- Patient Engagement Advisory Committee
- Pediatrics Advisory Committee
- Peripheral and Central Nervous System Advisory Committee
- Pharmacy Compounding Advisory Committee
- Pharmacy Compounding Drugs AC
- Psychopharmacologic Drugs Advisory Committee
- Pulmonary-Allergy Drugs Advisory Committee
- Risk Communication Advisory Committee (Administratively Inactive)
- Science Board to the Food and Drug Administration
  - Technical and Electronic Product Safety Standards AC
- Technical and Electronic Products Safety Standards Advisory Committee
- Tobacco Products Advisory Committee

5. Justification that the information or advice provided by the Federal advisory committee or subcommittee is not available from another Federal advisory committee, another Federal Government source, or any other more cost-effective and less burdensome source.

The Blood Products Advisory Committee (BPAC) was established to review and evaluate available data concerning the safety, effectiveness, and appropriate use of blood, products derived from blood and serum or biotechnology which are intended for use in the diagnosis, prevention, or treatment of human diseases, and make appropriate recommendations to the Commissioner of Food and Drugs. The Committee also advises the Commissioner of Food and Drugs of its findings regarding donor screening and testing, product labeling, clinical and laboratory studies involving such products, and the affirmation or revocation of biological product licenses.

No other FDA advisory committee is specifically focused on whole blood, blood components, plasma-derived products, and related biologics. These products raise unique scientific, technical, and public health issues involving donor eligibility and screening, transfusion-transmitted infectious disease risk, manufacturing controls, and clinical use that require the specialized expertise BPAC provides. At times, the Committee also functions as a medical device panel to address related device issues within its area of expertise.

6. If the consultation is a committee renewal, a summary of the previous accomplishments of the committee and the reasons it needs to continue.

Summary of Previous Accomplishments:

On May 9, 2024, the Committee met in open session to discuss strategies to reduce the risk of transfusion-transmitted malaria by testing blood donations from donors at risk of malaria exposure.

Agency Action: In January 2025, FDA issued a draft guidance for industry proposing a selective testing strategy to reduce the risk of transfusion-transmitted malaria (TTM). The draft guidance outlines testing strategies for blood donations that considers:

Testing donations from donors with a history of malaria.

- One-time testing of donors who resided in a malaria-endemic country.
- Testing donors who traveled to a malaria-endemic region in the past 12 months.
- Testing donations collected in U.S. regions identified by FDA as having local malaria transmission.

The guidance document for blood establishments is now in the public comment phase. The guidance reflects the scientific and operational considerations discussed at the committee meeting and is intended to help blood establishments reduce the risk of malaria transmission through tailored testing.

The committee is critical for the review and evaluation of data on the safety and effectiveness, and appropriate use of blood products intended for use in the diagnosis, prevention, or treatment of human diseases.

7. Explanation of why the committee/subcommittee is essential to the conduct of agency business.

Reasons for Continuation:

The Committee plays a critical role in enabling FDA to meet the requirements of section 505(n)(1) and (s)(1) of the Federal Food, Drug, and Cosmetic Act by providing expert scientific advice and recommendations. The BPAC is the only FDA advisory committee that provides specialized expertise in whole blood, blood components, plasma-derived products, and related biologics. These products raise unique scientific, technical, and public health issues involving donor eligibility and screening, transfusion-transmitted infectious disease risk, manufacturing controls, and clinical use.

In conclusion, this public interest determination documents that renewing the committee is in the public interest, essential to the conduct of agency business, and that the information to be obtained is not already available through another advisory committee or source within the Federal Government.

This notice is issued under the Federal Advisory Committee Act as amended (5 U.S.C. 1001 *et seq.*). For general information related to FDA advisory committees, please visit us at *http://www.fda.gov/AdvisoryCommittees/default.htm.*

Grace R. Graham,

Deputy Commissioner for Policy, Legislation, and International Affairs.

[FR Doc. 2026–09108 Filed 5–6–26; 8:45 am]

BILLING CODE 4164–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Notice of Criteria for Determining Maternity Care Health Professional Target Areas

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

ACTION: Notice of final response.

SUMMARY: HRSA published a 30-day public notice in the **Federal Register** on February 3, 2026, (**Federal Register** volume 91, number 22, pp. 4927–4931) soliciting feedback on updated criteria for determining maternity care target areas (MCTA). In particular, HRSA requested feedback on proposed changes to the criteria and point scales for MCTAs by removing the criterion for Social Vulnerability Index (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 time/distance to the nearest source of accessible care outside of the MCTA. This notice responds to the comments received during this 30-day public notice period and sets forth updated MCTA scoring criteria.

DATES: The proposed update to Maternity Care Health Professional Target Areas will be implemented starting August 15, 2026.

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

SUPPLEMENTARY INFORMATION:

Background

Section 332 of the Public Health Service (PHS) Act (42 U.S.C. 254e) provides that the Secretary of HHS designate Health Professional Shortage

Areas (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, **Federal Register** notice (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/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).

On February 3, 2026, through an FRN, HRSA announced a 30-day public comment period to solicit input on updated criteria for determining MCTAs (91 FR 4927). In particular, HRSA requested feedback on proposed changes to 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 for travel time/distance to the nearest source of accessible care outside of the MCTA. HRSA carefully evaluated and analyzed the comments received and used them to guide the final decision on how to update criteria used in MCTAs.

Comments on the Proposed Criteria for Identifying Maternity Care Target Areas

HRSA received 14 responses to the request for comments. The following is a breakdown of those 14 responses. Of those 14 responses, six comments were from public interest/advocacy organizations, three comments were from state government agencies, two comments were from academic institutions/researchers, two comments were from health care providers/institutions, and one comment was from an individual/private citizen. Of the 14 comments received, one comment fell outside of the scope of this request. The remaining 13 comments and HRSA's responses are summarized below.

