort that will be required to use it.

NH has areas throughout the state that have been designated as primary medical care, dental, and mental health (psychiatrist only and core MH) HPSAs with types ranging from geographic area, population group, and state federal prison. We also have MUA and MUP designations, though these have not been updated for many years.

- Designation Planning and Preparation

  In NH, a great deal of up-front effort goes into collecting and organizing the data needed for designation. NH collects, analyzes, and integrates the data for designation on an ongoing basis. Our provider data (physician, dentist, psychiatrist, and core mental health) is integrated with demographic, geographic and health access data via a GIS platform to support our analysis. Data and systems include state licensure, National Provider Identifier (NPI), and American Community Survey (ACS) data. These are integrated via GIS technology. Provider lists from licensure are validated with local community members for input, and surveys are disseminated. We believe our provider data and ACS data is a more accurate starting point for assessing an area as compared to the data in the SDMS system (see additional comments below). Surveys are then fielded, with the intent to have completed surveys for 100% of providers in the area of interest, although two-thirds is the traditional requirement when complete response is not feasible. Staff follow-up (often by phone) with providers who have not responded or who have incomplete or unclear responses. Survey results are organized and analyzed in our own data/GIS systems prior to entry into SDMS so the result is largely known in advance of submission. It should be noted that New Hampshire is one of the smallest states in the nation (44th in population), with current designations largely focused on the most rural parts of the state. Our effort per designation, therefore, may be higher than in other areas of the country where the data can be used more widely across more designation requests.

- SDMS Application

  The SDMS system is relatively new (opened in December 2014). The legacy ASAPS system was taken off-line months earlier, creating a backlog in new designation processing. It was launched with little opportunity for input or testing by the state staff that would be using it, and scan training. There have been significant functional, technical, system issues encountered since the system was launched, which have resulted in increased user effort. Despite the issues, staff has worked extensively to learn the system, coordinate with BHW analysts to address issues, participate in 'hypercare' calls with HRSA, complete applications, and respond to any questions about the

application that BHW analysts may have. It is difficult to disentangle the efforts related to the implementation from the effort needed in a fully implemented system. New policy requirements, implemented in parallel and as part of the new system, have also added notably to the burden and have been the source of much confusion. Designations that we know will qualify based on our analysis cannot be entered in the new system at present due to issues pending resolution.

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

The purposes of the NH DHHS and HRSA's Shortage Designation branch have traditionally been quite congruent in terms of accurately documenting primary care provider capacity and accessibility in the state, and identifying areas where access is lacking for various reasons. Several features of the new SMDS system, however, have added effort that we feel does not enhance the value for either agency. These relate primarily to the use of the NPI as the basis for assessing capacity, and several other requirements in the system related to that choice. Our process has traditionally started with the list of licensed providers in NH – a list which is updated every 2 years and which continuously adds newly licensed providers. This list defines those legally able to practice in the state. Our base list does not currently have NPI# included for providers, though this is planned for the future. By comparison, the NPI has no update requirement and has been shown to match the real capacity in less the 50% of cases. Requiring PCO's to start with the NPI, and further to document the reason for inactivating all erroneous providers, adds much effort without improving the data for the designation. The decision to base all future changes to capacity on NPI weekly updates, and to request that the PCO's address these, further exacerbates this issue. Also, the request that the state should document provider capacity for all providers listed, as opposed to just those in the designation being requested, would vastly increase the burden if enforced. We would be happy to work to identify the NPI# of those providers we do identify in a given RSA, and hope to have the capacity to do this universally in the future, but we should not be made to account for NPI providers as the starting point.
It is also worth noting that, at the time of this submission, the population data in the SMDS system is incorrect, with numbers based on the Total, rather than the Resident Civilian Population as required by statute. We identified this issue 6 months ago, and recently were informed that the agency now agrees that this is a problem, but no date for a resolution has been set. We are unable to proceed with pending designations due to issues stemming from this problem, and all population-based data coming from the system is incorrect until this is resolved. This has required a great deal of effort without yielding designation results. A variety of other system deficits have been identified and communicated to HRSA as well.
The PCO's were also asked to develop an 'equilibration plan', intended to balance the designation update workload across a 4 year update cycle. This seemed like a positive move to adjust for inconsistencies in the timing of when designations were initially done. After developing and submitting that plan, however, it seems to have been disregarded, with the current suggestion being that designations would be updated annually to address changes in the NPI data and underlying population shifts. This does not seem consistent with the requirements of the regulations. It also ends decades of precedent in the 3-4 year update cycle, and does not seem to add meaningful value to the process or the accuracy of the data, while increasing the effort significantly.

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

New Hampshire is in the process of implementing a statewide physician survey linked to the licensure renewal process. This survey, once implemented, is expected to yield nearly comprehensive data on all providers in the state, including the parameters needed for the shortage designation process. The effort needed to use this information in the SMDS system, however, is thwarted by the lack of an upload process for adding providers and information into the system. At present, all provider information must be manually

entered in the system, requiring each provider to first be located, and then data entry to be done via keyboard although it is already in compatible electronic format. This increases effort and introduces the possibility of error. The prior designation system had the ability to upload provider data. Furthermore, as noted above, we must then locate and address all providers from the NPI that are not validly listed and remove their capacity while documenting the reason for removing them.

New Hampshire is also making increased use of Medicaid claims data in the designation process. This data definitively measures the level of Medicaid primary care office visit activity, reducing the effort and increasing the accuracy of the results significantly. Because the data entry is manual, and all NPI providers must be addressed, the process of applying this data in SDMS adds unnecessary burden back. Many providers in an area don't accept Medicaid, but they, along with erroneously listed providers, must be identified and manually updated based on the SDMS processes. It would also greatly reduce effort if the system would allow claims to be entered at the organizational level, as many organizations do not bill Medicaid separately for each of their providers. The capacity would be the same in either case, but the aggregate claims counts readily available must be broken out by provider for entry into SDMS, which requires the involvement of the organization and customized reporting. Lastly, once CMS has completed implementation of the requirement for states to upload comprehensive Medicaid claims data centrally, HRSA may consider extracting this data directly into the designation software. This would reduce effort and inconsistency in process at the state level, though local review will still be required.

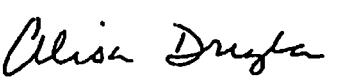
5. General comments

The NH Department of Health and Human Services does, overall, appreciate the effort to modernize the technology behind the designation submission software. In general, the software component of the new SDMS system has the potential to be an improvement over the ASAPS system used in the past, once the remaining identified programming issues have been resolved. Some of the policy decisions made with the implementation of the system, however, threaten to undermine these benefits; resulting in greatly increased burden and no improvement in accuracy. It appears that these policies could be adjusted with minimal impact or need to revise the actual software behind the SDMS, and we hope HRSA will revisit these. Also, increased testing and training on the new software, before the legacy system was taken off line, would have greatly reduced the effort and difficulty of implementing the new software.

We do want to emphasize that, while automation and software facilitation of the designation process is beneficial, the need for a human component in the process remains high. The data and technology is not yet sufficient to accurately capture actual provider capacity, and the context of the local service area cannot be gleaned from the data. The PCO's have the shared goal of accurately assessing primary care access in their states, as well as the knowledge, data, and local context to do so in a way that current data alone cannot. We hope that HRSA recognizes the value of the partnership between the PCO's and the Designation Branch as they continue to enhance the systems by which they interact.

We appreciate the opportunity to comment.

Sincerely,



Alisa Druzba, MA
Administrator
Rural Health and Primary Care

From: Laura J. Hale [mailto:ljhale@health.nv.gov]
Sent: Tuesday, April 07, 2015 5:41 PM
To: HRSA Paperwork
Cc: Scott Jones
Subject: HRSA ICR: Shortage Designation Management System OMB No. 0906-xxxx-New

To whom it may concern:

I am writing in response to the Information Collection Request related to SDMS OMB No. 0906-xxxx-New

Comments for the NV Primary Care Office (PCO) are as follows:

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

    a. HPSA designation is a critical gauge in identifying locations that require assistance in provider recruitment and retention. At both the federal and state level, programs like the National Health Service Corps, Nurse Corps, State Loan Repayment Program and the J1 Visa Waiver Program use the HPSA score as a gatekeeper to allow access to provider recruitment and retention tools.

    b. The SDMS application is useful in organizing data from multiple sources to calculate health professional shortages and allowing state-based personnel to configure *rational service areas* consistent with the unique features and requirements of their state.

    c. The SDMS application is new and has many problems that are gradually being addressed by HRSA/BHW.

2. *The accuracy of the estimated burden:*

    a. The transition from "ASAPS" to "SDMS" has created substantial increase in workload due, primarily, to three significant issues:

        i. Inability to upload provider data sets means that state PCO staff must manually enter tens of thousands of records, each with multiple fields of information; and

ii. Utilization of National Provider Identifier (NPI) database populates SDMS with a substantial amount of inaccurate data for providers and practice site addresses, requiring manual adjustments; and

iii. Default to "40 hours" for provider "tour hours" requires manual change for a significant percentage of records.

