DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Request for Public Comment on the Updated Criteria for Determining Maternity Care Health Professional Target Areas

AGENCY: Health Resources and Services Administration (HRSA), Department of Health and Human Services (HHS).

ACTION: Request for public comment on the updated criteria for determining maternity care health professional target areas.

SUMMARY: The Public Health Service (PHS) Act directs HHS, through HRSA, to identify maternity care target areas (MCTAs; geographic areas within health professional shortage areas (HPSAs) that have a shortage of maternity care health professionals) for the purpose of assigning National Health Service Corps participants who are maternity care health professionals to HPSAs with a shortage of such professionals. On September 27, 2021, HRSA published a **Federal Register** notice (FRN) soliciting feedback on proposed criteria to be used to identify MCTAs. On May 19, 2022, HRSA published an FRN that summarized and responded to the comments received during the 60-day comment period and presented the final criteria which are used to identify and score MCTAs. One of the criteria selected was the Social Vulnerability Index (SVI). SVI was used to assign points based on the relative level of social vulnerability within an area. Areas with SVI values at or above the 75th percentile received 2 points. Areas with SVI values between the 50th and 75th percentiles received 1 point. Areas with SVI values below the 50th percentile received 0 points. HRSA is now proposing to change the criteria and point scales for MCTAs by removing the criterion for SVI and reallocating its two points as follows: one point to population-to-full-time-equivalent maternity care health professional ratio and one point to score for travel distance/time to nearest source of accessible care outside of the MCTA.

DATES: Submit comments no later than March 5, 2026.

ADDRESSES: Electronic comments should be submitted to the Shortage Designation Branch by email at *sdb@hrsa.gov.*

FOR FURTHER INFORMATION CONTACT: Matthew Patterson, Senior Advisor, Division of Policy and Shortage Designation, Bureau of Health Workforce, HRSA, 5600 Fishers Lane, phone number: (301) 594–5110, Mail Stop 15SWH03, Rockville, Maryland 20857, or *sdb@hrsa.gov.*

SUPPLEMENTARY INFORMATION: Section 332 of the PHS Act (42 U.S.C. 254e), provides that the Secretary of HHS designate HPSAs based on criteria established by regulation. HPSAs are defined in statute to include (1) urban and rural geographic areas which the Secretary determines have shortages of health professionals, (2) population groups with such shortages, and (3) public or private medical facilities or other public facilities with such shortages. The required regulations setting forth the criteria for designating HPSAs are codified at 42 CFR part 5.

Section 332(k)(1) of the PHS Act provides that the Secretary, acting through the HRSA Administrator, shall identify shortages of maternity care health services ''within health professional shortage areas.'' Section 332(k)(1) further requires HRSA to identify MCTAs and distribute maternity care health professionals within HPSAs using the MCTAs so identified.

In a September 27, 2021, FRN (86 FR 53324), HRSA requested feedback on six proposed criteria to identify MCTAs: (1) ratio of females ages 15–44 to full time equivalent maternity care health professional; (2) percentage of females 15–44 with income at or below 200 percent of the federal poverty level (FPL); (3) travel time and distance to the nearest provider location with access to comprehensive maternity care services; (4) fertility rate; (5) SVI; and (6) four maternal health indicators (pre-pregnancy obesity, pre-pregnancy diabetes, pre-pregnancy hypertension, and prenatal care initiation in the first trimester). HRSA finalized the MCTA criteria on May 19, 2022 (87 FR 30501).

Change to the MCTA Scoring and Criteria

HRSA is changing the criteria and point scales for MCTAs by removing the SVI criterion, which had a point value of 0–2. Congress established MCTAs to ensure shortage areas identified as in need of maternity care health services had access to care. The SVI is used to help public health officials and local planners better prepare for and respond to emergency events, not to necessarily determine access to care. In recognition of the congressional intent, HRSA will reallocate one SVI point to the population to full time equivalent maternity care health professional ratio and the other SVI point to score for travel distance/time to nearest source of accessible care outside of the MCTA. Reallocating a point to the population-to-provider ratio strengthens the weight of areas with provider shortages, which is a key aspect of shortage designation, and reallocating a point to the travel time/distance strengthens the weight of geographic barriers, which directly impacts access to care especially in rural communities.

