2020, has changed its format and time. The meeting will now be a 2-day webinar and conference call only on Tuesday, December 8, 2020, from 10:00 a.m.–5:00 p.m. Eastern Time (ET) and Wednesday, December 9, 2020, from 10:00 a.m.–2:00 p.m. ET. The webinar link, conference dial in number, meeting materials, and updates will be available on the COGME website: *https://www.hrsa.gov/advisory-committees/graduate-medical-edu/meetings/index.html.*

FOR FURTHER INFORMATION CONTACT: Shane Rogers, Designated Federal Official, Division of Medicine and Dentistry, Bureau of Health Workforce, HRSA, 5600 Fishers Lane, 15N142, Rockville, Maryland 20857; 301–443–5260; or *BHWCOGME@hrsa.gov.*

Correction: Meeting will be a 2-day webinar and conference call only rather than in-person as previously announced.

Maria G. Button,

Director, Executive Secretariat.

[FR Doc. 2020–20940 Filed 9–22–20; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Revised Geographic Eligibility for Federal Office of Rural Health Policy Grants

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

ACTION: Request for public comment.

SUMMARY: HRSA's Federal Office of Rural Health Policy (FORHP) has sought to identify clear, consistent, and data-driven methods of defining rural areas in the United States. FORHP uses the Office of Management and Budget (OMB)'s list of counties designated as part of a Metropolitan Statistical Area (MSA) as the basis for determining eligibility to apply for or receive services funded by its rural health grant programs. FORHP designates all counties that are not part of a MSA as ''rural'' and eligible for rural health grant funding or services. In addition, FORHP designates census tracts within MSAs as rural for grant purposes using Rural-Urban Commuting Area (RUCA) codes. FORHP is proposing modifications to how it designates areas to be eligible for its rural health grant programs so that community organizations serving rural populations within MSAs will be able to apply for resources and allow more of the rural populations within MSAs to access services provided using grant funds. This notice seeks comments on the proposed methodology for designating areas eligible for rural health grant programs.

DATES: Submit written comments no later than October 23, 2020.

ADDRESSES: Written comments should be submitted to *ruralpolicy@hrsa.gov.*

FOR FURTHER INFORMATION CONTACT: Steve Hirsch, Public Health Analyst FORHP, HRSA, 5600 Fishers Lane, Rockville, MD 20857, Phone number: (301) 443–0835 or Email: *ruralpolicy@hrsa.gov.*

SUPPLEMENTARY INFORMATION: FORHP was authorized by Congress in the Omnibus Budget Reconciliation Act of 1987, Public Law 100–203, codified at 42 U.S.C. 912, and located in HRSA. Congress charged FORHP with informing and advising the Department of Health and Human Services on matters affecting rural hospitals and health care and coordinating activities within the Department that relate to rural health care. Since the 1990s, FORHP has also issued grants for programs of innovative models of health care delivery in rural areas. Historically, applicant organizations for these grants, authorized under Section 330A of the Public Health Service Act, were required to be located in rural areas. However, when the programs were recently reauthorized under Section 4214 of the Coronavirus Aid, Relief, and Economic Security Act the requirement was amended to allow organizations to apply that are located in urban areas but serve rural areas.

Historically, there have been two principal definitions of ''rural'' that were in use by the Federal Government: the Census Bureau definition (*https://www.census.gov/programs-surveys/geography/guidance/geo-areas/urban-rural.html*) and the OMB definition (*https://www.census.gov/programs-surveys/metro-micro.html*). Neither definition defined ''rural'' directly, but rather defined ''urban'' areas and then designated locations that do not meet the ''urban'' definition as ''rural.''