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

a. Clearer instructions and standard operating procedures would help standardize the designations. The SDMS manual for policies and procedures (MMP) is disorganized and incomplete; related power points appear to have more clear information on policy but are outdated and appear to be based on the old ASAPS system. Also, for new staff, learning the designation process becomes a difficult process as complete instructions are not all in one manual.

b. If NPI is to be a primary source of data, there need to be more incentives and/or requirements at the national level for all providers to maintain their information.

4. *The use of automated collection techniques or other forms of information technology to minimize the information collection burden:*

a. By far, the most time consuming and challenging aspect of the designation process is the provider survey. There is no federal requirement and in many states no state requirement for providers to give us the provider information needed to complete designations. The PCOs need to contact 2/3 of the total primary care doctors, dentists and mental health professionals in the state which represents thousands of providers. HRSA should change the 2/3 survey requirement, which is not a mathematically driven procedure, to a randomized, statistically driven sampling process. Randomized sampling to represent large populations is an accurate, well defined procedure in statistics that would reduce substantially the provider survey requirement and not base the requirement on the arbitrary value of 2/3. Once a baseline of providers is established for each state, random samples could be generated to survey for open or closed panel, tour hours and payer mix to generalize to the broader population.

Thank you for the opportunity to comment.

Laura Hale, Manager

Primary Care Office

Division of Public and Behavioral Health

(775) 684-4041

ljhale@health.nv.gov

From: Schwartz, Coleen - Ohio
Sent: Monday, June 08, 2015 6:24 PM
To: HRSA Paperwork
Subject: Information Collection Request Title: Shortage Designation Management System OMB No. 0906-xxxx-New

Thank you for the opportunity to comment on the HRSA Shortage Designation Management System (SDMS) as it relates to the Paperwork Reduction Act. The following comments are offered by the Ohio Primary Care Office.

1) **Necessity and utility of the proposed information collection for the proper performance of the agency's functions:**

It is necessary and useful to collect population and health care professional data in order to designate Health Professional Shortage Areas (HPSA) and Medically Underserved Areas/Populations (MUA/P). These designations of underservice are necessary for HRSA to properly perform its functions related to the National Health Service Corps and Federally Qualified Health Center programs.

2) **Accuracy of the estimated burden:**

The total estimated annualized burden hours table is problematic for several reasons.

a) An adequate explanation of the table is not provided. What is meant by the designation planning and preparation form? How was the number of responses per respondent determined?

b) Adequate information on the new SDMS system is not available to accurately estimate the burden on system users. Since the system was launched with limited functionality in September 2014, numerous technical and design issues have been identified. With many of these issues unresolved at this time, an accurate assessment of the time needed to prepare, complete and submit applications in the system is not possible.

c) A decision about HPSA update cycles is needed to accurately estimate the annual burden. The current practice is to update HPSA designations every three years. A move to an annual update cycle as HRSA is currently considering will increase the annual burden.

d) The estimated burden does not appear to include time to train personnel in the new system, which is time-intensive for new users and will likely continue to be required as system updates are made.

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

There are opportunities to improve the data currently used in the SDMS system.

a) Census data that is currently pre-populated in the system should be changed to allow for compliance with federal criteria (resident civilian population should replace total population) and accurate designations (poverty calculations should be based on the population for whom poverty is determined).

b) More information about the National Provider Identifier (NPI) data that pre-populates the system is needed in order to assess its usefulness in the designation of HPSAs and MUAs. Several significant issues have been identified with the initial data and close monitoring and follow-up will be needed as NPI delta files are incorporated into the system.

c) The system should accommodate state and local data. Examples include state Medicaid-eligible population data (which varies by state and is more accurate than using the currently pre-populated population below 200% poverty) and infant mortality/low birthweight data (where sub-county data can reveal access issues not evident in the pre-populated county-level data).

d) Consider comments from the SDMS Super User Group consisting of PCO representatives from each region of the country.

4) **Use of automated collection techniques or other forms of information technology to minimize the information collection burden:**

The system should allow states to import state-level provider data as opposed to requiring individual provider record updates. Our state is in the process of implementing a Minimum Data Set to be collected within the licensure process for all health professions. Part of our state plan was to improve the efficiency of the HPSA and MUA/P designation process by uploading this new data into SDMS, as the previous federal designation system had allowed.

Thank you for your consideration.

Coleen Schwartz, MHA

Administrator

Primary Care Office

Ohio Department of Health

246 North High Street, 7th Floor

Columbus, Ohio 43215

Oregon Primary Care Office/Oregon Health Authority
Comments on Paperwork Reduction Act
Federal Register April 3, 2015
Comments due: June 8, 2015
Send comments to: Paperwork@hrsa.gov
Information Collection Request Title: Shortage Designation Management System OMB No. 0906-xxxx-New.

Document Citation: 80 FR 18240, Document Number: 2015-07673

State Primary Care Offices were given the opportunity to respond to the Paperwork Reduction Act notice published in the April 3, 2015 Federal Register. PCOs were asked to comment on four specific questions related to the Shortage Designation Management System (SDMS) and process for designating Health Professional Shortage Areas (HPSA) and Medically Underserved Areas/Populations (MUA/P).

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

The State of Oregon relies on the accurate collection of data for shortage designations for several safety net state and federal programs:

- National Health Service Corps Scholarship/Loan Repayment awards
- NHSC State Loan Repayment Program awards
- Nurse Education Scholarship/Loan Repayment Program awards
- J1 Visa Waiver Program
- Rural Health Clinic Program
- Medicare Bonus Payment Incentive
- Federally Qualified Health Center site approval
- Oregon Medicaid Primary Care Provider Loan Repayment awards

(2) The accuracy of the estimated burden.

The estimated burden stated in the Notice *is a serious under-representation* of what is expected to be required. Please note below:

	# of Providers	Estimated Time Per Provider for Study	Average Number of Hours Per HPSA to Update (including Contiguous Areas)	Estimated Additional Time to Process Application in SDMS	Total Estimated Hours Per HPSA Application
Primary Care	**5435**	**13 minutes**	**15.1**	**8.0**	**23.1**
Dental Care	**2564**	**13 minutes**	**12.3**	**8.0**	**20.1**
Mental Health	**6211**	**13 minutes**	**47.0**	**8.0**	**55.0**

The estimate provided in the Notice was 4.25 hours per application.

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

- Providers and their office staff should be educated about the shortage designation process. Very few understand why the PCO is asking questions related to their practice. If this was better understood by providers and their office staff, the surveying process would take less time and the quality of the data would be more reliable.
- Also, see below (4)

(4) The use of automated collection techniques or other forms of information technology to minimize the information collection burden.

- Oregon has found the National Provider Identification (NPI) data to be unreliable because providers have no incentive to keep their information updated and correct. The Oregon PCO has spent many hours deleting healthcare providers who are no longer practicing clinical medicine, have relocated their practice out of state or who are no longer practicing at the address listed in SDMS. Many providers now work at multiple clinics, so the PCO is required to enter additional clinic addresses and the hours spent in practice at each clinic. Also, there are providers working in our communities but who are not listed in NPI and there is no way to enter this information into SDMS. It quickly became apparent that the NPI data would not minimize the information collection burden for Oregon PCO, and, in fact place a large collection burden on the PCO.
- Oregon licensure board information continues to be scrutinized by the PCO, as the addresses given to the boards are not verified before being published. A provider's corporate or home office may be listed, even though no medical care is performed at that location. Some information needed for the shortage designation applications, such as clinical hours, is collected by the licensure boards. For low-income Designations, Oregon is able to use Medicaid Claims to make these determinations.
- *What would make the biggest difference for Oregon's PCO would be to allow for a verifiable set of state data to be offered to HRSA, which includes NPI numbers. Those data would then taken and matched against what was prepopulated in the SDMS through a program. This would eliminate the need to have the PCO manually change the estimated 50% or more of the data prepopulated in SDMS which are not accurate.*

HRSA Information Collection Clearance Officer
Room 10C-03
Parklawn Building
5600 Fishers Lane
Rockville, MD 20857

Information Collection Request Title: Shortage Designation Management System OMB No. 0906-xxxx-New

To Whom it May Concern:

The South Dakota Primary Care Office (PCO) is located within the South Dakota Office of Rural Health and is responsible for completing all activities related to preparation, analysis, and submission of Health Professional Shortage Area (HPSA) and Medically Underserved Area (MUA) designations for South Dakota. The comments are organized in 4 sections that answer the specific areas that Health Resources and Services Administration has requested comments on.