HRSA considered the impact of this change on existing MCTAs. As of September 2025, there were over 7,600 designated MCTAs—19 percent received 2 points towards the SVI criterion, 41 percent received 1 point, 33 percent received 0 points, and 6 percent did not have SVI criterion scores. Based on internal analysis of the proposed changes, by removing SVI and redistributing the points, MCTA scores will increase overall by 6.6 percent. In total, 200 of the more than 7,600 MCTAs may be subject to a decrease in MCTA score. These largely include MCTAs designated for Medicaid eligible population, low-income migrant seasonal worker population, low-income migrant farmworker population, and other population primary care HPSAs.

Primarily, HRSA uses MCTA's to distribute awards to eligible maternity care health professionals through the National Health Service Corps Loan Repayment Programs. HRSA awards these providers using either the primary care HPSA or the MCTA score of their site, whichever is higher. Although a decrease in MCTA score could potentially result in some maternity care professionals applying with lower MCTA scores, the impact may be mitigated since these providers can apply using either the primary care HPSA or the MCTA score of their site, whichever is higher.

The impact analysis is detailed in the chart below.

HPSA subtypes with a MCTA	N	Current average MCTA score	New average MCTA score	Change in average MCTA score	% Change in average MCTA score
HRSA-funded Health Center	1,359	18.1	19.3	+ 1.2	+ 6.6

HPSA subtypes with a MCTA	N	Current average MCTA score	New average MCTA score	Change in average MCTA score	% Change in average MCTA score
Health Center Look-Alike	168	15.9	17.3	+ 1.3	+ 8.4
HPSA geographic	919	12.8	14.1	+ 1.3	+ 10.5
HPSA geographic high needs	324	17.8	18.0	+ 0.2	+ 0.9
HPSA population	2,239	14.6	15.4	+ 0.8	+ 5.4
Indian, tribal, and urban Indian	919	15.3	16.2	+ 0.8	+ 5.5
Rural health clinic	1,749	16.0	17.3	+ 1.3	+ 8.2
Total	7,677	15.6	16.6	+ 1.0	+ 6.6

Note: Data is rounded to the first decimal point. Differences in the ''Change in Average MCTA Score'' and ''% Change in Average MCTA Score'' columns are due to rounding.

HRSA requests public comments on the agency's decision to eliminate the SVI criterion and to reallocate the corresponding two-point value by assigning one point to the population-to-full-time-equivalent maternity care health professional ratio and one point to the travel distance/time to the nearest source of accessible care outside of the MCTA.

Updated Approach for Determining MCTAs

An MCTA score will be generated for each primary care HPSA using the HPSA's service area. The following five scoring criteria will be included in a composite scale that will be used to identify MCTAs with the greatest shortage of maternity care health professionals: (1) ratio of females ages 15–44 to full time equivalent maternity care health professional ratio; (2) percentage of females 15–44 with income at or below 200 percent of the FPL; (3) travel time and distance to the nearest provider trained and licensed to provide the necessary care; (4) fertility rate; and (5) maternal health index which contains the following six indicators: pre-pregnancy obesity, pre-pregnancy diabetes, pre-pregnancy hypertension, prenatal care initiation in the first trimester, cigarette smoking, and the behavioral health factor. Each of these five criteria will be assigned a relative weight based on the significance of that criterion relative to all the others.

The weighted scores will be summed to develop a composite MCTA score ranging from zero to 25, with 25 indicating the greatest need for maternity care health professionals in the MCTA. Accordingly, the higher the composite score, the higher the degree of need for maternity care health services.

Score for Population-to-Full-Time-Equivalent Maternity Care Health Professional Ratio

The population-to-provider ratio will measure the number of women of childbearing age in the service area compared to the number of maternity care health professionals in the service area. Women of childbearing age will be defined as women between the ages of 15–44 years old and maternity care health professionals will be defined as Obstetricians-Gynecologists (OB–GYN) and Certified Nurse Midwives (CNMs). A population-to-provider ratio of 1,500:1 will be used as a minimum requirement for a population to be considered reasonably served by OB–GYNs and CNMs.

Population-to-provider ratio point values will be distributed as follows:

Population-to-provider ratio	Points
Ratio ≥6,000:1, or No CNMs or OB–GYNs and Population (Pop) ≥500	6
6,000:1 > Ratio ≥5,000:1, or No CNMs or OB–GYNs and Pop ≥400	5
5,000:1 > Ratio ≥3,000:1, or No CNMs or OB–GYNs and Pop ≥300	4
3,000:1 > Ratio ≥2,000:1, or No CNMs or OB–GYNs and Pop ≥200	3
2,000:1 > Ratio ≥1,500:1, or No CNMs or OB–GYNs and Pop ≥100	2
Ratio <1,500:1, or No CNMs or OB–GYNs and Pop <100	0

HRSA invites public comment on the revised methodology for the scoring distribution.

