

Health Resources and Services Administration

Shortage Designation Management System

OMB Control No. 0915-XXXX

Supporting Statement A

A. Justification

1. Circumstances Making the Collection of Information Necessary

This is a new information collection request for Office of Management and Budget (OMB) approval of the Health Resources and Services Administration's (HRSA) Shortage Designation Management System (SDMS). The legislative authorities for shortage designation are Section 332 and Section 330(b)(3) of the Public Health Service (PHS) Act (Attachments A and B). Specifically, approval is being requested for the Designation Planning and Preparation form and the SDMS application.

SDMS will be the online application and review system for shortage designations approved by HRSA. The information collected in the online SDMS applications is necessary to determine which geographic areas, population groups, and facilities are qualified and suitable to receive these federal shortage designations. HRSA has the responsibility for designating and de-designating certain types of shortage designations on behalf of the Secretary.

Shortage designation is used to identify geographic areas, population groups, or facilities determined by the Secretary of Health and Human Services to have a shortage of health professionals or underserved in terms of access to primary health care services. There are two types of shortage designations, each linked to a HRSA activity or function: Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas/Medically Underserved Populations (MUA/Ps).

HPSAs are used to identify areas, population groups, and facilities within the United States that are experiencing a shortage of health professionals. HPSAs were originally established by Congress to place National Health Service Corps (NHSC) providers receiving scholarships or student loan repayment in exchange for service in federally designated shortage areas (Sec. 331-338H of PHS Act). HPSAs are now used by a variety of other programs, including, but not limited to, the NURSE Corps, the J-1 Visa Waiver program, and the CMS Medicare Incentive Payment program.

MUA/Ps are areas, or populations within areas, designated by the United States Department of Health and Human Services (HHS) as having a shortage of health care services. MUAs designate the entire population of a particular geographic area. MUPs designate particular groups of underserved people within an area (e.g., homeless populations or Medicaid-eligible populations). MUA/Ps are a prerequisite for eligibility for grant awards to plan, develop, and operate a HRSA-supported health center under Section 330 of the PHS Act, and also are used by the CMS Rural Health Clinic Program and the J-1 Visa Waiver Program.

This current request for an ICR is in existence without an OMB control number.

2. Purpose and Use of Information Collection

The respondents for this information collection will be individual States – through their State Primary Care Offices (PCOs) – that seek to improve primary care service delivery and workforce availability in their State or territory to meet the needs of underserved populations. PCOs will submit a SDMS application for review and approval by HRSA to obtain a shortage designation in their state. The SDMS application seeks to collect necessary information that will enable HRSA to make determinations about the rational service areas proposed for shortage designation. The application will ask for national, state and local data on the geographic area, population group, or facility that is experiencing a shortage of health professionals or services and the number of health professionals relative to the population covered by the proposed designation. HRSA uploads national data from the Census Bureau and CDC into SDMS which is used to populate designations applications with data points on population, poverty, ethnicity, and health indicators. This means PCOs do not have to gather all these data points for each application. As needed, PCOs may provide more specific or current state or local data on specific special populations (e.g. migrant farmworkers, homeless, Medicaid eligible, tourists); health indicators (e.g. state and regional alcohol and substance misuse rates, fluoridation rates), and providers (e.g. hours spent working at specific locations, populations served). PCOs are also allowed to upload documents into each application so that they have the ability to provide any state specific data that they have available to supplement applications.

The list of specific national, state, and local data sources may be found in Attachment G. Applications are approved for shortage designations according to criteria required by Federal statute and regulation (Attachments A and C respectively).

The application and supporting documentation capture information that is relevant to identify rational service areas with the greatest need for health care services. It is particularly important to have regularly updated applications that provide current information so that limited resources can be targeted to communities based on need. PCOs have primary responsibility for initiating an application for a new or updated shortage designation, or withdrawing designations that no longer meet the designation criteria. HRSA will review the applications and make the final determination on all shortage designations.