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

The South Dakota PCO believes that having the required data points accurate as possible for HSPA and MUA designations is important. There are several data points that are required to submit HSPA or MUA designation; the data points are pulled from several sources: federal, state, or local. The HPSA or MUA designations are important because the designations are used for numerous federal programs, for example National Health Service Corps (NHSC) programs, Medicare bonus payments, and additional programs. Most of the required data points can be collected from existing sources either federal, state, or local sources. One data element that South Dakota PCO is not able to collect from existing sources is provider's FTE per location. South Dakota PCO is able to work with the licensing boards to collect a list of providers that are licensed, but the information does not include the provider's FTE location information. The provider's FTE location information is not collected in the National Provider Identifier (NPI) data either. For South Dakota to be able to collect the provider's FTE location information either the PCO or a contractor must reach out to the providers to collect the information. The provider's FTE location information is important because that is the basis for determining the population to provider ratio. The population to provider ratio determines if an area will or will not be designated.

(2) The accuracy of the estimated burden,

Based on South Dakota PCO's experience completing HPSA designation applications, the estimated burden of 6 hours underestimates the hours to compete an application. South Dakota PCO estimates that the time to complete an application is greater than the 6 hours that was estimated, based previous experience submitting applications. The estimated burden states that each state has a total of 23 HPSA and MUA designations. South Dakota PCO

believes that estimated burden underestimates the number of designations. For South Dakota the total number of HPSA and MUA designations is 155.

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

South Dakota PCO has submitted problems and issues to both South Dakota's project officer and the SDMS Super User group. The SDMS Super User group maintains a list of suggestions for ways to enhance the quality, utility, and clarity of the information. The link to the SDMS Super User group list of suggestions is as follows: https://docs.google.com/spreadsheets/d/1GbdScgmA_IfI9r3Bp8D7RYnI7FG_AaYQpyJxcmoGMGk/edit?pli=1#gid=0.

(4) The use of automated collection techniques or other forms of information technology to minimize the information collection burden.

South Dakota PCO supports the use of information technology to minimize the information collection burden. One way to improve the use of information technology is to allow PCOs to import data files for the providers in SDMS instead of having the PCOs update the provider's information one-by-one. Having to update provider's information one-by-one is a time consuming process and time could be saved by PCOs being able upload data files with the data points in SDMS for the providers. Also, the South Dakota PCO has noticed that several providers' addresses could not be geocoded and then the provider is not included in the population to provider ratio. There should be a way to correct this problem so that addresses are properly geocoded and therefore the population to provider ratio would be calculated properly with all of the providers in the service area being used.

Thank you for the opportunity to respond to the burden statement. Please feel free to contact myself if you have any questions or comments.

Respectfully Submitted,

Name: Kyle Fuchs

Title: Primary Care Office Coordinator

State: South Dakota

Primary Care Office
Comments on Paperwork Reduction Act
Federal Register April 3, 2015

Thank you for the opportunity to provide Comments on the Paperwork Reduction Act notice published in the Federal Register on April 3, 2015. The Texas Primary Care Office (TPCO) has been a cooperative agreement partner in the designation of underserved areas since 1978. The management of the TPCO has been consistent, with only two directors since the office was funded. The current manager has 20 years of experience with the designation of Health Professional Shortage Areas and Medically Underserved Areas.

HRSA specifically requests comments on

(1) the necessity and utility of the proposed information collection for the proper performance of the agency's functions,

Necessity: Information is collected to prioritize underserved areas for federal and state interventions that are intended to increase access to health care services. The programs that ~~require~~ utilize HPSA or MUA designations, in statute, require the designation of these areas for participation in programs, making the designations a necessity. According to HRSA, there are over 30 federal programs that use HPSAs or MUAs and there are additional programs at the state level that use HPSAs or MUAs.

Utility: The utility of the HPSA designations is only met when the provider and population data is accurate and confirmed at the state and local level. The previous process for updating HPSAs and reviewing areas requesting designation, engaged the Primary Care Office with state and local data sources. Although updates were only required every three years, changes in provider data was used to update HPSAs when requested, such as the loss of a physician or dentist that resulted in a shortage of providers.

The utility of MUA designations is not met. Although they are still required in statute for certification of Rural Health Clinics, Federally Qualified Health Centers and Look Alikes, they are not updated and the Index of Medical Underservice (IMU) is out of date, so any attempt to apply the old IMU to an area would not be an accurate measure of a medically underserved area or population. There are 319 MUA/P designations in Texas and 47% were designated in 1978 and have not been updated since that date. 74% of the MUAs were designated in the last century. The utility of MUA designations for "proper performance" is inaccurate, whether they are 35 years old or more recent based on the 35 year old Index of Medical Underservice.

(2) the accuracy of the estimated burden

Two estimates of the burden of were identified in a table in the Paperwork Reduction Act notice:

- Designation Planning and Preparation estimate
  According to the estimate, each state will spend 4.25 hours planning and preparing data for designations. This estimate falls far short in that it fails to account for the time it takes to update the NPI data provided in the SDMS system. The burden estimate only addresses the time to develop a plan for the designation process.

  The estimate of time required for Designation Planning and Preparation for Texas is based on the total number of NPI Records- 60,195 multiplied by 5 minutes per record or 5,016 hours. An additional 20 hours for planning is reasonable, for a total time for Planning and Preparation of 5036 HOURS. This is the time it takes to verify that the provider is primary care (medical, dental or mental health), remove sub-specialists, zero-out providers not germane to the designation (Nurse Practitioners, Chiropractors, deceased providers, no longer in practice, etc.), verify the tour hours at each practice location, edit or correct practice location information,

indicate status that might include Residents/Interns, National Health Service Corps, J-1 Visa Waiver physicians, and indicate the percent of practice time spent serving Medicaid, Medicare, Uninsured and Sliding Fee patients. The 5 minutes per record is conservative and likely to be far shorter than the actual time required to prepare the data for designation analysis. Technical problems with SDMS have required the TPCO re-enter data for many providers and fields.

The Texas Department of State Health Services Health Professions Resource Center (HPRC) receives licensing data for over 20 health professions. For primary care physicians and dentists, the number of providers that would be expected to be practicing in Texas would be 27,970 which is less than half the records currently in the NPI data in SDMS. This is based on data from HPRC, which has tracked workforce data for over a quarter of a century.

- SDMS Application estimate
  After NPI data (provider attributes) are updated, the process of submitting an SDMS application was estimated by HRSA to take 1.75 hours. The burden estimated that each state, on average, would submit 23 applications. Since there are 15,000 HPSA designations nationally, the average number per state, if evenly distributed would be 280 per state, not 23. Since they are not evenly distributed, the actual number of HPSAs in Texas is 938. Our estimate, based on submitting HPSAs over the years, is 4 hours per designation. **The estimate for submitting all HPSAs in one year, as proposed by the Associate Administrator of the Bureau of Health Workforce, would take 3752 hours for Texas. The total for Planning, Preparation, and submission of SDMS designation applications would be 8,778 hours. This is four times more hours than the PRA estimate for the entire country.**

Table A: Total Estimated Annualized burden hours (Rows 1-4 are from PRA, Rows 5-7 TPCO)

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	1	54	4.25	229.50
SDMS Application	54	23	1,242	1.75	2,173.50
Total	54	—	1,296	—	2,403.00
Texas: Designation Planning and Preparation	Texas	NPI Records: Primary Care: 25,846 Dental: 12,174 Mental Health: 22,175	60,195	5 Minutes per NPI record	20 hours for planning, 5,016 for NPI data. 5,036 total burden hours.
Texas SDMS Applications	Texas	HPSAs: Primary Care: 360 Dental: 243 Mental Health: 335	938	4 Hours per HPSA	3,752 hours for Texas Only
Total (Texas Only)	Texas	----	61,133	---	8,778.5 hours

Table B: Texas HPSA data from HRSA ~~Geospacial~~ Data Warehouse, June 30, 2014, for estimate in Table A.

Comment [CJE1]: They changed the name with the last "improvements"

Table 3. Primary Care Health Professional Shortage Areas, by State, as of June 30, 2014 HPSA Data for Texas							
	Total Designations	Geo/Area HPSAs	Pop Group HPSAs	Facility HPSAs	Population of Designated HPSAs	Percent of Need Met	Practitioners Needed to Remove Designations
Primary Care	360	160	39	161	4,993,638	67.95%	517
Dental	243	110	7	126	3,986,042	63.60%	354
Mental Health	335	210	3	122	7,769,063	45.21%	201
TOTAL	938	480	42	409			1072

(3) ways to enhance the quality, utility, and clarity of the information to be collected,

Quality: The quality of the data can be improved by allowing the PCOs to work with BHW to better filter and edit the NPI data. For example, the filtering based on taxonomy was not complete in that physicians with a second taxonomy were not removed from the NPI data. An example is a physician with a second taxonomy of emergency medicine. Since this is not a primary care specialty, all physicians who identify second specialty taxonomy should be filtered out before they are included in the SDMS provider data. Additionally the provider data is inaccurate since the PCOs are not able to add providers who are missing from the NPI data. PCOs have been told that only providers in the NPI data will be used for determining designations. Even if the PCO can identify providers who are missing, there is no way to add them to the system.