Score for Percentage of Population With Income at or Below 200 Percent of the Federal Poverty Level

The percentage of women of childbearing age living in the service area at or below 200 percent of the FPL will be used to score MCTAs, based on poverty data from the U.S. Census Bureau.

Population with income at or below 200 percent of the FPL point values will be distributed as follows:

Population with income at or below 200% FPL ratio	Points
Percentage of population with income at or below 200% FPL ≥50%	5
50% > Percentage of population with income at or below 200% FPL ≥45%	4
45% > Percentage of population with income at or below 200% FPL ≥40%	3
40% > Percentage of population with income at or below 200% FPL ≥35%	2
35% > Percentage of population with income at or below 200% FPL ≥30%	1
Percentage of population with income at or below 200% FPL <30%	0

This scoring methodology was finalized in the May 19, 2022, FRN (87 FR 30501), and HRSA is not proposing any changes.

Score for Travel Distance/Time to Nearest Source of Accessible Care Outside of the MCTA

The nearest source of accessible care is defined as the nearest provider trained and licensed to provide the necessary care, as determined by the Esri StreetMap Premium road network. Travel time and distance is defined as the average time to travel by road miles or the actual distance in road miles to the nearest source of care.

Travel time and distance to the nearest source of accessible care point values will be distributed as follows:

Travel time and distance	Points
Time ≥90 min or Distance ≥90 miles	6
90 min > Time ≥75 min or 90 miles >Distance ≥75 miles	5
75 min > Time ≥60 min or 75 miles >Distance ≥60 miles	4
60 min > Time ≥45 min or 60 miles >Distance ≥45 miles	3
45 min > Time ≥30 min or 45 miles >Distance ≥30 miles	2
Time < 30 min and Distance <30 miles	0

HRSA invites public comment on the revised methodology for scoring distribution.

Score for Fertility Rate

Fertility rate has been included to reflect the increased need for maternity care services among populations that experience a higher rate of births. Women of childbearing age will be derived from the American Community Survey and births will be derived from the National Vital Statistics System.

Fertility Rate point values will be distributed as follows:

Fertility rate	Points
Fertility Rate ≥90th Percentile	2
90th Percentile > Fertility Rate ≥50th Percentile	1
Fertility Rate <50th Percentile	0

This scoring methodology was finalized in the May 19, 2022, FRN (87 FR 30501), and HRSA is not proposing any changes.

Score for Maternal Health Indicators

Maternal health indicators are defined as factors associated with poor maternal health outcomes using data from the National Vital Statistics System and the Shortage Designation Management System. Scores will consider pre-pregnancy obesity, pre-pregnancy diabetes, pre-pregnancy hypertension, cigarette smoking before or during pregnancy, whether prenatal care began in the first trimester, and access to behavioral health services. Only women of childbearing age will be considered for these indicators. HRSA will use the National Vital Statistics System Natality file as the data source to determine the sub-score for pre-pregnancy obesity, pre-pregnancy diabetes, pre-pregnancy hypertension, cigarette smoking before or during pregnancy, and whether prenatal care began in the first trimester. The Shortage Designation Management System Mental HPSA file will be the data source to determine the sub-score for the behavioral health access factor.

Maternal Health Indicator criteria point values will be distributed as follows:

- *Pre-Pregnancy Obesity*

Pre-pregnancy obesity is defined as having a body mass index of 30 or higher. One point will be awarded if the prevalence of pre-pregnancy obesity in the area is greater than or equal to the 50th percentile among all counties in the United States. If the prevalence of pre-pregnancy obesity in the area is less than the 50th percentile among all counties, zero points will be awarded.

Pre-pregnancy obesity	Points
Prevalence of pre-pregnancy obesity ≥50th percentile	1
Prevalence of pre-pregnancy obesity <50th percentile	0

This scoring methodology was finalized in the May 19, 2022, FRN (87 FR 30501), and HRSA is not proposing any changes.

- *Pre-Pregnancy Diabetes*

One point will be awarded if the prevalence of pre-pregnancy diabetes in the area is greater than or equal to the 50th percentile among all counties in the United States. If the prevalence of pre-pregnancy diabetes in the area is less than the 50th percentile among all counties, zero points will be awarded.

Pre-pregnancy diabetes	Points
Prevalence of pre-pregnancy diabetes ≥50th percentile	1
Prevalence of pre-pregnancy diabetes <50th percentile	0

This scoring methodology was finalized in the May 19, 2022, FRN (87 FR 30501), and HRSA is not proposing any changes.