In the early 1990s, the Census Bureau defined ''rural'' as all areas that were not part of an urbanized area (UA) or were not part of an incorporated area of at least 2,500 persons. UAs were defined as densely settled areas with a total population of at least 50,000 people. The building block of UAs is the census block, a sub-unit of census tracts. The Census Bureau introduced the urban cluster (UC) concept for the 2000 Census. UCs are defined based on the same criteria as UAs, but represent areas containing at least 2,500 but fewer than 50,000 people. Both UAs and UCs use 500 persons per square mile as their minimum density criterion.

The other major federal definition was based on the OMB's list of counties that are designated as part of a MSA. All counties that were not designated as a part of a MSA were considered ''rural'' or, more accurately, non-metropolitan. MSAs, in 1990, had to include ''a city of 50,000 or more population,'' or ''a Census Bureau defined urbanized area of at least 50,000 population, provided that the component county/counties of the MSA have a total population of at least 100,000.'' At that time, around three quarters of all counties in the United States were non-metropolitan and not classified as parts of MSAs.

After the 2000 Census, OMB also began to classify counties using a smaller urban core. The concept of a Micropolitan statistical area closely parallels that of the MSA, but a Micropolitan statistical area is based on an urban core with a population of 10,000 through 49,999 and Micropolitan counties are still considered non-metropolitan.

As currently classified, OMB builds both MSAs and Micropolitan Statistical Areas around a central county, or counties, which contains an urban core. Surrounding counties can be designated as part of the Core Based Statistical Area (CBSA) based on the presence of core population and/or the commuting patterns of the working population. A county may be included in only one CBSA.

A county qualifies as a central county of a CBSA if it meets the following requirements:

(a) Has at least 50 percent of the population in urban areas of at least 10,000 population; or

(b) Has within the boundaries a population of at least 5,000 located in a single urban area of at least 10,000 population.

Since urban areas are not defined by administrative boundaries, such as city limits or county borders, they can extend into one or more counties as long as the population density criterion (a minimum of 500 people per square mile) is met.

A county qualifies as an outlying county of a CBSA if it meets the following commuting requirements:

(a) At least 25 percent of the workers living in the county work in the central county or counties of the CBSA; or

(b) At least 25 percent of the employment in the county is accounted

for by workers who reside in the central county or counties of the CBSA.

Outlying counties are not required to include any UA or UC population. In some cases, counties may be considered outlying because of reverse commuting into the county from other counties in the MSA.

Because Micropolitan counties are not included in MSAs, they are included in the set of non-metropolitan counties along with counties that are not part of any CBSA.

There are measurement challenges with both the Census and OMB definitions. Some policy experts note that the Census definition classifies quite a bit of suburban area as rural. The OMB definition includes rural areas in MSA counties including, for example, the Grand Canyon which is located in a MSA county. Consequently, one could argue that the Census Bureau standard includes an over count of the rural population whereas the OMB standard represents an undercount. To address these concerns and find a middle ground between the two definitions, FORHP funded the development of Rural-Urban Commuting Area Codes (RUCAs) (*https://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes/*) in partnership with the Economic Research Service (ERS) of the Department of Agriculture. FORHP believes RUCAs allow more accurate targeting of resources intended for the rural population. Both FORHP and the Centers for Medicare & Medicaid Services (CMS) have used RUCAs to determine programmatic eligibility for rural areas inside of MSAs, identified as rural census tracts within these MSA counties.

RUCA codes classify census tracts using measures of population density, urbanization, and daily commuting. RUCA codes are based on the same theoretical concepts used by the OMB to define county-level Metropolitan and Micropolitan areas. By using the smaller census tract unit instead of the county, RUCAs permit a finer delineation of ''rural'' and ''urban'' areas to reflect the experience of residents. Using data from the Census Bureau, every census tract in the United States is assigned a RUCA code. Currently, there are ten primary RUCA codes with 21 secondary codes (see Table 1).

