interviewing resumed in July, but not for all areas.

All of these changes affected response rates, in terms of who was most likely to complete the mailed surveys or participate in interviews, etc. The Census Bureau concluded that the 2020 ACS 1-year data were not ''reasonable'' as respondents disproportionately ''had higher levels of education, had more married couples and few never married citizens, had less Medicaid coverage, had higher median household incomes, and fewer non-citizens, and were more likely to live in single-family housing units'' than respondents in previous years. Therefore, the Census Bureau decided not to release standard 2020 ACS 1-year estimates. The Census Bureau is providing only ''experimental estimates'' for 2020 ACS 1-year data.[3] The Census Bureau indicated that the experimental 2020 estimates were released in an attempt to account for the differential response from more educated, higher income, single-family households, but also acknowledged the approach has not been thoroughly investigated.[4]

Upon their release, HRSA examined the 2020 ACS experimental estimates and compared the change in poverty share using a 3-year estimate incorporating the 2020 experimental estimate with prior year-to-year changes since 2014—the first year of annual updates to poverty share data using 3-year ACS estimates. Using the 2020 experimental estimates, HRSA noted an increase in the variability, with 12 states having their largest observed relative percentage change, 9 states having large (>5 percent) relative percentage changes, and 6 states having large (>5 percent) relative decreases in poverty share from the prior year. Moreover, in years prior, large relative percentage changes were most often increases, but the opposite occurred in 2020 using the experimental estimates, *i.e.,* six states would have a large decrease vs. three states would have a large increase. Thus, due to the greater observed data variability and number of states that would experience large decreases in their poverty share, HRSA has concerns about the accuracy of the 2020 experimental estimates as applied to the MCH allocation. For smaller states, in particular, large relative decreases in poverty share can result in meaningful absolute decreases in the poverty-based allocation. As state budgets are impacted by the COVID–19 pandemic, HRSA proposes a conservative approach that limits such decreases based on uncertain experimental estimates to the extent possible.

In order to ameliorate these concerns and because of the nature of the data, HRSA proposes that the ACS 2020 experimental estimates not be used in calculating MCH block grant allocations. Instead, HRSA proposes that the FY 2023 funding allocation be based on the same poverty data used in the FY 2022 allocation (*i.e.,* pooled 1-year estimates for 2017, 2018, and 2019 ACS). Funding allocations for FY 2024 and FY 2025 would continue to incorporate the latest 1-year ACS data while skipping the 2020 experimental data (*i.e.,* for FY 2024, the 2018, 2019, and 2021 ACS data will be used; for FY 2025, the 2019, 2021, and 2022 ACS data will be used). In FY 2026, the temporary change to the method for calculating allocations will no longer be necessary, and HRSA will resume pooling of 3 consecutive 1-year estimates (2021–2023). HRSA's proposal to temporarily change the method of calculating allocations continues to support the objective of distributing funding according to greatest need. In so doing, HRSA will avoid the use of lower quality and potentially inaccurate poverty data for 2020 that would result in larger funding fluctuations than observed in previous years, and will continue to use the latest available data in future years. With this approach, no state will see a decrease in its poverty-based allocation of funding in FY 2023.

If the poverty data used for the FY 2022 allocation is used again for the FY 2023 allocation, all states will receive the same proportion of poverty-based funding as they received in FY 2022, which will prevent potentially inaccurate changes in allocations. HRSA recognizes the possibility that the changes seen with 2020 ACS experimental estimates may actually reflect real changes in the distribution of children in poverty which may be seen when the 2021 ACS 1-year estimates (to be released in Fall 2022) are incorporated. If that is the case, then the difference in FY 2024 allocations as compared to the FY 2023 allocations will accurately reflect those changes by incorporating the 2021 data.

Diana Espinosa,

Deputy Administrator.

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[3] The Census Bureau defines experimental data products as ''innovative statistical products created using new data sources or methodologies that benefit data users in the absence of other data products . . . Census Bureau experimental data may not meet all of HRSA's data quality standards. Because of this, HRSA clearly identifies experimental data products and includes methodology and supporting research with their release.'' *https://www.census.gov/data/experimental-data-products.html.*

[4] *https://www.census.gov/programs-surveys/acs/data/experimental-data.html.*

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

[OMB No. 0906–xxxx–New]

Agency Information Collection Activities: Proposed Collection: Public Comment Request Information Collection Request Title: Optimizing Virtual Care Grant Program Performance Measures

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

ACTION: Notice.