In terms of the information collection request, general forms include the Provider Management functionality (Designation Planning and Preparation) and the Mapping Tool (SDMS Application) (Attachments D, E, F, and G respectively). All forms, tools, and documents are completed by the PCO submitting the application. Applications are submitted and reviewed for designation on a rolling basis, and there are no set timelines for new designation application submissions.

3. Use of Improved Information Technology and Burden Reduction

This information collection activity will be web-based. The link to the online application and instructions are available at <https://programportal.hrsa.gov/> for PCOs (Attachment H).

HRSA previously used another online application system, the Application Submission and Processing System (ASAPS), to create, review, and make determinations on HPSA and MUA/P applications. ASAPS was built on the manual business process and HPSA methodology defined in the 1970s. There was no OMB control number for ASAPS or the all-paper designation process that preceded it. While ASAPS had major advantages over the all-paper process that preceded it, the HPSA and MUA/P application process in ASAPS involved the creation of paper files for each application for every rational service area in every state and U.S. territory. From 2013 to 2015, this process led to the printing of over 33,000 pieces of paper.

In August 2013, HRSA launched an initiative to review the shortage designation process. In September 2014, SDMS was created allowing HRSA to retire ASAPS. SDMS is a single, automated system that simplifies the designation process with improved data standardization and data integrity, a new and improved user-interface, improved external communication functionality, and enhanced system support. The new system eliminated the need to print, process, and store over 16,000 pieces of paper annually and has brought transparency to the shortage designation process. In September 2014, SDMS was launched to allow PCOs to begin updating their state's provider data for future use in designation applications. PCOs were not required to submit any new or updated designation applications since the launch of SDMS, but PCOs may submit an application if they deem it necessary. This decision was made in an effort to ease the transition from ASAPS to SDMS and to stand up the new system while it is still in development. SDMS continues to improve with the addition of new and enhanced functionality focused on eliminating the need to mail out review findings to agencies and applicants.

4. Efforts to Identify Duplication and Use of Similar Information

The SDMS does not duplicate any other application and is unique to HPSA and MUA/P designations.

5. Impact on Small Businesses or Other Small Entities

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

6. Consequences of Collecting the Information Less Frequently

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

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

- **NHSC Program [HRSA]**: The National Health Service Corps builds healthy communities by supporting qualified health care providers dedicated to working in areas

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

- **Health Center Program [HRSA]**: Health centers are non-profit private or public entities that serve designated MUA/Ps or special MUPs comprised of migrant and seasonal farmworkers, the homeless or residents of public housing. MUA/Ps are a prerequisite for eligibility for grant awards to plan, develop, and operate a HRSA-supported health center under Section 330 of the PHS Act. If MUA/P applications were collected less frequently, the Health Center Program would not be able to award new access points efficiently.
- **Medicare HPSA Physician Bonus Program [CMS]**: Section 1833(m) of the Social Security Act provides bonus payments to physicians who furnish Medicare Part B services in areas that are designated by HRSA as primary care geographic HPSAs under section 332 (a)(1)(A) of the PHS Act. In addition, psychiatrists furnishing services in mental health HPSAs are also eligible to receive bonus payments. If HPSA applications were collected less frequently, there would be no guarantee that bonus payments would be given to providers serving in areas of greatest need.
- **Rural Health Clinic Program [CMS]**: The Rural Health Clinic (RHC) program is intended to increase access to primary care services for Medicaid and Medicare patients in rural communities. RHCs can be public, nonprofit, or for-profit healthcare facilities, however, they must be located in rural, underserved areas. The site must be in a U.S. Census non-urbanized area, and in an area designated as a shortage area within the last four years. If designation applications were collected less frequently, any clinic that is located in an area that was not newly designated or updated as an existing designation within the last four years would not be certified as an RHC.
- **Indian Health Service Scholarship Program [IHS]**: The IHS Scholarship Program (IHS SP) provides qualified American Indian and Alaska Native health professions students an opportunity to establish an educational foundation for each stage of their pre-professional careers. IHS SP service commitment can be fulfilled at an IHS facility, Tribal facility, Urban Indian program, or a private practice located in a designated HPSA that serves a patient base of which at least 75 percent of the patients are documented members or descendants of federally or state-recognized Tribes. If HPSA applications were collected less frequently, there would be no guarantee that IHS providers pursuing private practice could serve in areas of greatest need. The pool of eligible service areas would be limited to existing HPSAs, and the pool may become smaller as some existing HPSAs lose their designation.