Additionally, demographic data is not correct specifically in the area of poverty populations. This causes errors in designating high need areas and in the calculation of HPSA scores. The recommendation is to correct this data ASAP.

Utility: The NPI data does not meet the needs of the states or programs that use the designations. The data in SDMS, based on NPI numbers is an over count of primary care providers, in other words there are twice as many primary care providers in the data than identified by the HPRC. If 5016 hours are spent to update and glean this data, the data will then reflect an under count. The inability of PCOs to add missing providers will result in many more areas being designated, but not based on factual information.

There are policy revisions in the Provider Management User Guide such as a new minimum population size for areas with no providers. This change was not published for comment or discussed; and it impacts rural frontier counties. The change will withdraw HPSAs with no providers because the population is too small, not because the area is not a shortage area. Additionally, the SDMS will not allow a designation of an area that has an international border. This is one of several examples of issues with the utility and application of SDMS, which includes problems that PCOs have been told do not have a fix.

In the early stages of SDMS development, PCOs requested a "sandbox" or area where the designation data could be reviewed to determine if it was eligible for designation or to determine the extent of the contiguous areas. This feature has not been developed, nor are there plans to do this. This means that a designation must be withdrawn before it can be further analyzed for any update or revision. ~~This~~ The requested function was clearly to improve the utility of the system.

Clarity: NPI data available in SDMS is missing fields that would allow a more expedient review. For example, the second taxonomy which is usually a specialty—like emergency medicine would be searchable and make it easier to zero out those non-primary care providers. By the selectively filtering the data available in the NPI data, the PCO must take additional time to locate provider information.

Demographic data is not visible to PCOs until after the RSA and CA analysis passes the system. It is at this point that PCOs learned that the data was not correctly calculated. For clarity, providing the demographic data in a data base for the entire state would provide up-front clarity and help guide the designation process—toward high need or population designation, depending on the data indicator. The file in SDMS that is named Designation Demographic and Health Data Export includes all of the designations, but the demographic and health data fields are blank.

Although related to utilization, clarity in the Goal for the current year is missing. It is not clear if the goal is to update HPSAs and MUAs across the country with the push of a button on January 1, 2016; or if the goal is to update all the HPSA scores for currently designated areas; or if the goal is to update the HPSAs that were last designated in 2011 and will be over 4 years old. The lack of clarity on the goal makes it difficult to prioritize the overwhelming expectation that 60,000 provider attributes are to be updated this year. PCOs were told that updating every provider was unnecessary if we wanted to accept the ASAPs provider data in the HPSA Archive Report for Providers. If that data is considered acceptable, why are we using the NPI data?

Clarity on the process required to use SDMS is also missing. Project officers cannot see the screens or views used by the PCOs. Additionally, most of them are not familiar enough with the designation process to advise or assist the PCOs with problems and issues. We have designations that passed all systems checks in SDMS but were refused due to a lack of knowledge on the part of the project officer. Cases and examples are available upon request. The resources online: Manual for Policies and Procedures, Provider Management User Guide, Primary Care Office Portal User Guide, and Mapping Tool User Guide are very general and vague about the step by step process for updating provider attributes and submitting designations. Error messages rarely provide information on how to resolve the issue and project officers have no experience to assist.

(4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

PCOs are far more data-savvy than the contractor and HRSA realize. The most expedient way to minimize the information collection burden would be to allow the PCOs to link data with data that is more accurate and up to date.

The way SDMS is set up is: 1) Edited NPI data populates the system. 2) The user can only make changes and edits to the Provider Profile or few changes to the Search results data. The process would be minimized if 1) the PCO could make changes to the NPI data base 2) changes would then populate the Provider Profile. This would allow the PCO to search and find, then edit providers that are not used for designation or require changes—such as NHSC, J-1 Waiver, Residents and Interns, as well as physicians no longer licensed in the state (based on linking licensure data to NPI data.) This would also allow PCOs to add missing providers to the data.

It is unclear why updates will require a new record each time an address is changed or a provider is working at more than one location. Licensing data shows multiple practice addresses on one line rather than duplicating the licensees' information. Over time this is going to greatly increase the lines of data, including providers that have been zeroed out in the first year.

The data collection burden would also be minimized if SDMS could generate reports, such as National Health Service Corps providers and J-1 visa waiver providers. It is not comprehensible that the NHSC system which shares the Portal with SDMS can't identify the current NHSC providers. Additionally it is unclear why the PCOs would have to provide the names and locations of J-1 visa waiver physicians

since that data is entered into SDMS. Again, linking data and generating reports would reduce the information collection burden.

Finally, the ability to run an "error" report the day after changes have been entered and updated would save time and assure that data entry errors that impact HPSA designation and scoring have been addressed would be a major improvement in the system.

Other Comments: From the beginning of discussions about replacing ASAPs and initiating a new designation system, the PCOs have offered their willingness to assist HRSA. The lack of collaboration has resulted in a system that could improve the designation process, but SDMS will not improve the process unless the issues with data and data management are addressed. Few states have been able to have a HPSA designation submitted and approved, even after 6 months (submission of applications came on-line in December 2014.) Many states still struggle to update provider attributes or are facing an impossible work load. The lack of knowledge and experience with SDMS and the policies for designation make the project officers ineffective and unable to provide assistance, for the most part. Problems with SDMS, such as designating counties on an international border are not resolved. Zeroing out providers in institutional settings and then needing to count them for Facility designations (OFAC, State Hospitals, and Prisons) are functional problems. To state that OFAC applications can be created, reviewed updated, reinstated, etc., is a false statement if the issue of provider identification and tour hours has not been resolved.

Similarly messaging that all states have been able to update provider attributes since September 2014 is also not true, when updates are invalidated or over-written in the system (NHSC Dentists for example.) Similarly, many states zeroed out non-psychiatric or Core Mental Health Providers (CMHP), only to be told that there was a different process and that CMHP data was to be re-entered. The time and effort of entering data and then re-entering it on the three page provider profile is redundant and time consuming when a sort, search and find report could identify providers and allow a much faster process to update the information.

Respectfully Submitted,

Name: Connie Berry

Title: Manager, Texas Primary Care Office

State: Texas

Vermont Department of Health
State Office of Rural Health & Primary Care June 8, 2015

Comments on:

Information Collection Request Title: Shortage Designation Management System OMB No. 0906-xxxx-New.

Document Citation: 80 FR 18240, Document Number: 2015-07673

Link: https://federalregister.gov/a/2015-07673

The Vermont State Office of Rural Health & Primary Care (SORH/PC) is the designated Primary Care Office (PCO) for Vermont and is responsible for completing all functions related to health professional shortage designation in the state of Vermont. In this capacity Vermont's SORH/PC is pleased to provide HRSA with comments regarding '80 FR 18240'. Like other states, we have organized our comments below in four sections.

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

To ensure a fair and accurate distribution of resources under a variety of federal and state programs, it is absolutely necessary to periodically collect, verify, analyze and report accurate clinician hours and location data from a variety of health care professionals to identify geographic areas of greatest need throughout the Vermont. For nearly 20 years, Vermont has collected data on work hours, locations and other demographic from Doctors of Medicine, Osteopathy, Psychiatry, Dentistry and Physicians Assistants on a voluntary basis. This approach has required significant follow-up but doing so, we were able to achieve a 98% response rate from these professionals.

This highly accurate data has been used to identify and prioritize state incentive resources and to apply for federal Health Professional Shortage Area (HPSA) and Medically Underserved Areas/Populations (MUA/Ps) for establishing FQHCs, RHCs and participation in NHSC and now SLRP. Shortage designations are a key function of our PCO work and essential to partners like Bi-State Primary Care Association and its members, Vermont AHEC Network, and others including planners, legislators, employers and recruiters. We take this work very seriously in Vermont and have two full-time staff dedicated to this work.

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

Based on our experience completing HPSA applications over the past several years, the estimated burden listed in '80 FR 18240' of 4.25 hours for planning and 1.75 hours for applications are vastly under-estimated. Single HPSA applications under the previous designation system (ASAPS) took between four and eight hours to submit in past years. That did not include validating and correcting 1-4 fields in every clinician record in HRSA's new system (SDMS). We are now estimating that reviewing, updating and validating every record for each discipline will take us up to 280 hours before December 31, 2015. This represents approximately 2,800 provider records to be corrected (349 dentists plus 953 primary care physicians plus 1,493 mental health providers as listed in SDMS).

Our staff estimates that she can update approximately 10 records per hour in SDMS totaling 280 hours (or 7 weeks) of solid work.

