

**Health Resources and Services Administration**

**Shortage Designation Management System**

**OMB Control No. 0906-0029 - Extension**

**Supporting Statement A**

**A. Justification**

**1. Circumstances Making the Collection of Information Necessary**

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

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

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

MUA/P designations are geographic areas, or population groups within geographic areas, that are experiencing a shortage of primary care health care services based on the Index of Medical Underservice (IMU) which is used by the Health Resources and Services Administration (HRSA) to identify and score Medically Underserved Areas/Populations (MUA/Ps) based on the ratio of providers per 1,000 population, percent of population at the Federal Poverty Level, percent of population age 65 or over, and infant mortality rate. MUAs are designated for the entire population of a particular geographic area. MUP designations are limited to subsets of the population within a geographic area. MUA/Ps are a prerequisite for eligibility for grant awards

to plan, develop, and operate a HRSA-supported health center under Section 330 of the PHS Act.

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

- Rural Health Clinic Program [Center for Medicare and Medicaid Services (CMS)]
- HPSA Physician Bonus Program [CMS]
- Indian Health Service Scholarship Program [Indian Health Service]
- J-1 Visa Exchange Visitor Program [HHS, Department of State (DoS), United States Citizenship and Immigration Services (USCIS)]
- Conrad 30 State Program [State governments, HHS, DoS, USCIS]

## **2. Purpose and Use of Information Collection**

As part of HRSA's cooperative agreement with the State Primary Care Offices (PCOs), the State PCOs conduct needs assessment in their states, determine what areas are eligible for designations, and submit designation applications for BHW review via the SDMS. Requests that come from other sources are referred to the PCOs for their review, concurrence, and submission via SDMS. To obtain a federal shortage designation for an area, population, or facility, PCOs must submit a shortage designation application through SDMS for review and approval by HRSA. Both the HPSA and MUA/P application require local, state, and national data on the population that is experiencing a shortage of health professionals and the number of health professionals relative to the population covered by the proposed designation. With the development of the SDMS, Census Bureau, American Community Survey, and Centers for Disease Control and Prevention data is automatically populated in the system when PCOs select the rational service area for designation. The application and supporting documentation capture information that is relevant to identify rational service areas with the greatest need for health care services and identification of qualifying shortages.

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

In terms of the information collection, general forms include the SDMS Application and Supporting Documents [see Attachment D]. The Supporting Documents are created and

provided by the applicant and are only required as necessary to explain or enhance information included in the application. These documents may include:

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

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

### **3. Use of Improved Information Technology and Burden Reduction**

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

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. This system has eliminated the need to print, process, and store over 16,000 pieces of paper annually and has brought transparency to the shortage designation process. This initiative also resulted in the digitization of over 380,000 pages of legacy application documents that had accumulated over the years of the previous application system. SDMS continues to improve with the addition of new and enhanced functionality focused on eliminating the need to mail out review findings to agencies and applicants.

### **4. Efforts to Identify Duplication and Use of Similar Information**

The SDMS does not duplicate any other application and is unique to HPSA and MUA/P designations. These applications are the only known mechanism for collecting geographic,

population, provider, and facility specific information that can be used to designate HPSAs and MUA/Ps.

## **5. Impact on Small Businesses or Other Small Entities**

The information collection will not have a significant impact on small entities. The information being requested or required has been held to the absolute minimum required for the intended use of the data.