- **J1 Visa Exchange Visitor Program Waiver [HHS, DoS, USCIS]:** The J-1 Visa is an exchange visitor non-immigrant visa that can be used by students of 17 different types of programs to promote cultural exchange, including international medical graduates pursuing residency and fellowship training in the United States. The J-1 visa allows holders to remain in the U.S. until their studies are completed or up to 7 years. At the completion of their studies, they are expected to return to their home countries for two years before applying to re-enter the United States. A J-1 Visa Waiver waives the two-year home residency requirement and allows a physician to stay in the country to practice in a federally designated Health Professional Shortage Area (HPSA) or Medically Underserved Area (MUA) if recommended by an interested federal government agency. State government agencies may also recommend J-1 physician waiver requests through the Conrad State 30 program. If designation applications were collected less frequently, there would be no guarantee that J1 Visa waiver physicians could serve in areas of greatest need. The pool of eligible service areas would be limited to existing designations, and the pool may become smaller as some existing HPSAs lose their designation.
- **Conrad 30 State Program [State governments, HHS, DoS, USCIS]:** The Conrad 30 Waiver program addresses the shortage of qualified doctors in medically underserved areas by allowing medical doctors who hold a J-1 visa to apply for a waiver for the 2-year residence requirement upon completion of the J-1 exchange visitor program. Although each state has developed its own application rules and guidelines for the Conrad 30 Waiver program, the program requirement to practice in a designated HPSA, MUA, or MUP applies to all J-1 medical doctors. If designation applications were collected less frequently, there would be no guarantee that Conrad 30 physicians pursuing could serve in areas of greatest need. The pool of eligible service areas would be limited to existing designations, and the pool may become smaller as some existing HPSAs lose their designation.

There are no legal obstacles to reduce the burden.

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

The request fully complies with the regulation.

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

Section 8A

A 60-day Federal Register Notice was published in the Federal Register on April 3, 2015, vol. 80, No. 64; pp. 18240-18241 (Attachment I). There were 19 questions and 25 public comments (Attachment J). Public comments were from a variety of sources including State PCOs, Primary Care Associations, and advocacy groups.

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

General concerns raised about the proposed information collection were as follows:

- **The estimated burden hours included in the 60-day Federal Register Notice largely underestimated the total amount of time it will take to complete a shortage designation application in SDMS.** Commenters universally agreed that the amount of hours reported for designation planning and preparation and the SDMS application will be much longer than the original estimates. While some commenters did not have an hourly estimate of how long it would take to complete a SDMS application, other commenters presented a wide range of hourly estimates based on their state's estimated workload. The commenters hourly estimates of the total amount of time it will take to complete a shortage designation in SDMS ranged from 5 hours to 60 hours.
- **The current data collection process for updating providers for shortage designation applications in SDMS is too time consuming.** Many commenters agree that the process for updating providers in SDMS is improving, but much is left to be done in order for SDMS to become the efficient and accurate system PCOs need. Commenters would like the ability to upload state collected survey data into SDMS instead of manually updating each provider record. Commenters note that there are problems with the accuracy of the provider National Provider Identifier (NPI) data already uploaded into SDMS, which is supplied by the Center for Medicaid and Medicare's National Plan and Provider Enumeration System (NPPES) database. Some commenters remark that their providers have not updated their NPI records in several years, and PCOs often have more updated and accurate provider data based on their provider surveys. Commenters note that manually updating each provider with incorrect data listed in the NPI record takes a large amount of time.
- For a summary of all topics mentioned and HRSA's response, please see Attachments J, O, and P.