This estimate does not include the next step of competing and submitting shortage designation applications which could take an additional 2-4 hours for each application attempted. Neither does it include time taken previously to gather data from every licensed provider practicing in the state for each key profession. Our staff also has to write, negotiate, test and link survey instruments for each profession every two years during relicensing; then collect, follow-up and verify survey data for every profession being surveyed; then calculate initial provider FTE: population ratios for all RSAs to identify and prioritize potential designation applications.

In past years, Vermont has qualified for only a few HPSA and/or MUA/P designations, based primarily on the strength of our health care workforce relative to other states nationwide. Therefore, Vermont PCO staff might spend seven full weeks of work to update NPI data in SDMS in 2015 and still not be eligible for a single HPSA or MUA/P designation. We believe in accurate data, but there has to be a method that is more efficient, reliable and less resource demanding.

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

Vermont has several systems in place that help ensure accuracy and validity of the FTE data collected from health care professionals statewide.

a. Since 2013, the Vermont legislature has mandated the collection of FTE, location and other data from Dentists, Physicians and Psychiatrists and additional health care professionals tied to their re-licensing cycles, usually every two years. The additional professions pertinent to Health Professional Shortage Area (HPSA) designations include: Clinical Social Workers, Clinical Psychologists, Family & Marriage Therapists and Psychiatric Nurse Practitioners. Vermont is also collecting similar data from every clinician in an additional 30+ health care related professions for our own workforce planning needs.
b. Vermont also has had a Predefined Rational Service Area (PRSA) plan approved by HRSA more than 10 years ago. In this plan, developed from user data from Medicare and other health insurance providers, and other sources of information, Vermont identified about 40 RSAs reflecting actual care patterns and centers of population from our 250 towns (or townships). These RSAs range in size from a single town to 18 towns. With minor revisions in 2011 to 'reclaim' border towns where more than 50% of the population sought care across a state line, this same basic map is still in effect.
c. As in other states, the population data of the service area or population group is obtained from the U.S. Census and then divided by the number of health professional FTEs serving that population in order to obtain an accurate population to provider ratio which is the heart of the current shortage designation regulations.

Working together, HRSA and States could leverage the need for clear, consistent and current FTE data on key health professionals through development of uniform minimum data elements and

survey tools; encourage statutory or regulatory mandates for key professions to report hours, locations and other data as a component of relicensing; and technical support for states that need assistance in collecting, verifying, reporting and using this data across the nation.

For further suggestions on improving the SDMS system Vermont recommends that HRSA review the recommendations of the SDMS Super User group from national PCOs.

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

The current SDMS system does not allow states to import provider FTE data en masse. This must be remedied. Whether states collect statewide data during relicensing cycles or conduct ad hoc surveys of local providers within individual RSAs, the ability to collect and upload provider data into SDMS within predefined parameters negotiated between HRSA and PCOs would save States significant time and prevent data entry errors, therefore increasing accuracy of national data, a fairer distribution of limited federal and state resources and increase confidence in the system by states, practices and decision-makers.

Other comments:

Vermont's PCO and others stand ready to work with HRSA to develop appropriate systems to collect, validate and use provider data that is up-to-date, accurate and consistent across states. We look forward to further cooperation and partnerships.

Thank you for this opportunity to comment on the workforce burden of updating data in SDMS.

Sincerely,

John Olson

John A. Olson, M.Ed.
Chief, State Office of Rural Health & Primary Care
VT Dept. of Health
108 Cherry Street, PO Box 70
Burlington, VT 05401
(802) 951-1259
John.Olson@state.vt.us

Washington State Department of Health

The Washington State Department of Health (DOH) PCO is the agency charged with HPSA designations for the state of Washington. This is in response to your request for public comment on the HPSA ICR

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

   - HPSA designations are determined with provider and population data. While population data changes slowly, provider data can change rapidly. Accurate provider full time equivalency (FTE) data in a region is critical for HPSA. Without it, HPSAs may not accurately portray a shortage in accordance to the methodology. We are concerned this will be the case with use of SDMS/NPI, amounting to a somewhat whimsical an inequitable delivery of federal resources.

   - Washington State does not ask HPSA questions during license renewal. The most accurate way to find provider FTE, and what high-risk populations providers see, is via surveys. Surveys create an understanding beyond the numbers enhancing what the data says. The new plan to use National Provider Identification (NPI) to estimate FTE leads to serious inaccuracies.

     - It doesn't reflect or keep up with high provider mobility, creating mistaken provider locations in the shortage designation management system (SDMS). For example, Wyoming has 300 primary care physicians but the NPI states they have over 681 (And of those 300, it is unclear how many have been placed incorrectly within the state). Similar rates of inaccuracy have been found in Washington as in other states. Asotin Co, WA has 10 active primary care providers but the NPI states 22. This represents an 50% plus error rate. Such error rates are unacceptable and will lead to inexact HPSA scores that in all likelihood will reduce access in needy communities in States like Washington for reasons that will become more obvious below.
     - Many providers do not update their NPI data for many years. It appears providers create their NPI when they begin practicing but do not update when they relocate after residency. This is problematic for states that train many more providers than they recruit. Currently, the responsibility lies with the states to confirm the NPI data is correct and, if it is not, amend it. Even if a state zeroes out 'lost providers,' the state these providers relocate to might not find them. This inconsistency skews the data, favoring the communities providers relocate to vs. where they train, leading to inequitable drawing down of federal resources, increasing access in unmerited areas and decreasing it in areas of need.
     - NPI is not a cost-effective method and constitutes a blatant unfunded mandate upon state PCOs. It increases the nationwide time spent on each incorrectly placed provider. For example, Washington has 9,357 primary care providers listed in SDMS' NPI database. We have spent 5 minutes on average to confirm a provider who may be

zero'd out or relocated. When considering the over 50% location error rate, we expect to spend 390 hours correcting provider location **for primary care alone** (9,357/2*5/60=389.9). If the states providers relocate to found them, they would also spend a similar chunk of time updating their NPI. Considering the NPI method increases time, but it hasn't been proven to increase accuracy, we are concerned that it is less efficient and cost-effective than the current system. Most states are not funded or staffed to handle the extra burden of this work.

- With NPI, it takes substantively longer to complete HPSA designations. Because some states are simply not in a position to update their NPI. They may begin relying on the NPI SDMS list as it stands to find their practitioners in an effort to save time. With the 50% location error rate, this may further cause data messiness overestimates and underestimates, depending on the state. States who are able to contact all of their providers personally will be at a disadvantage. In other words, there may be a penalty for accuracy and high quality work but in the end, as long as we are not allowed to use a more disciplined method, HPSA designation work becomes highly inaccurate, more unverifiable than it was in the past, and a mockery of the reasons why the process was established in the first place—we will be going backwards.

2. The accuracy of the estimated burden

Based on our experience '80 FR 18240' underestimates burden. We estimate that a medium-sized county's HPSA takes 62 hours to complete. Our PCO takes 16 hours to confirm providers, 22 hours to survey clinics broken up over 4 weeks because of follow up, 6 hours to enter the collected data into our system and SDMS, 12 hours to confirm NPI data and zero out providers, and 6 hours to draw an appropriate Rational Service Area and Contiguous Areas as well as assign the nearest source of care and upload appropriate documentation.

The above estimates do not consider that the SDMS system has added significant time burden because of unanticipated system glitches of the information platform. Each time a glitch is found we must email HRSA error notifications and wait for response. It is not uncommon to wait several days before an error notification finally reaches the programmer. Since glitches are so common, and we must wait for email response and this process can take hours. We also found many revised policies and procedures do not follow the Federal HPSA Regulations. This requires us to follow up with the federal government and lose working time grieving the process. Additionally, SDMS training is not up to measure of the task and we have yet to be able to submit provider data files into the system. It has taken many hours to learn the new system and it will take many more. Realistically, for a state the size of Washington it would take at least 2FTE to resource this process with all of its inconsistencies and demands.

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

- A simple solution is to keep using the current state survey data. This alleviates the possibility a community needing more providers is denied a higher HPSA score and a community without need receives a higher HPSA score.
- Respect that provider FTE cannot be discerned from current data sources and surveys of physicians must still occur. In effect, you have only created more work that does not lead to higher quality or rigor of data.
- Don't use NPI at all or figure out how to fully automate that system nationwide in a way that leads to accurate automatic updates.
- Create a file that can be downloaded into the system.
- Follow the current federal regulations.
- Resolve the bugs in SDMS.
- Accept paper HPSA requests until SDMS is functioning properly.
- Allow the HPSA designations to remain active for three years so states don't spend triple the time surveying and renewing designations. Updating designations yearly would de-stabilize a community by increasing provider turnover.

Please note, we have also submitted many recommendations previously. Washington's Laura Olexa is a member of the SDMS Super User group and will continue to provide support in improving the SDMS system.

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

The current SDMS system does not allow states to import provider FTE data. Uploading provider FTE data into SDMS would save time and prevent data entry errors. We have tried electronic HPSA surveys to save time but have found providers are most likely to fill out paper surveys. We would like to continue using surveys, and not NPI, to locate providers.