- *Pre-Pregnancy Hypertension*

One point will be awarded if the prevalence of pre-pregnancy hypertension among women in the area is greater than or equal to the 50th percentile among all counties in the United States. If the prevalence of pre-pregnancy hypertension among women in the area is less than the 50th percentile among all counties, zero points will be awarded.

Pre-pregnancy hypertension	Points
Prevalence of pre-pregnancy hypertension ≥50th percentile	1
Prevalence of pre-pregnancy hypertension <50th percentile	0

This scoring methodology was finalized in the May 19, 2022, FRN (87 FR 30501), and HRSA is not proposing any changes.

- *Cigarette Smoking*

One point will be awarded if the prevalence of cigarette smoking before or during pregnancy among women in the area is greater than or equal to the 50th percentile among all counties in the United States. Before pregnancy will be defined as smoking one or more cigarettes daily for the 3 months prior to pregnancy. During pregnancy will be defined as smoking one or more cigarettes during any trimester of pregnancy. If the prevalence of cigarette smoking before or during pregnancy among women in the area is less than the 50th percentile among all counties, zero points will be awarded.

Cigarette smoking	Points
Prevalence of Cigarette Smoking Before or During Pregnancy ≥50th percentile	1
Prevalence of Cigarette Smoking Before or During Pregnancy <50th percentile	0

This scoring methodology was finalized in the May 19, 2022, FRN (87 FR 30501), and HRSA is not proposing any changes.

- *Prenatal Care Initiation in the 1st Trimester*

One point will be awarded if the prevalence of women who did not initiate prenatal care in the first trimester of their pregnancy is greater than or equal to the 50th percentile among all counties in the United States. Zero points will be awarded if the prevalence of women who did not initiate prenatal care in the first trimester of their pregnancy is less than the 50th percentile among all counties.

Prenatal care in first trimester	Points
Prevalence of No Prenatal Care in First Trimester ≥50th percentile	1
Prevalence of No Prenatal Care in First Trimester <50th percentile	0

This scoring methodology was finalized in the May 19, 2022, FRN (87 FR 30501), and HRSA is not proposing any changes.

- *Behavioral Health Factor*

One point will be awarded if a portion or all of the MCTA service area is designated as a mental health HPSA meeting the following population-to-provider median ratio thresholds based on its mental health provider type. Zero points will be awarded if a portion or all of the MCTA service area is not designated as a mental health HPSA or if the mental health designation does not meet the population to provider ratio threshold.

Behavioral health factor	Points
Portion or all of MCTA service area is designated as a mental health HPSA meeting the following population-to-provider ratio thresholds based on its mental health provider type • *Psychiatrist ONLY:* Psychiatrist population-to-provider ratio ≥45,000:1 *Core Mental Health:* Core mental health population-to-provider ratio ≥18,000:1 • *Psychiatrist and Core Mental Health:* Psychiatrist population-to-provider ratio ≥35,000:1 and core mental health population-to-provider ratio ≥6,000:1 • *No Psychiatrists or Core Mental Health Providers:* ≥7,500: 0	1
Portion or all of MCTA service area is designated as a mental health HPSA and does not meet the population-to-provider ratio thresholds above, OR is not designated as a mental health HPSA	0

This scoring methodology was finalized in the May 19, 2022, FRN (87 FR 30501), and HRSA is not proposing any changes.

Paperwork Reduction Act

The criteria used to identify MCTAs under section 332(k) of the PHS Act, as described in this announcement, will not involve data collection activities that fall under the purview of the Paperwork Reduction Act of 1995. If the methods for determining MCTAs fall under the purview of the Paperwork Reduction Act, HRSA will seek the Office of Management and Budget

clearance for proposed data collection activities.

Ann M. Sheehy,

Acting Principal Deputy Administrator.

[FR Doc. 2026–02130 Filed 2–2–26; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Center for Scientific Review; Notice of Closed Meetings

Pursuant to section 1009 of the Federal Advisory Committee Act, as amended, notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: Center for Scientific Review Special Emphasis Panel; Topics in Health Services.

Date: February 18, 2026.

Time: 2:00 p.m. to 6:00 p.m.

Agenda: To review and evaluate grant applications.

Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.

Meeting Format: Virtual Meeting.

Contact Person: Shiv A. Prasad, Ph.D., Scientific Review Officer, Scientific Review Program, Division of Extramural Activities, National Institutes of Health, NIAID, Rockville, MD 20892, *shiv.prasad@nih.gov*.