HRSA recognizes the commenters' objections to the accuracy of the original burden estimate. Nine commenters provided estimates based on their experience using SDMS to submit HPSA applications, and as a result, HRSA has updated the estimated burden hours based on the feedback received. The updated burden estimate should reflect a more accurate picture of the current shortage designation application process from start to finish.

In addressing the time necessary to update provider information, HRSA encouraged PCOs to use the fall of 2014 and all of 2015 and 2016 to update providers. For 2015, 2016, and 2017, HRSA would not withdraw or propose withdrawal of any HPSA that had been over three years since their last update. This is in recognition of the large volume of provider data that needs to be updated to stand up SDMS after its initial launch. Once all of the providers are updated, HRSA estimates that the shortage designation application process will be less burdensome and will reduce the total amount of time required to update or create a SDMS application for shortage designation.

In response to the comments regarding the burden of updating each provider on an individual basis, HRSA has developed a Provider Management Import Tool (Attachment K) to provide PCOs the capability to add, update, or deactivate provider location data in bulk by modifying SDMS generated excel files.

HRSA recognizes the commenters' concern with using CMS' NPI database to manage providers for all SDMS applications. The purpose of using NPI data for SDMS applications is to have a standard data set across all states and territories. Using CMS' NPI data has a two-fold benefit: it allows HRSA to have standard data for all states and territories submitting shortage designation applications and it helps CMS better track bonus payments to providers participating in the Medicare HPSA Physician Bonus Program. Since CMS' bonus payment programs are dependent upon shortage designations, CMS is working on ways to determine ways to incentivize providers to keep their NPI records current. A summary of CMS' NPPES 3.0 Modernization project taken from the following website (<https://www.hhs.gov/idealab/projects-item/modernizing-the-national-plan-and-provider-enumeration-system/>). Please see Attachment Q for an outline of what has been accomplished by the modernization team so far.

This is a summary of the NPPES 3.0 Modernization project taken from the following website (<https://www.hhs.gov/idealab/projects-item/modernizing-the-national-plan-and-provider-enumeration-system/>)

This is what has been accomplished by the modernization team so far (per attachment Q):

1. Developed New Open Source architecture;
2. Modernized look / facilitated usability;
3. API (read-only) Customer Service Improvements launched in Dec 2015;
4. Can now explain and disclose more info over the phone, to authorized users;
5. No longer supplies paper forms as an equal alternative to using NPPES;
6. Single sign on ability;
7. Ability to update many records at the same time; and,
8. Provided more optional identifier fields:
 - a. "direct address" email,
 - b. More physical addresses (weekly, monthly, and annual locations including hours at each site), and,
 - c. More org names (weekly, monthly, and annual locations including hours at each organization).

CMS is also working to identify additional options for innovative and cost effective methods to encourage record maintenance and verify self-reported data using internal and external sources, such as:

- Medical licensure information from State medical boards;
- Geographical data to validate the address of health care providers;
- Checks against Internal Revenue Service tax identification numbers;
- Enabling delegation authority so others may more easily manage NPPES records on provider's behalf;

- Allow for two-way sharing of data in NPPES to other CMS system such as PECOS (the provider Medicare enrollment system); and
- Create public and internal application programming interfaces (APIs) that will make the NPPES data easier to use by the public and as an internal resource for HHS and CMS.

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

Section 8B

To get an estimate of the burden collection for the approximate time (in hours) that it will take them to prepare and plan a designation application and the time it will take them to complete and submit a SDMS Application, HRSA consulted the following individuals in January 2015:

Tracy Bradford
Office of Rural Health and Primary Care
Arkansas Department of Health
4815 West Markham Street - Slot 22
Little Rock, AR 72205
(501) 280-4563

Britt Catron
Primary Care/Rural Health Office
New Mexico Department of Health
300 San Mateo, NE, Suite 900
Albuquerque, NM 87108
(505) 841-5869

Halley Lee
Office of Rural Health
South Dakota Department of Health
600 E. Capitol Avenue
Pierre, SD 57501
(605) 773-3366

Theresa Taylor
Virginia Department of Health
Office of Minority Health and Health Equity
109 Governors Street, 10th Floor East
P.O. Box 2448
Richmond, VA 23219-2448
(804) 864-7426

In response to the 60 day FRN, several commenters noted that the original burden estimate largely underestimated the total amount of time needed to complete a shortage designation

application. Some commenters provided specific hourly estimates based on their workload and we were able to update our burden estimate based on their feedback.