5. **General comments**

The proposed switch to NPI has not proven cost-effective and may hinder our ability to improve access to health care services. We feel until the system is updated regularly, the NPI method is incapable of providing the information needed to accurately score HPSAs. If you decide to plough forward with this current folly, you need to consider increasing funding to state PCOs but even then you might still not get accurate data and you will end up surely with a very expensive, inefficient and ineffective system.

Thank you for the chance to comment.

`Wisconsin Primary Health Care Association Comments on: Link: https://federalregister.gov/a/2015-07673

HRSA Information Collection Clearance Officer
Room 10C-03
Parklaw Building
5600 Fishers Lane
Rockville, MD 20857

Re: *Information Collection Request Title:* Shortage Designation Management System OMB No. 0906-xxxx-New

To Whom It May Concern:

The Wisconsin Primary Health Care Association (WPHCA) serves as a contractor for the Wisconsin Primary Care Office (PCO) and is responsible for completing all functions related to the preparation, analysis, and submission of shortage designations for the state of Wisconsin. In this capacity WPHCA is pleased to provide HRSA with comments regarding the burden statement published in volume 80, number 64, page 18240 in the Federal Register on April 3, 2015. Our comments are organized in 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 shortage designation application such as resident civilian population, provider Full Time Equivalency (FTE), race, ethnicity, poverty status, status of water fluoridation, and drug and alcohol abuse. WPHCA believes that having this data as accurate as possible 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 areas 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 Wisconsin state licensure and re-licensure data or the National Provider Identifier (NPI) data. Thus, the provider FTE per location data must be collected by the Primary Care Office or 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 will or will not be designated and what the base score for that area will be. Other data points on the other hand, such as the percent of the population using fluoridated water does not influence if an area is designable.

2. The accuracy of the estimated burden

Based on WPHCA's experience completing Health Professional Shortage Area (HPSA) designation applications, the estimated burden of 6 hours is grossly understated in the burden statement. WPHCA estimates that an average HPSA takes 30 hours to complete. It takes on average 5 hours to determine an accurate list of clinics in the service area and contiguous areas, 13 hours to survey these clinics, 6 hours to enter the collected data into the Shortage Designation Management System (SDMS) and correct inaccurate National Provider Identifier (NPI) data that SDMS comes prefilled with, and 6 hours to draw an appropriate Rational Service Area and Contiguous Areas as well as assign the nearest source of care and upload appropriate documentation.

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

Many pieces of data go into a shortage designation application such as resident civilian population, provider FTE, race, ethnicity, poverty status, status of water fluoridation, and drug and alcohol abuse. Most of this data can be collected from existing sources such as the US Census. The provider FTE, however, cannot be collected from existing sources. In some states this data is collected during the re-licensure process. Currently, Wisconsin does not collect provider FTE during the re-licensure process and thus the burden lies on WPHCA via our contract with the PCO to survey clinics for this data.

SDMS is currently pre-filled with NPI data. Much of the NPI data has not been updated by providers since 2007. The result is that most providers do not work at the location listed in NPI and WPHCA has to spend time identifying the appropriate reason code for why the provider is no longer working at the location listed in NPI.

For further suggestions on improving the SDMS system WPHCA recommends HRSA review the recommendations of the SDMS Super User group. The current list of suggestions from the SDMS Super User group is attached for reference and the latest suggestions can be found at: https://docs.google.com/spreadsheets/d/1fzB4Kx1jvIMsBC4F1LTqO5IFXVL-p7PL0AmRk2DljHE/edit?usp=sharing

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

WPHCA supports the use of information technology to minimize the collection burden. Unfortunately, the current SDMS system has led to an increase in the collection burden as compared to the predecessor system called ASAPS. Here are some specific examples:

- SDMS does not allow states to import provider FTE data as the previous system did.
- The previous system allowed states to start with a blank slate rather than having to spend valuable time correcting inaccurate NPI data.

- The system is not able to geocode some providers, and whereas, the previous system in those situations allowed the user to enter in the census tract and MCD data by hand, the current system has no way to enter the correct geocode location for these providers.
- The current system requires users to have staff in other states enter address location hours for providers whose NPI address locates them in another state. Since many providers in NPI have not updated their practice address since 2007 this is an unrealistic ask of PCOs.

Furthermore, the current system does not follow federal regulations in a number of aspects, such as using total population rather than using the civilian resident population for the population to provider ratio, not allowing users to create and submit psychiatrist only mental health HPSA applications, inaccurately assigning .5 FTE to providers residing in the US on a J1 Visa Waiver instead of 0FTE, not having a place to enter inpatient care hours, and a number of other issues explained in detail in the recommendations from the SDMS Super User group.

Again, WPHCA supports the use of information technology to minimize the collection burden and encourages the Bureau of Health Workforce (BHW) to work collaboratively with PCOs to find a technological solution that minimizes rather than maximizes the collection burden.

5. General comments

We believe that the annualized burden hours do not accurately reflect the actual burden within states shortage designation processes because of the limited input that BHW sought out from PCOs.

The "Total Estimated Annualized Burden hours" table indicates that the "Number of respondents" is 54 for both "Designation Planning and Preparation" and "SDMS Application". WPHCA originally interpreted this to mean that 54 PCOs had submitted data to BHW and based on these responses the "Average burden per response (in hours)" was calculated. Because the annualized burden statement is significantly lower than the time required to prepare, analyze, and submit a Wisconsin shortage designation, and because the Wisconsin PCO did not submit any data for this burden statement, WPHCA reached out to mailing paperwork@hrsa.gov to find out how many states provided data for this burden estimate. From this request WPHCA learned that only 4 states were surveyed. WPHCA then reached out to each of the four states to understand how they are able to complete their designations in such a short time period. WPHCA's findings for each of the four states are shared below.

New Mexico had given BHW data regarding an atypical designation that did not contain any clinics and, thus, did not require providers to be surveyed. For this reason, their response should not have been used to calculate the average because most HPSAs contain multiple clinics and more than one provider per clinic. South Dakota's designation used to provide time estimates to BHW only had one healthcare facility and that facility had requested the designation, thus, almost eliminating the need to survey. Again, this was not a typical application and should not have been used to calculate an average. Virginia receives provider FTE data from their licensure board and, thus, does not need to take the time that other states do to survey providers.

Arkansas was the only state out of the four used that stood behind the numbers supplied to BHW. In the case of Arkansas the person completing the HPSA designations has been doing this work for 16 years and has developed relationships with many of the clinics that help him receive survey data much quicker than in other states. In addition the HPSA reported to HRSA was a rural HPSA which tend to have less clinics that need to be surveyed.

In three of the four scenarios that BHW used to formulate their burden estimates, the specific shortage designations used to inform estimates were anomalies. The fourth scenario is also an extreme situation due to the longevity of the HPSA staff and the relationships with providers.

Thank you for the opportunity to respond to the burden statement. Please feel free to contact Aleksandr Kladnitsky (akladnitsky@wphca.org or 608-443-2941) of my staff if you have any questions or comments.

Sincerely,

Stephanie Harrison

PCO Super Users Group Issues and Recommendations for Improvement

The most current list of issues can be found at:
https://docs.google.com/spreadsheets/d/1fzB4Kx1jvIMsBC4F1LTqO5IFXVL-p7PL0AmRk2DljHE/edit?usp=sharing

Below is a summary of the high priority issues, defined as issues that prevent submission of accurate shortage designation applications, and medium priority issues, defined as issues that add extraneous burden to PCOs. The full list of issues can be found in the above Google Spreadsheet which has been shared weekly by the SDMS Super User group with BHW on a weekly basis since February 2015.

I. Issue ID 2
   a. Some providers are not geocoded, as in they are not tied to a Minor Civil Division, Census Tract, and County by SDMS, although they have latitude and longitude assigned. This happens for original data prepopulated in SDMS and for additional practice locations added by PCOs. When this happens these providers are not counted in the provider side of the population to provider ratio for a HPSA designation.

II. Issue ID 16
   a. System does not currently allow for a user to continue an application if the Rational Service Area does not qualify. This is a major barrier for PCOs because PCOs often need to what Contiguous Areas will be required to survey prior to completing the designation.