Name of Committee: Center for Scientific Review Special Emphasis Panel; Alcohol and Neurotoxicology.

Date: February 24, 2026.

Time: 12:00 p.m. to 3:00 p.m.

Agenda: To review and evaluate grant applications.

Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.

Meeting Format: Virtual Meeting.

Contact Person: Eileen Marie Moore, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892, (301) 594–8928, *eileen.moore@nih.gov*.

Name of Committee: Center for Scientific Review, Special Emphasis Panel; PAR Panel: Review of Support for Research Excellence, (SuRE) (R16) and SuRE-First Independent Research (SuRE-First) (R16) applications.

Date: March 4, 2026.

Time: 10:00 a.m. to 3:00 p.m.

Agenda: To review and evaluate grant applications.

Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.

Meeting Format: Virtual Meeting.

Contact Person: Shinako Takada, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892, 301–827–5997, *shinako.takada@nih.gov*.

Name of Committee: Risk, Prevention and Health Behavior Integrated Review Group; Interdisciplinary Clinical Care in Specialty Care Settings Study Section.

Date: March 5–6, 2026.

Time: 9:30 a.m. to 5:30 p.m.

Agenda: To review and evaluate grant applications.

Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.

Meeting Format: Virtual Meeting.

Contact Person: Abu Saleh Mohammad Abdullah, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892, (301) 827–4043, *abuabdullah.abdullah@nih.gov*.

Name of Committee: Biological Chemistry and Macromolecular Biophysics Integrated Review Group; Maximizing Investigators' Research Award—E Study Section.

Date: March 10–11, 2026.

Time: 10:00 a.m. to 5:00 p.m.

Agenda: To review and evaluate grant applications.

Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.

Meeting Format: Virtual Meeting.

Contact Person: Vandana Kumari, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892, (301) 496–3290, *vandana.kumari@nih.gov*.

Name of Committee: Center for Scientific Review Special Emphasis Panel; Fellowships: Aging, Neurodegeneration, and Neurotoxicology.

Date: March 11–12, 2026.

Time: 9:30 a.m. to 6:30 p.m.

Agenda: To review and evaluate grant applications.

Address: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892.

Meeting Format: Virtual Meeting.

Contact Person: Rahat Rani Khan, Ph.D., Scientific Review Officer, Office of Grants Management and Scientific Review, National Center for Advancing, Translational Sciences, 6701 Democracy Blvd., Rm. 1078, Bethesda, MD 20892, (301) 594–7319, *Khanr2@mail.nih.gov*.

(Catalogue of Federal Domestic Assistance Program Nos. 93.306, Comparative Medicine; 93.333, Clinical Research, 93.306, 93.333, 93.337, 93.393–93.396, 93.837–93.844, 93.846–93.878, 93.892, 93.893, National Institutes of Health, HHS)

Dated: January 29, 2026.

Bruce A. George,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2026–02199 Filed 2–2–26; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Office of the Director, Notice of Charter Renewal

In accordance with Title 41 of the U.S. Code of Federal Regulations, Section 102–3.65(a), notice is hereby given that the charter for the National Center for Advancing Translational Sciences Council (NCATSC or Council) is being renewed for an additional two-year period on February 7, 2026. It is determined that the Council is in the public interest in connection with the performance of duties imposed on the National Institutes of Health by law, and that these duties can best be performed through the advice and counsel of this group.

The Public Interest Determination follows:

Annual budget and expected costs. The estimated annual costs to operate the Council include the following:

i. Federal personnel (based on full-time equivalent (FTE) usage basis) and other Federal internal costs. The estimated annual person years of staff support required is 1.0, at an estimated annual cost of $255,456. The estimate for other Federal internal costs is $4,242.

ii. Proposed payments to members and number of members. The estimated payments for three non-Federal members is $2,400; the estimated prorated salary of three Federal members is $2,244.

iii. Reimbursable costs. The estimate for reimbursable costs, including members' travel expenses, is $18,221.

Total dollar value of grants expected to be recommended during the fiscal year.

In fiscal year 2025, the Council reviewed 3,525 grant applications in the amount of $6,798,714,682. In addition, the Council reviewed 26 contract proposals in the amount of $94,834,948.

Criteria for selecting members. The Council will consist of not more than 18 members appointed by the Secretary (appointed members) and the following nonvoting ex officio members: the Secretary; the Director, NIH; the Director, NCATS; a representative from the Centers for Medicare and Medicaid