## **6. Consequences of Collecting the Information Less Frequently**

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

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

- **NHSC Program [HRSA]:** The National Health Service Corps builds healthy communities by supporting qualified health care providers dedicated to working in areas of the United States with limited access to care. The NHSC provides funding support to encourage selected primary health care professionals to practice in HPSAs. HPSAs were specifically created to target placement of NHSC providers in areas with the highest need for health professionals. If new HPSA applications were collected and existing HPSAs reviewed less frequently, there would be no guarantee that NHSC providers could be placed in areas of greatest need. The pool of eligible service areas would be limited to existing HPSAs, and the pool may become smaller as some existing HPSAs lose their designation.
- **Health Center Program [HRSA]:** Health centers are non-profit private or public entities that serve designated MUA/Ps or special MUPs comprised of migrant and seasonal farmworkers, the homeless or residents of public housing. MUA/Ps are a prerequisite for eligibility for grant awards to plan, develop, and operate a HRSA-supported health center under Section 330 of the PHS Act. If MUA/P applications were collected less frequently, the Health Center Program would not be able to award new access points efficiently.
- **Medicare HPSA Physician Bonus Program [CMS]:** Section 1833(m) of the Social Security Act provides bonus payments to physicians who furnish Medicare Part B services in

areas that are designated by HRSA as primary care geographic HPSAs under section 332 (a)(1)(A) of the PHS Act. In addition, psychiatrists furnishing services in mental health HPSAs are also eligible to receive bonus payments. If HPSA applications were collected less frequently, there would be no guarantee that bonus payments would be given to providers serving in areas of greatest need.

- **Rural Health Clinic Program [CMS]:** The Rural Health Clinic (RHC) program is intended to increase access to primary care services for Medicaid and Medicare patients in rural communities. RHCs can be public, nonprofit, or for-profit healthcare facilities, however, they must be located in rural, underserved areas. The site must be in a U.S. Census non-urbanized area, and in an area designated as a shortage area within the last four years. If designation applications were collected less frequently, any clinic that is located in an area that was not newly designated or updated as an existing designation within the last four years would not be certified as an RHC.
- **Indian Health Service Scholarship Program [IHS]:** The IHS Scholarship Program (IHS SP) provides qualified American Indian and Alaska Native health professions students an opportunity to establish an educational foundation for each stage of their pre-professional careers. IHS SP service commitment can be fulfilled at a/an: IHS facility, Tribal facility (contracted under the Indian Self-Determination Act [P.L. 93-638]), Urban Indian program (assisted under Title V, Health Services for Urban Indians, of the IHCA [P.L. 94-437]), or a private practice located in a designated HPSA that serves a patient base of which at least 75 percent of the patients are documented members or descendants of federally or state-recognized Tribes. If HPSA applications were collected less frequently, there would be no guarantee that IHS providers pursuing private practice could serve in areas of greatest need. The pool of eligible service areas would be limited to existing HPSAs, and the pool may become smaller as some existing HPSAs lose their designation.
- **J-1 Visa Exchange Visitor Program [HHS, DoS, USCIS]:** The J-1 Visa is an exchange visitor non-immigrant visa that can be used by students of 17 different types of programs to promote cultural exchange. International medical graduates pursuing residency and fellowship training in the United States often have J-1 Visas. The J-1 Visa allows holders to remain in the U.S. until their studies are completed or up to 7 years. At the completion of their studies, they are expected to return to their home countries for two years before applying to re-enter the United States. A J-1 Visa Waiver waives the two-year home residency requirement and allows a physician to stay in the country to practice in a federally designated HPSA or MUA if recommended by an interested federal government agency. State government agencies may also recommend J-1 physician waiver requests through the Conrad State 30 program. If designation applications were collected less frequently, there would be no guarantee that J-1 Visa

waiver physicians could serve in areas of greatest need. The pool of eligible service areas would be limited to existing designations, and the pool may become smaller as some existing HPSAs lose their designation.

- **Conrad 30 State Program [State governments, HHS, DoS, USCIS]:** The Conrad 30 Waiver program allows medical doctors who hold a J-1 Visa to apply for a waiver for the 2-year residence requirement upon completion of the J-1 exchange visitor program. The program addresses the shortage of qualified doctors in medically underserved areas. Although each state has developed its own application rules and guidelines for the Conrad 30 Waiver program, the following program requirements apply to all J-1 medical doctors. The J-1 medical doctor must:
  - o Agree to be employed full-time in H-1B nonimmigrant status at a health care facility located in an area designated by HHS as a HPSA, MUA, or MUP,
  - o Obtain a contract from the health care facility located in an area designated by HHS as a HPSA, MUA, or MUP,
  - o Obtain a “no objection” letter from his or her home country if the home government funded his or her exchange program, and
  - o Agree to begin employment at the health care facility within 90 days of receipt of the waiver, not the date his or her J-1 Visa expires.