III. Issue ID 17
   a. There is no place in SDMS to enter hospital hours separately from outpatient hours nor is there a way to indicate if hospital hours are included in the total direct patient care hours. The regulations require that hospital hours be added to the direct patient care hours or that the direct patient care hours be multiplied by an adjustment factor.
      i. "Practitioners who are semi-retired, who operate a reduced practice due to infirmity or other limiting conditions, or who provide patient care services to the residents of the area only on a part-time basis will be discounted through the use of full-time equivalency figures. A 40-hour work week will be used as the standard for determining full-time equivalents in these cases. For practitioners working less than a 40-hour week, every four (4) hours (or 1/2 day) spent providing patient care, in either ambulatory or inpatient settings, will be counted as 0.1 FTE (with numbers obtained for FTE's rounded to the nearest 0.1 FTE), and each physician providing patient care 40 or more hours a week will be counted as 1.0 FTE physician. (For cases where data are available only for the number of hours providing patient care in office settings, equivalencies will be provided in guidelines.)"
         1. Link to regulation
   b. In ASAPS the equivalencies were as follows (Link)

Primary Care Specialty	Average Office Hours per Week 1/	Average Hours All Direct Patient Care per Week 2/	Ratio of Office Hours to All Direct Patient Care Hours	Office Hours to All Direct Patient Care Hours Adjustment Factor
General/Family	35.1	49.9	.703	1.4
Practice Pediatrics	31.9	46.0	.693	1.4
Internal	27.1	49.5	.547	1.8
Medicine Obstetrics / Gynecology	29.2	55.5	.526	1.9
All Primary Care 3/	30.8	50.1	.618	1.6

c. PCOs are hesitant to update SDMS data until this issue is resolved because PCOs do not want to go back and re-enter provider information. For example a PCO may have a provider that works 20 hours in an office based setting and 10 hours doing rounds. In this case the PCO currently would enter 20 hours into SDMS. Later once an area is created to enter hospital hours that PCO would need to go back and enter 10 hours for the rounds. Furthermore, any HPSAs completed now would be inaccurate and the population to provider ratio would not be comparable to the last time the HPSA was designated.
d. Some PCOs may choose to enter the sum of hospital and office based hours as we did in ASAPS. If that is the case and later equivalencies are created the hours for those providers may inaccurately be adjusted upward. (In ASAPS there was a button one could click to state that hospital hours were included in the total).

IV. Issue #18

a. When a provider is indicated as a J1 Visa Waiver his or her FTE is counted as .5 FTE rather than 0 FTE.
    i. "Graduates of foreign medical schools who are not citizens or lawful permanent residents of the United States will be excluded from physician counts."
        1. Link to Regulation
    ii. Aleks tested this with [redacted] County MH HPSA (SDMS ID [redacted]) because there is only one provider in that county and that provider works 28 hours. Aleks marked that provider as having a J1 Visa Waiver and the final application states there are .5 FTE in the RSA.

V. Issue #21

a. SDMS does not let the user choose between the ratios allowed in the HPSA legislation to be used in a mental health designation. Currently, PCOs must enter a zero and a reason code for all non-psychiatrist MH providers pre-populated into SDMS in order to complete a psychiatrist only application.

(a) The area has—

(i) A population-to-core-mental-health-professional ratio greater than or equal to 6,000:1 and a population-to-psychiatrist ratio greater than or equal to 20,000:1, or

(ii) A population-to-core-professional ratio greater than or equal to 9,000:1, or

(iii) A population-to-psychiatrist ratio greater than or equal to 30,000:1;

(b) The area has unusually high needs for mental health services, and has—

(i) A population-to-core-mental-health-professional ratio greater than or equal to 4,500:1 and

A population-to-psychiatrist ratio greater than or equal to 15,000:1, or

(ii) A population-to-core-professional ratio greater than or equal to 6,000:1, or

(iii) A population-to-psychiatrist ratio greater than or equal to 20,000:1;

b. 3. Mental health professionals in contiguous areas are overutilized, excessively distant or inaccessible to residents of the area under consideration.

c. Link to Regulation

VI. Issue # 39

a. The population data being used in the SDMS system is wrong. All data is based on the Total Population instead of the 'Resident Civilian" population. As a result the % Low Income and poverty is calculating incorrectly, the population to provider ratio reported is incorrect, and other factors, such as the % elderly and the % minority race/ethnicity are all incorrect. The total population includes Institutional and Group Quarters populations that include prisons, dorms, military barracks, etc

i. "The population count used will be the total permanent resident civilian population of the area, excluding inmates of institutions."

1. Link to Regulation

VII. Issue #44

a. In Mental Health designations in SDMS, when attempting a Geographic with High Needs designation the system will not allow you to continue with a designation if the area doesn't meet the 20% of 100% poverty even if the RSA meets the Alcohol/Substance Abuse prevalence. SDMS doesn't allow for us to select alcohol/substance abuse prevalence as the reason for High Needs designation. The option to select alcohol/substance abuse isn't until later in the application after the RSA has been validated and created. But SDMS only looks at poverty rate, and youth/elderly ratio for high needs indicators during the RSA creation.

4. *Determination of unusually high needs for mental health services.* An area will be considered to have unusually high needs for mental health services if one of the following criteria is met:

(a) 20 percent of the population (or of all households) in the area have incomes below the poverty level.

(b) The youth ratio, defined as the ratio of the number of children under 18 to the number of adults of ages 18 to 64, exceeds 0.6.

(c) The elderly ratio, defined as the ratio of the number of persons aged 65 and over to the number of adults of ages 18 to 64, exceeds 0.25.

(d) A high prevalence of alcoholism in the population, as indicated by prevalence data showing the area's alcoholism rates to be in the worst quartile of the nation, region, or State.

(e) A high degree of substance abuse in the area, as indicated by prevalence data showing the area's substance abuse to be in the worst quartile of the nation, region, or State.

b.
   i. Link to Regulation

VIII. Issue #67

a. There is no way to override an "overlap" even when it is inaccurate. This means that PCOs cannot continue on applications where SDMS has identified an overlap.

IX. Issue #71

a. "RSA Provider Report" opens an Excel spreadsheet with no information. Without this report PCOs have no way to verify which providers were counted in the SDMS.

X. Issue #73

a. States that border foreign countries cannot complete HPSA applications for RSAs that have part of the polygon go into the foreign country, SDMS does not have a function to select and remove foreign Contiguous Area. Therefore the HPSA application cannot complete the Contiguous Area analysis because of the polygon entering a foreign country

XI. Issue ID 4

a. For MUP - system is using service area instead of population group for "Population 65 Years of Age and Older" percentage. HRSA website states "The weighted values for percent of population age 65 and over (V2) and the infant mortality rate (V3) would be those for the requested segment of the population in the area of residence, if available and statistically significant."

XII. Issue ID 40

a. The pervious system sent an email automatically to select parties notifying them of the application submission. This triggered the 30-day comment period. SDMS does not have this functionality. The current setup requires the PCO to distribute notification to the select parties even though sending a copy of the application to those parties is not an option at this time. In addition, for some states sending out such notice is a bureaucratic nightmare that could be avoided if the system sent out an automatic e-mail.

RWHC
Your partner. Your source.

June 8, 2015

HRSA Information Collection Clearance Officer
Room 10C-03
Parklaw Building
5600 Fishers Lane
Rockville, MD 20857
Submitted electronically via: paperwork@hrsa.gov

Subject: *Information Collection Request Title:* Shortage Designation Management System
OMB No. 0906-xxxx-New (FR Vol. 80, No. 16), April 3, 2015

The Rural Wisconsin Health Cooperative (RWHC) appreciates the opportunity to comment on the Health Resources and Services Administration (HRSA) notice seeking comments on the new Shortage Designation Management System (SDMS) for purposes of designating areas of health professional shortage. Our comments are meant to support the more detailed comments from the Wisconsin Primary Health Care Association (WPHCA). WPHCA serves as a contractor for the Wisconsin Primary Care Office (PCO) and is responsible for completing all functions related to the preparation, analysis, and submission of shortage designations for the state of Wisconsin.

Established in 1979, RWHC is owned and operated by thirty-nine, rural acute, general medical-surgical hospitals. Our vision that rural Wisconsin communities become the healthiest in America has led us to a twin mission of advocacy and shared services.

RWHC has focused much of our efforts on working to increase the health care workforce in rural Wisconsin. From heading the Wisconsin Health Workforce Data Collaborative and surveying our nursing workforce to helping to create the Wisconsin Academy of Rural Medicine aimed at medical students wanting to practice in rural areas, RWHC believes it is critical to increase rural workforce to increase rural access to health care.

With this experience, we look forward to HRSA using the comments in response to this notice to improve the SDMS as we believe that plentiful and accurate data are crucial to appropriately surveying and designating Health Professions Shortage Areas (HPSAs). RWHC knows that having this data as accurate as possible is important to properly determine if an area has a shortage of primary care physicians, psychiatrists, or dentists. This also plays a vital role in the allocation of federal and state resources for Medicare and Medicaid payments and loan repayment, as they are based on an areas shortage designation status and score.

RWHC supports the use of information technology to minimize the collection burden for designation purposes. Unfortunately, it seems that Wisconsin does not collect necessary provider information during the re-licensure process and thus, the burden lies on WPHCA and the PCO to

survey clinics for this data. Further, we have heard the concerns from WPHCA and our PCO about the lack of ability to import provider information to the SDMS or the inaccuracies from the National Provider Identifier (NPI) data that SDMS comes prefilled with as significant problems with the SDMS over the prior system and how this will only increase collection burden if not resolved. RWHC recommends that HRSA's Bureau of Health Workforce review the recommendations of the SDMS Super User group and dialogue with this group of experts to enhance and improve the SDMS.