TABLE 1—PRIMARY RUCA CODES, 2010

Code classification	Description
1	Metropolitan area core: Primary flow within an urbanized area (UA).
2	Metropolitan area high commuting: Primary flow 30% or more to a UA.
3	Metropolitan area low commuting: Primary flow 10% to 30% to a UA.
4	Micropolitan area core: Primary flow within an urban cluster of 10,000 to 49,999 (large UC).
5	Micropolitan high commuting: Primary flow 30% or more to a large UC.
6	Micropolitan low commuting: Primary flow 10% to 30% to a large UC.
7	Small town core: Primary flow within an urban cluster of 2,500 to 9,999 (small UC).
8	Small town high commuting: Primary flow 30% or more to a small UC.
9	Small town low commuting: Primary flow 10% to 30% to a small UC.
10	Rural areas: Primary flow to a tract outside a UA or UC.
99	Not coded: Census tract has zero population and no rural-urban identifier information.

Current FORHP Definition of Rural

In addition to all areas of non-metro counties, specific census tracts in Metropolitan counties are considered rural and eligible for grant funding or to receive services under FORHP grant funding. These include census tracts inside MSAs with RUCA codes 4–10 and 132 large area census tracts with RUCA codes 2 and 3 that FORHP has designated as rural. The 132 MSA tracts with RUCA codes 2–3 are at least 400 square miles in area with a population density of no more than 35 people per square mile.

Following the 2010 Census, the FORHP definition included approximately 57 million people, or about 18 percent of the population and 84 percent of the area of the United States. More information about the current FORHP definition of rural is located on the HRSA website (*https://www.hrsa.gov/rural-health/about-us/definition/index.html*) and information on whether counties or individual addresses qualify as rural can be identified in a search tool at the HRSA Data Warehouse (*https://data.hrsa.gov/tools/rural-health*).

Why We Propose Modifying FORHP's Rural Definition

The goal of FORHP is to increase access to care for underserved populations and build health care capacity in rural areas. To support that goal, we must ensure that there are clear, consistent, and data-driven methods of defining rural areas in the United States. Further, FORHP must ensure that the rural definition used to determine eligibility to apply for or receive services under FORHP's rural health grant programs accurately identifies rural communities. FORHP believes that the combination of non-metropolitan counties with the set of ''rural'' census tracts within MSAs has allowed FORHP to correctly classify much of the rural population in the country as eligible for rural health grants. However, since the 2010 Census we have received feedback from rural stakeholders expressing concern that some areas with rural character in MSAs are not being identified through the current methodology.

FORHP believes that the increasing concentration of job growth in MSAs and changes in how OMB designates outlying counties as part of MSAs have led to growth in the number of MSA counties that either have no population in either UCs or UAs or that have no population in a UA but do have UC population.

Both the designation of outlying counties in MSAs and the classification of RUCA codes in census tracts are dependent on commuting data and therefore the location of jobs. During the recession, employment losses in non-metropolitan counties began earlier and were deeper than losses in MSA counties. While job growth in MSAs and non-metropolitan counties were initially similar, in the long term employment in non-metropolitan areas remained below the level where it had been before the recession. According to ERS, ''Between 2010 and 2018, non-metropolitan employment grew at an average annual rate of 0.4 percent, compared to 1.5 percent per year in MSAs. By the second quarter of 2019, non-metropolitan employment remained more than 1 percent below the pre-recession level, while MSA employment exceeded the pre-recession level by more than 9 percent.'' In the years since the recession, job growth has been concentrated not just in MSAs, but in

the largest MSAs. According to a McKinsey Global Institute report from 2019, ''Just 25 cities (megacities and high-growth hubs, plus their urban peripheries) have accounted for more than two-thirds of job growth in the last decade . . . By contrast, trailing cities have had virtually no job growth for a decade—and the counties of Americana and distressed Americana have 360,000 fewer jobs in 2017 than they did in 2007.''