9. Explanation of any Payment/Gift to Respondents

Respondents will not receive any payment or gifts besides the grant funding from the HRSA for the Primary Care Services Resource Coordination and Development Program (Attachment L).

10. Assurance of Confidentiality Provided to Respondents

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

Applicability of the Privacy Act

The Privacy Act is not applicable to SDMS. SDMS does not collect any PII data. The system does get extracts of publically available data on health care providers (such as name, NPI #, primary work address, etc.). However, this data is all public record.

Core to the Shortage Designation process is the following Federal data sources:

- CMS National Plan and Provider Enumeration System (NPPES) – provides publically available National Provider Identifier (NPI) records for individual U.S. medical professionals;
- Census American Community Survey (ACS) – provides community level population and poverty data; and
- Center for Disease Control (CDC) Infant Mortality Rates – provides community level infant natality and mortality rates.

SDMS imports weekly the publically available NPI file for individual medical providers, which includes the following information:

- Name,
- NPI #,
- Primary work address,
- Discipline and specialty, and
- Licensure information.

CMS makes this data public on their website. Please refer to the following link on the NPI: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/NPIBooklet.pdf>

SDMS uses the above data sources as part of the shortage designation process in creating HPSAs and MUA/Ps.

SORN

Currently SDMS is a subsystem to BMISS (The Bureau of Health Workforce Management Information System Solution). BHW is currently working on adding the providers' information SDMS gathers from CMS and new SDMS functionality to the existing BMISS SORN. The SORN for BMISS can be found at this link:

<http://www.hrsa.gov/about/privacyact/09150037.html>. The operations and maintenance costs can be found in Item 14.

PII

SDMS system does not collect any PII.

Privacy Impact Assessment

As SDMS is a subsystem to BMISS, BHW has a BMISS PIA (Attachment M). The BMISS PIA is currently going through the final stages of review with HHS.

11. Justification for Sensitive Questions

There are no questions of a sensitive nature.

12. Estimates of Annualized Hour and Cost Burden

Section 12A - Estimated Annualized Burden Hours

Burden Estimate:

Based on the public comments in response to the 60-day Federal Register Notice, HRSA updated the original burden estimate as follows:

Type of Respondent	Form Name	No. of Respondents	No. Responses per Respondent	Total Responses	Average Burden per Response (in hours)	Total Burden Hours
PCO	Designation Planning and Preparation	54	57	3078	23.40	72,025.20
PCO	SDMS Application	54	57	3078	11.33	34,873.74
Total		54		3078		106,898.94

There are 54 PCOs that are funded through the Primary Care Services Resource Coordination and Development Program cooperative agreement. Each PCO is responsible for submitting shortage designation applications on behalf of their state or territory. HRSA expects to receive approximately 3,057 applications per year; this estimate is based on the average number of geographic, population, and facility HPSA applications received during the cycles from Fiscal Year (FY) 2011 to FY 2013. In order to get the average responses per respondent, HRSA divided the anticipated 3,057 applications by 54 PCOs to come up with an average of 57 responses.

Before creating SDMS applications, PCOs undergo designation planning and preparation to map out which designation applications they wish to submit to HRSA for approval. It is estimated that it will take an average of 23.40 hours to plan and gather information from health provider surveys, state data sets, and other health and demographic data to submit with the online SDMS application. (54 applicants x (57 responses x 23.40 hours/response per application) = 72,025.20 total burden hours).

HRSA estimates that each PCO will submit an average of 57 designation applications for approval. The current application requests that applicants:

- create a Rational Service Area (RSA) by
 - selecting the RSA boundaries,
 - selecting the population center, and
 - creating the travel polygon;
- create and analyze Contiguous Areas; and
- find the provider outside the proposed designation who might serve as the Nearest Source of Care.