We appreciate HRSA's continued commitment to the needs of rural patients and believe that improving the SDMS will go a long way to achieving the goal of improving the rural health care workforce. We look forward to continuing our work together on our mutual goals of improving access and quality of health care for all rural Americans.

Sincerely,

Tim Size

Tim Size
Executive Director

Wyoming Department of Health

Commit to your health.
visit www.health.wyo.gov

Thomas O. Forslund, Director

Governor Matthew H. Mead

June 3, 2015

Ref: SA-2015-011

Jackie Painter, Director
Division of the Executive Secretariat
5600 Fishers Lane
Rockville, MD 20857

Re: Information Collection Request; Title: Shortage Designation Management System OMB No. 0906-xxxx-New; Document Citation: 80 FR 18240, Document Number: 2015-07673; **Link:** https://federalregister.gov/a/2015-07673

Dear Ms. Painter,

The Wyoming Primary Care Office (WYPCO) is pleased to provide the Health Resources and Services Administration (HRSA) with comments regarding *80 FR 18240*. The WYPCO has organized comments into five sections, numbered in reference to requested comments within *80 FR 18240*, with a final section involving "other comments." The WYPCO has great interest in HRSA recognizing issues within the Shortage Designation Management System (SDMS), and offers full support in improving the system to meet the demands of Health Professional Shortage Areas (HPSAs).

(1) the necessity and utility of the proposed information collection for the proper performance of the agency's functions:

The WYPCO necessitates collection of accurate healthcare professional full-time equivalencies (FTEs) for Health Professional Shortage Area (HPSA) designation applications. Accurate HPSA designations enable Wyoming's health clinics and providers to utilize more than 30 federal programs including Medicare bonus payments, the National Health Service Corps (NHSC), Federally Qualified Health Center (FQHC), and Rural Health Clinic (RHC) programs.

In addition, the information collected is used by state-funded programs including the Wyoming Healthcare Professional Loan Repayment Program and Wyoming Physician Recruitment Grant Program. Provider information gathered guides prioritization of awards based on the degree of provider need statewide.

(2) the accuracy of the estimated burden:

The WYPCO feels the estimated burden in *80 FR 18240* is substantially understated. The WYPCO disagrees not only with the estimated burden, but also with the methodology of summarizing average burden by SDMS applications. SDMS applications are highly dependent upon the amount of providers within a HPSA and the number of providers per application range exponentially between rural areas and

metropolitan areas in Wyoming. The WYPCO recommends using burden per provider as a more accurate measurement of burden.

All non-Federal physicians who practice in specialties outlined under Title 42 regulations[1] for the designation of health professional shortage areas are surveyed annually by the WYPCO, rotating between Primary Care, Mental Health, and Dental. Primary care physicians are surveyed the first year, psychiatrists and core mental health providers the second year, and dental providers the third. Over a three-year period, the WYPCO estimates the hourly burden per provider for designation planning and preparation to be as follows:

Type of Burden	**Hourly Burden Per Provider**	**Minute Burden Per Provider**
Compare SDMS Database to Wyoming Database	0.00635	0.381
Compare extra providers in SDMS to licensure data	0.01339	0.8034
Research extra providers in SDMS who are licensed in WY and have qualifying specialty	0.25	15
Survey preparation, survey providers, and store survey data	1.14056	68.4336
Research providers omitted in SDMS	0.11429	6.8574
Enter data into SDMS	0.025	1.5

Pre-populating SDMS with National Provider Identifier (NPI) data increased the amount of providers from 313 primary care physicians, 32 psychiatrists, and 252 dental providers in the Wyoming Database to 618 primary care physicians, 63 psychiatrists, and 315 dental providers in SDMS. Core mental health providers are not included in the calculation of burden; inaccurate NPI data within SDMS renders designations based on core mental health providers useless. The WYPCO estimates providers per burden as follows:

Type of Burden	**Total Providers within WY per Burden**
Compare SDMS Database to Wyoming Database	996
Compare extra providers in SDMS to licensure data	399
Research extra providers in SDMS who are licensed in WY and qualify	278
Survey preparation, survey providers, and store survey data	685
Research providers omitted in SDMS	96
Enter data into SDMS	996

All types of burden except preparing to survey, surveying providers, storing of survey data, and entering data into SDMS are the result of using NPI data. The burden of time for designation planning and preparation by type of burden over a three-year time period is as follows:

[1] http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=cbdd3f5a2c9e91c56c80eb2322fcf358&mc=true&n=pt42.1.5&r=PART&ty=HTML

Type of Burden	Total Hours (3-Year Period)
Compare SDMS Database to Wyoming Database	6.32381
Compare extra providers in SDMS to licensure data	5.34375
Research extra providers in SDMS who are licensed in WY and qualify	69.50000
Survey preparation, survey providers, and store survey data	781.28514
Research on providers omitted in SDMS	10.97143
Enter data into SDMS	24.90000
Sum (3-Year Period)	**898.32413**

The WYPCO's average annual hourly burden is estimated to be approximately 299 hours (898.32413 hours / 3 years) for designation planning and preparation.

The WYPCO disagrees with HRSA's stated estimate of 23 as the average number of HPSA designations by state/territory. According to the Geospatial Warehouse,[2] U.S. states and territories (54) have 17,067 geographic and population HPSAs, averaging 316 per state/territory versus the 23 estimated by HRSA. Wyoming currently has 36 geographic and population HPSAs; utilizing the methodology for calculating burden by HPSA, the WYPCO averages 12 designations per year (36 designations / 3 years). The estimated annualized burden hours per HPSA for the WYPCO is approximately 25 hours (299.44318 hours / 12 designations per year) for designation planning and preparation. In comparison, HRSA's estimated average burden hours by HPSA of 4.25 is understated by approximately 587%.

The WYPCO is unable to accurately estimate the burden of time to create an application in SDMS due to current issues within the system. The WYPCO has only been able to complete one application to date as SDMS has been unstable and prohibitive to creating additional applications.

(3) ways to enhance the quality, utility, and clarity of the information to be collected:

NPI data utilized by SDMS is inaccurate, leading to the need for PCOs to spend numerous hours cleaning data. A recent analysis conducted by 36 states, including Wyoming, indicated that between 40%-60% of NPI data does not correlate with state and local datasets. Additionally, more than 30% of assessed workforce capacity at the service area level is not represented in NPI data. NPI data is the largest barrier to quality, utility and clarity of information collected, resulting in federal program resources and state program resources being assigned to incorrect areas of need. This inaccuracy is avoidable with the ability of the WYPCO to upload the Wyoming Database to SDMS in replacement of NPI data.

(4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden:

Pre-populated NPI data in SDMS results in additional hours needed by the WYPCO for designation planning and preparation. Given the opportunity to upload the Wyoming Database rather than using NPI data, the WYPCO would eliminate the need to compare the SDMS Database to the Wyoming Database, compare extra providers in SDMS to licensure data, research extra providers in SDMS who are licensed and qualify to be counted for designation in Wyoming, and research providers omitted in SDMS. The

[2] http://datawarehouse.hrsa.gov/

WYPCO estimates the ability to upload the Wyoming Database would save approximately 117 hours over a three-year period (39 hours annually).

Other Comments:

The WYPCO is deeply concerned with the process HRSA used to collect data in order to estimate the burden of SDMS. The WYPCO understands only four states were surveyed and those 4 states were chosen because they had successfully submitted an application in SDMS. Given the large amount of burden for the majority of HPSAs, the WYPCO believes applications which were submitted at the time of the burden survey were applications which had the least amount of burden in comparison to other HPSAs. Those PCOs needing a much longer amount of time to complete an SDMS application were not surveyed as a result. The WYPCO finds the estimated burden to be highly skewed, and largely inaccurate. It is the WYPCO's hope that HRSA utilizes the WYPCO's estimated burden for Wyoming to adjust SDMS, or resurvey all PCOs on time burden using sound surveying and statistical procedures.

The WYPCO would like to thank HRSA for the opportunity to comment on the estimated impact of SDMS. We urge the consideration of stated comments during the analysis of impacts of SDMS on HPSAs, and advocate for the ability to upload the Wyoming Database to SDMS. Please contact Weston Mueller, Data Manager, by telephone at (307) 777-6814 or via e-mail at weston.mueller1@wyo.gov with any questions you may have.

Sincerely,

Sharla Allen

Sharla Allen, MSHA, Manager
Office of Rural Health
Rural and Frontier Health Unit

SA/wm/kw

c: Wendy E. Braund, MD, MPH, MSEd, FACPM, State Health Officer and Senior Administrator, Public Health Division