Summary of Comments

Social Vulnerability Index

HRSA received three comments that supported the February 3, 2026, FRN proposal to remove the SVI and reallocate points to population-to-full-time-equivalent maternity care health professional ratio and travel time/distance to the nearest source of accessible care outside of the MCTA. Ten comments did not support the proposal detailed in the February 3, 2026, FRN.

The three commenters who supported the removal of SVI as a MCTA criteria all mentioned that reallocation of the points to population-to-full-time-equivalent maternity care health professional ratio and travel time/distance to the nearest source of accessible care outside of the MCTA would better measure access to maternity care providers, and discussed that this will advantage rural communities in regards to MCTA scoring and ultimately recruiting and retaining maternity care providers to serve in those areas. Two specifically mentioned transportation issues and road terrain conditions as additional barriers to health care access facing rural communities. One commenter specifically stated the removal of SVI and reallocation of points to population-to-full-time-equivalent maternity care health professional ratio and travel time/distance to the nearest source of accessible care outside of the MCTA was equitable and will assist in National Health Service Corps Loan Repayment Program recruitment.

The remaining 10 relevant comments were opposed to the HRSA proposal to remove SVI. Nine commenters believe the system should continue to look at multiple factors, including clinical and social challenges, to better understand where care is needed. Five of the 10 commenters recommended retaining SVI or replacing it with a similar metric, however, not all commenters had suggestions on what metric could replace SVI. Two commenters recommended using the Social Deprivation Index as a direct replacement, and one specifically mentioned using the Centers for Disease Control and Prevention National Vital Statistics System. Five commenters requested HRSA monitor how scoring changes affect provider placement and recruitment. Four commenters stated that removal of SVI may adversely affect rural areas via reduced workforce placement, and four also recommended that HRSA should conduct an impact analysis prior to implementation of any policy change.

Response

HRSA thanks all commenters for their input on the proposed change to MCTA criteria and recognizes that there are many factors that should be considered when making changes to the way shortage areas are scored. Many commenters indicated that SVI should be maintained; however, HRSA's position is that SVI is used to help public health officials and local planners better prepare for and respond to emergency events, not necessarily to determine access to care. Congress established MCTAs through the Improving Access to Maternity Care Act of 2018 (Pub. L. 115–320) to ensure that shortage areas in need of maternity care health services have access to maternity care. The proposed reallocation of points from SVI to the nearest source of accessible care will work to better quantify the distances some communities must travel to seek maternity care, and reallocation of points from SVI to the population-to-full-time-equivalent maternity care health professional ratio will work to better quantify the availability of maternity care providers versus the population in the area under consideration for designation. These two values closely align with access to maternity care, and therefore, the congressional intent in establishing MCTAs. HRSA understands the sensitivity around workforce recruitment and retention, especially in rural areas. HRSA may continue to evaluate the components of these two values, including the definition of maternity care health professional. HRSA conducted an impact analysis on currently designated MCTAs, including those in rural areas, in the February 3, 2026, FRN, showing that the anticipated effect of these changes will be an overall increase of 6.6 percent to MCTA scores.

Conclusion

HRSA appreciates the comments and recommendations received from the public. HRSA considers many of the comments received to be useful and informative to future discussions on how to strengthen MTCAs moving

forward. After consideration of the public comments received, HRSA is implementing the final MCTA criteria as proposed. Details on the final approach are below. If you have any questions, please contact Matthew Patterson at *sdb@hrsa.gov.*

Final Approach for Determining Maternity Care Health Professional Target Areas

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; (2) percentage of females 15–44 with income at or below 200 percent of the FPL; (3) travel time/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 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 Obstetricians-Gynecologists 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

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 United States 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

Score for Travel Time/Distance to the 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/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/distance to the nearest source of accessible care point values will be distributed as follows:

Travel time/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

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 (*i.e.,* ages 15–44) 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

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 (*i.e.,* aged 15–44) 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

- *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

- *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

- *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. Smoking before pregnancy will be defined as smoking one or more cigarettes daily for the 3 months prior to pregnancy. Smoking 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

• *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

• *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 ONLY:* 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

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.

Thomas J. Engels,

Administrator.

[FR Doc. 2026–09056 Filed 5–6–26; 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; Special Topics in Cancer Biology.

Date: June 1, 2026.

Time: 3:00 p.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: Wing-hang Tong, Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892, (302) 402–0360, *tongw@mail.nih.gov*.

Name of Committee: Risk, Prevention and Health Behavior Integrated Review Group; Lifestyle Change and Behavioral Health Study Section.

Date: June 4–5, 2026.

Time: 10:00 a.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: Pamela Jeter, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 10J08, Bethesda, MD 20892, (301) 827–6401, *pamela.jeter@nih.gov*.

Name of Committee: Integrative, Functional and Cognitive Neuroscience Integrated Review Group; Behavioral Neuroendocrinology, Neuroimmunology, Rhythms, and Sleep Study Section.

Date: June 8–9, 2026.

Time: 9:00 a.m. to 7:00 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: Simon Peter Peron, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Dr., Room 1009K, Bethesda, MD 20892, (301) 594–6236, *peronsp@csr.nih.gov*.

Name of Committee: Aging and Neurodegeneration Integrated Review Group; Aging Systems and Geriatrics Study Section.

Date: June 9, 2026.

Time: 9:00 a.m. to 9:00 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: Roger Alan Bannister, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 1010–D, Bethesda, MD 20892, (301) 435–1042, *bannisterra@csr.nih.gov*.

Name of Committee: Biological Chemistry and Macromolecular Biophysics Integrated Review Group; Macromolecular Structure and Function B Study Section.

Date: June 9–10, 2026.

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