It is estimated that it will take an average of 11.33 hours to review the instructions, complete the forms, and upload the necessary documents to the online SDMS application. (54 applicants x (57 applications x 11.33 hours/response per application) = 34,873.74 total burden hours).

HRSA received a wide range of hourly estimates from the nine commenters who provided data for the burden estimate calculation. Out of 9 commenters, 4 estimated that it would take between 6 – 10 hours to complete planning and preparation activities for a SDMS application, 3 commenters estimated that it would take between 20 – 27 hours to complete a SDMS application, and 2 commenters estimated that it would take between 52 and 56 hours to complete a SDMS application. When estimating how long it would take to complete a SDMS application, 7 estimated that it would take between 3 – 6 hours and the other 2 commenters estimated that it would take between 28 and 40 hours. While this updated burden estimate is higher than the original estimate, HRSA estimates that the burden estimate will shrink after PCOs complete their initial update of provider data to help stand up the system and gain more experience using the new system.

Through SDMS, HHS has largely removed the burden on the PCOs to source any demographic, health or travel data for shortage designation applications. HHS populates the SDMS with Census, ACS, CDC, and ESRI data for these points, and will begin regularly updating these standard national data sets in January or February of each year as new data sets become available.

The data HHS relies most heavily on the PCOs to provide is data on health care providers who provide direct patient care in their respective states and territories. All of the updates PCOs make to provider data to stand-up SDMS will be saved and pre-populate for future applications. However, it should be noted that if there is a change to the provider’s information that HHS relies on the PCOs to collect between the time the PCO initially updated the data to stand up SDMS and their next application submission involving that provider, it will need to be changed again. At this time we cannot predict the volume of such changes. However, it should be noted that SDMS will automatically update even a number of provider data changes (e.g. provider deaths, exclusions, and changes of practice address) through weekly imports of NPI update files.

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Section 12B

Estimated Annualized Burden Costs

Type of Respondent	Total Burden Hours	Hourly Wage Rate	Total Respondent Costs
PCO	106,898.94	\$28.48	\$3,044,481.81
Total			\$3,044,481.81

The wage rate was calculated based on the wage rate for a Management Analyst, specifically for the State Government (OES Designation) hourly mean average of \$28.48. (http://www.bls.gov/oes/current/naics4_999200.htm)

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

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

14. Annualized Cost to Federal Government

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

Federal Employee Costs:

Instrument	GS-Level/Base Pay Rate	Project Time per FTE	Number of FTEs	Total Annual Cost
SDMS Application Review	\$76,378 (GS-12, Step 1)	.50	11	\$420,079
Total				\$420,079

All SDMS applications are reviewed and processed internally by 11 HRSA staff with an average pay rate of \$76,378.00 (equivalent to a GS-12, Step 1 at 2015 pay rate level). It is estimated that the annualized total cost to the government will be \$420,079.00.

Contractor costs:

Contract costs for the on-line application system include operations and maintenance costs, development, modernization, and enhancement costs, and hosting services costs.

Period of Performance	Type	Amount
6/1/2015 to 5/31/2016	Operations & Maintenance (O&M) (includes improvements & production support)	\$2.19 million
6/1/2015 to 5/31/2016	Development, Modernization & Enhancement (DME)	\$3.94 million
6/1/2015 to 5/31/2016	Hosting Services <ul style="list-style-type: none">• Represents 40% of the total annual hosting charges; 60% allocated to BMISS	\$.48 million

The total annualized cost to the Federal Government is \$7,030,079.00.

15. Explanation for Program Changes or Adjustments

This is a new information collection.

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

The HPSA statute requires that the lists of designated HPSAs are annually published in the *Federal Register* by July 1 (Attachment N). In addition, lists of designated HPSAs and MUA/Ps are updated daily on the HRSA Websites,

<http://datawarehouse.hrsa.gov/tools/analyzers/hpsafind.aspx> and <http://muafind.hrsa.gov/>, so that interested parties can access the information in real time.

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

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

18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.