Starting with the 2000 Census, OMB eliminated the use of measures of settlement structure, such as population density and percent of population that is urban, as criteria for inclusion of outlying counties as part of an MSA. Instead, commuting became the sole deciding factor as long as

(a) at least 25 percent of the employed residents of the county work in the CBSA's central county or counties, or

(b) at least 25 percent of the jobs in the potential outlying county are accounted for by workers who reside in the CBSA's central county or counties.

After the 2000 Census, the number of outlying MSA counties with no urban population quadrupled from 24 in the 1993 OMB listing to 96 in the 2003 listing. After the 2010 Census, there were 97 MSA outlying counties with no urban population.

For counties with no urban population, some stakeholders have raised the concern that commuting patterns may not reflect suburbs and urban amenities spreading outward from an urban area into rural areas. Instead, a lack of job opportunities in the rural area is causing workers to commute into an urban area from a rural area. This increased commuting does not represent an increase in access to services for rural residents but can instead represent a local economic decline. As OMB states, ''For instance, programs that seek to strengthen rural economies by focusing solely on counties located outside metropolitan statistical areas could ignore a predominantly rural county that is included in a metropolitan statistical area because a high percentage of the county's residents commute to urban centers for work.''

Comparing Rural and Urban Counties

The data presented in Table 2 shows that outlying MSA counties which have no UA population are more similar to non-metropolitan counties than they are to central MSA counties. Table 2 displays characteristics of the mean population and land area for counties in the United States (excluding Alaska and Puerto Rico). The average MSA county has a large population, over 200,000 people, most of whom live in UAs (84 percent of the total) with another 4 percent in UCs. Only 12 percent of the average MSA county population is rural as defined by the Census Bureau. The average non-metropolitan county has only approximately 10 percent of the population of the average MSA county, with the majority of people (59 percent) living in Census defined rural areas.

When looking at central MSA counties compared to the outlying MSA counties, there are large differences between the two. The average central county's population is seven times larger than the average outlying county and almost half the outlying county's population is in Census defined rural areas compared to just under 10 percent of the average central county's population. Even more striking, comparing outlying MSA counties that have no UA population at all or that have no UA or UC population at all shows that these MSA counties without densely settled areas are much more similar to non-metropolitan counties than they are to central MSA counties.

In population totals, density, and the proportion of the population living outside Census defined UAs and UCs, the outlying MSA counties with no UA population most closely resemble Micropolitan counties. The outlying counties with no UA or UC population at all, which do not include any town of even 2,500 residents, resemble the non-CBSA counties.

TABLE 2—COUNTIES BY URBANIZATION AND DENSITY [1]

County classification	County pop.	Number of counties	Urban pop.	Urban (%)	UA pop.	% UA	UC pop.	% UC	Census rural pop.	% Rural	Pop. density per sq. mile	Land area in sq. miles
Metro	**224,809**	**1,166**	**197,393**	**88**	**188,132**	**84**	**9,262**	**4**	**27,416**	**12**	**276**	**813**
Metro Central	331,742	728	300,832	91	291,341	88	9,491	3	30,910	9	367	929
Metro Outlying	47,077	438	25,468	54	16,588	35	8,880	19	21,609	46	76	621
Metro Outlying w/No Urbanized Area [2]	***23,185***	***286***	***6,969***	***46***	***0***	***0***	***6,969***	***46***	***16,216***	***54***	***36***	***650***
Metro Outlying w/No Urban Population	***10,880***	***97***	***0***	***0***	***0***	***0***	***0***	***0***	***10,880***	***100***	***17***	***624***
Nonmetro	**23,341**	**1,946**	**9,468**	**40.60**	**125**	**0.50**	**9,344**	**40.00**	**13,872**	**59**	**23**	**1,034**
Micropolitan	42,004	654	21,576	51.40	350	0.80	21,226	50.50	20,428	48	39	1,074
Neither	14,255	1,292	3,486	24.50	12	0.10	3,474	24.40	10,769	75.50	14	1,013

Proposed Methodology To Determine Eligibility for Rural Health Grants

FORHP proposes to modify its existing rural definition by adding outlying MSA counties with no UA population to its list of areas eligible to apply for or receive services funded by FORHP's rural health grants. Compared to the current definition, this modification would have the following impacts. The current set of eligible non-metropolitan counties and rural census tracts within metropolitan counties would still be eligible. Additional counties would gain eligibility for rural health grants.