SUMMARY: In compliance with the requirement for opportunity for public comment on proposed data collection projects of the Paperwork Reduction Act of 1995, HRSA announces plans to submit an Information Collection Request (ICR), described below, to the Office of Management and Budget (OMB). Prior to submitting the ICR to OMB, HRSA seeks comments from the public regarding the burden estimate, below, or any other aspect of the ICR.

DATES: Comments on this ICR should be received no later than August 23, 2022.

ADDRESSES: Submit your comments to *paperwork@hrsa.gov* or by mail to the HRSA Information Collection Clearance Officer, Room 14N136B, 5600 Fishers Lane, Rockville, MD 20857.

FOR FURTHER INFORMATION CONTACT: To request more information on the proposed project or to obtain a copy of the data collection plans and draft instruments, email *paperwork@hrsa.gov* or call Samantha Miller, the acting HRSA Information Collection Clearance Officer at (301) 443–9094.

SUPPLEMENTARY INFORMATION: When submitting comments or requesting information, please include the information collection request title for reference.

Information Collection Request Title: Optimizing Virtual Care Grant Program Performance Measures, OMB No. 0906–xxxx—New.

Abstract: The Health Center Program and supplemental awards for health centers are authorized by Section 330(d) of the Public Health Service Act (42 U.S.C. 254b(d)). Notably, HRSA is

authorized to make supplemental awards for health centers to ''implement evidence-based models for increasing access to high-quality primary care services, which may include models related to expanding the use of telehealth and technology-enabled collaborative learning and capacity building models.'' Under the Optimizing Virtual Care (OVC) grant program, 29 high-performing health centers received 2-year one-time funding supplemental awards to increase health care access and quality for underserved populations through virtual care such as telehealth, remote patient monitoring, digital patient tools, and health information technology platforms. Specifically, award recipients will use OVC funding to develop and implement innovative evidence-based strategies with the potential to be adapted, leveraged, and scaled across the Health Center Program to increase access to care and improve clinical quality by optimizing the use of virtual care with a specific focus on medically underserved communities and populations.

The goal of the OVC grant program is to continue to support innovation that began during the COVID–19 pandemic, when health centers quickly expanded their use of virtual care to maintain access to essential primary care services for underserved communities. HRSA-funded health centers serve medically underserved populations facing barriers to virtual care access, such as low digital literacy, low connectivity capabilities, or limited technology access. The OVC grant recipients will serve as a model for how to increase equitable virtual care, generating and refining strategies that can be adapted and scaled across the Health Center Program.

Need and Proposed Use of the Information: The information collected on OVC grant recipient activities and performance will help HRSA demonstrate, adapt, assess, and disseminate promising practices, strategies, and novel models of virtual care across the nation's health centers. The information will support an assessment that yields:

- Data on how to optimize the use of virtual care in the Health Center Program to enhance access to care and improve clinical quality for medically underserved communities and populations.
- Information on how to adapt, leverage, and scale up the OVC grant program models across other HRSA funding opportunities.
- Information on strategies to promote and scale virtual care innovations focused on increasing health equity for Health Center Program patients.

The assessment will include descriptive analyses of grant recipient activities and performance, including analyses of trends over time. The analyses will inform recommendations for performance measures that HRSA could scale across the Health Center Program and across other grant programs.

The grant recipient activities related to implementation of novel models of virtual care, including aggregate data on patients served and the services they received, will be captured via monthly progress reports. A set of health center performance measures will be captured in a bi-annual progress report and will provide insight into health equity and virtual care. Grant recipients will collect and report performance measures based on project goals and objectives that span four key population health and clinical domain areas, including (1) Increased Access to Care and Information; (2) Improve Clinical Quality and Health Outcomes; (3) Enhance Patient Care Coordination; and (4) Promote Health Equity.

Likely Respondents: Respondents will be the 29 health centers that received one-time funding supplemental awards through the Optimizing Virtual Care grant program.

Burden Statement: Burden in this context means the time expended by persons to generate, maintain, retain, disclose, or provide the information requested. This includes the time needed to review instructions; to develop, acquire, install, and utilize technology and systems for the purpose of collecting, validating and verifying information, processing and maintaining information, and disclosing and providing information; to train personnel and to be able to respond to a collection of information; to search data sources; to complete and review the collection of information; and to transmit or otherwise disclose the information. The total annual burden hours estimated for this ICR are summarized in the table below.

TOTAL ESTIMATED ANNUALIZED BURDEN HOURS

Form name	Number of respondents	Number of responses per respondent	Total responses	Average burden per response (in hours)	Total burden hours
OVC Monthly Progress Report	29	12	348	2	696
OVC Biannual Measures Report	29	2	58	48	2,784
Total	29		406		3,480

HRSA specifically requests comments on (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.

Maria G. Button,

Director, Executive Secretariat.

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