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

There are no legal obstacles to reduce the burden.

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

The request fully complies with the regulation.

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

### **Section 8A**

A 60-day *Federal Register* Notice was published in the Federal Register on May 19, 2025, vol. 90, No. 95; pp. 21318-19. There were a total of 51 public comments. See Attachment H for a summary of comments and HRSA’s response.

A 30-day *Federal Register* Notice was published in the Federal Register on December 17, vol. 90, No. 95; pp. 58569-71.

### **Section 8B**

There were no recent efforts to consult with persons outside the agency to obtain their views on the availability of data, frequency of collection, the clarity of instructions and record keeping, disclosure, or reporting format (if any), and on the data elements to be recorded, disclosed, or reported, because the information is still relevant and there were no major changes since the last submission to OMB. This is because HRSA receives feedback during the application period from both applicants and application reviewers (e.g., BHW Customer Care Center inquiries). Based on this, a separate effort to consult with persons outside the agency was not necessary.

#### **9. Explanation of any Payment/Gift to Respondents**

Respondents will not receive any payment or gifts.

#### **10. Assurance of Confidentiality Provided to Respondents**

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

#### **11. Justification for Sensitive Questions**

There are no questions of a sensitive nature.

#### **12. Estimates of Annualized Hour and Cost Burden**

##### **Section 12A - Estimated Annualized Burden Hours**

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

There are 54 PCOs that are funded through the Primary Care Services Resource Coordination and Development Program cooperative agreement. Each PCO is responsible for submitting shortage designation applications on behalf of their state or territory. Before creating SDMS applications, PCOs undergo designation planning and preparation to map out which designation

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

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

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

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

Modifications were not made to HRSA's original burden estimate as the information received from the commenter was specific to their processes and number of applications submitted.

## Section 12B

HRSA has determined that a Business Operations Specialist within a PCO would be the person most likely to do designation planning and preparation and as well as prepare and submit shortage designation applications.

### Estimated Annualized Burden Costs

Type of Respondent	Total Burden Hours	Median Hourly Wage Rate <sup>1</sup>	Total Respondent Costs
PCO	38,664	\$54.70	\$2,114,921
<b>Total</b>	<b>38,664</b>		<b>\$,2114,921</b>

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

<sup>1</sup> Median hourly wage based on the United States Department of Labor, Bureau of Labor Statistics for a Business Operations Specialist, Occupation Code: 13-1000 (<https://data.bls.gov/oes/#/industry/621300>). Hourly wage doubled to account for benefits.



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 <sup>2</sup>	Project Time per FTE	Number of FTEs	Total Annual Cost
SDMS Application Review	\$120,579 (GS-13, Step 1)	0.50	7	\$633,040
<b>Total</b>				\$633,040

All SDMS applications are reviewed and processed internally by 7 HRSA staff with an average Grade of a GS-13, Step 01 at a 2025 pay level. It is estimated that the annualized total cost to the government will be \$633,040.

##### 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
6/10/2025 to 6/09/2026	Operations & Maintenance (O&M)	\$1,200,000
6/10/2025 to 6/09/2026	Development, Modernization & Enhancement (DME)	\$4,300,000
6/10/2025 to 6/09/2026	Hosting Services	\$600,000

The total annualized cost to the Federal Government is **\$6,733,040** (includes Federal staff and contractor costs).

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<sup>2</sup> Table updated based off of OPM Salary Table 2025-DCB <https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2025/DCB.pdf>. Wage has been multiplied by 1.5 to account for overhead costs, for an annual base pay of \$180,868.50.

**15. Explanation for Program Changes or Adjustments**

There are no proposed changes or adjustments.

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

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

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

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

**18. Exceptions to Certification for Paperwork Reduction Act Submissions**

There are no exceptions to the certification.