Using OMB's April 2018 update of MSAs and the 2010 Census data on urban population by counties, there are 287 counties (286 reflected in Table 2 plus one county equivalent in Alaska) that are outlying counties in an MSA that have no UA population. Out of those counties, 97 had no UA or UC population at all. Many of the 287 counties (201) are already partially or fully eligible for Rural Health grants because they contain eligible census tracts. However, 86 previously ineligible counties would become fully eligible. These 86 counties include 42 outlying MSA counties that have no UA or UC population at all. Lists of the counties that will be designated as rural if this proposal is adopted are available at *https://www.hrsa.gov/rural-health/about-us/definition/datafiles.html.*

It is also important to note that there is no single definitive source for assigning rurality to a particular geographic area [3] [4] Rural definitions are

[1] This table excludes counties in Alaska and Puerto Rico. Alaskan boroughs (county equivalents) are much larger than counties in other states. One Alaskan borough would qualify as Metro Outlying with No Urbanized Area.

[2] The two bolded, italicized rows represent the counties that would become eligible in their entirety for Rural Health grants after this notice. The number of counties with no UA includes the counties that have no Urban population.

[3] U.S. Census Bureau. 2019. Understanding and Using American Community Survey Data: What Users of Data for Rural Areas Need to Know. Available from: *https://www.census.gov/programs-surveys/acs/guidance/handbooks/rural.html.* Accessed December 20, 2019.

[4] U.S. Department of Agriculture, Economic Research Service. What is Rural? Available from:

highly context dependent and while definitions of rurality may take into account a range of characteristics (*e.g.,* population density, commuting distance, land use, etc.), rural definitions do not reflect any single, inherent geographic attribute.[5] FORHP's proposal to modify our eligibility criteria to apply for or receive services funded by FORHP's rural health grants reflects our efforts to be responsive to stakeholder feedback and best target our programs towards the intended communities. This does not eliminate the fact that other rural definitions may be set by statute or regulation or the fact that other programs established outside of FORHP's 330A authorization may need to use a different definition of rural to meet program goals. No single definition of rural is perfect or advisable given the geographic variation that exists nationally and the varying needs of rural programs.

Request for Public Comment

FORHP is proposing to modify the rural definition it uses to determine geographic areas eligible to apply for or receive services funded by FORHP's rural health grants and requests comments from the public on the proposed methodology described above.

This request for comments is issued solely for information and planning purposes; it does not constitute a Request for Proposal, applications, proposal abstracts, or quotations. This request does not commit the Government to contract for any supplies or services or make a grant or cooperative agreement award or take any other official action. Further, HRSA is not seeking proposals through this Request for Information and will not accept unsolicited proposals.

HRSA is not obligated to summarize or publish a response to feedback received, or to respond to questions about the policy issues raised in this request. Responders are advised that the United States Government will not pay for any information or administrative costs incurred in response to this request; all costs associated with responding to this request will be solely at the interested party's expense.

List of References

Urban Area Criteria for Census 2000. **Federal Register**, Vol. 67, No. 51. March 15, 2002 *https://www.federalregister.gov/documents/2002/03/15/02-6186/urban-area-criteria-for-census-2000.*

Rural Employment Trends in Recession and Recovery. Economic Research Report Number 172, August 2014. *https://www.ers.usda.gov/webdocs/publications/45258/48731_err172.pdf?v=0.*

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The future of work in America: People and places, today and tomorrow. McKinsey Global Institute. July 2019. *https://www.mckinsey.com/featured-insights/future-of-work/the-future-of-work-in-america-people-and-places-today-and-tomorrow#.*

Standards for Defining Metropolitan and Micropolitan Statistical Areas. **Federal Register**/Vol. 65, No. 249/December 27, 2000. 82228–82238 *https://www.bls.gov/lau/frn249.pdf.*

2010 Standards for Delineating Metropolitan and Micropolitan Statistical Areas; Notice. **Federal Register**/Vol. 75, No. 123, June 28, 2010. 37246–37252. *https://www.govinfo.gov/content/pkg/FR-2010-06-28/pdf/2010-15605.pdf.*

Thomas J. Engels,

Administrator.

[FR Doc. 2020–20971 Filed 9–22–20; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

[Document Identifier: OS–0990–xxxx]

Agency Information Collection Request; 60-Day Public Comment Request

AGENCY: Office of the Secretary, HHS.

ACTION: Notice.

SUMMARY: In compliance with the requirement of the Paperwork Reduction Act of 1995, the Office of the Secretary (OS), Department of Health and Human Services, is publishing the following summary of a proposed collection for public comment.

DATES: Comments on the ICR must be received on or before November 23, 2020.

ADDRESSES: Submit your comments to *Sherrette.Funn@hhs.gov* or by calling (202) 795–7714.

FOR FURTHER INFORMATION CONTACT: When submitting comments or requesting information, please include the document identifier 0990-New-60D, and project title for reference, to Sherrette Funn, the Reports Clearance Officer, *Sherrette.Funn@hhs.gov,* or call 202–795–7714.

SUPPLEMENTARY INFORMATION: Interested persons are invited to send comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

Title of the Collection: HHS Teletracking COVID–19 Portal (U.S. Healthcare COVID–19 Portal).

Type of Collection: In use without an OMB number.

OMB No.: 0990–XXXX OS/OCIO.

Abstract: The data collected through this ICR informs the Federal Government's understanding of disease patterns and furthers the development of policies for prevention and control of disease spread and impact related to the 2019 Novel Coronavirus (COVID–19). One of the most important uses of the data collected through this ICR is to determine critical allocations of limited supplies (*e.g.,* protective equipment and medication). For instance, this collection has been used to distribute Remdesivir, a vital therapeutic that HHS distributes to the American healthcare system, via distinct data calls on regular intervals. As of July 10, HHS reduced the number requests for data from hospitals to support allocations of Remdesivir. HHS has stopped sending out one-time requests for data to aid in the distribution of Remdesivir or any other treatments or supplies. This consolidated daily reporting is the only mechanism used for the distribution calculations, and daily reports are needed to ensure accurate calculations.

Type of Respondent: We acknowledge the burden placed on many hospitals, including resource constraints, and have allowed for some flexibilities, such as back-submissions or submitting every business days, with the understanding that respondents may not have sufficient staff working over the weekend. It is our belief that collection of this information daily is the most effective way to detect outbreaks and needs for Federal assistance over time, by hospital and geographical area, and to alert the appropriate officials for action. It's requested that 5,500 hospitals, submit data daily on the

https://www.ers.usda.gov/topics/rural-economy-population/rural-classifications/what-is-rural.aspx. Accessed December 20, 2019.

[5] For a deeper discussion of this topic, please see: (a) National Academies of Sciences, Engineering, and Medicine 2016. Rationalizing Rural Area Classifications for the Economic Research Service: A Workshop Summary. Washington, DC: The National Academies Press. Accessed December 20, 2019. Available from: *https://doi.org/10.17226/21843;* and (b) Ratcliffe M, Burd C, Holder K, and Fields A, ''Defining Rural at the U.S. Census Bureau,'' ACSGEO–1, U.S. Census Bureau, Washington, DC, 2016. Available from: *https://www.census.gov/content/dam/Census/library/publications/2016/acs/acsgeo-1.pdf.*