DATES: Comments on the collection(s) of information must be received by the OMB desk officer by March 16, 2026.

ADDRESSES: Written comments and recommendations for the proposed information collection should be sent within 30 days of publication of this notice to *www.reginfo.gov/public/do/PRAMain.* Find this particular information collection by selecting ''Currently under 30-day Review—Open for Public Comments'' or by using the search function.

To obtain copies of a supporting statement and any related forms for the proposed collection(s) summarized in this notice, please access the CMS PRA website by copying and pasting the following web address into your web browser: *https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing*

FOR FURTHER INFORMATION CONTACT: William Parham at (410) 786–4669.

SUPPLEMENTARY INFORMATION: Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501–3520), federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. The term ''collection of information'' is defined in 44 U.S.C. 3502(3) and 5 CFR 1320.3(c) and includes agency requests or requirements that members of the public submit reports, keep records, or provide information to a third party. Section 3506(c)(2)(A) of the PRA (44 U.S.C. 3506(c)(2)(A)) requires federal agencies to publish a 30-day notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension or reinstatement of an existing collection of information, before submitting the collection to OMB for approval. To comply with this requirement, CMS is publishing this notice that summarizes the following proposed collection(s) of information for public comment.

1. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* CMS Electronic Data Interchange (EDI) Enrollment Registration, CMS EDI Enrollment Form, and CMS EDI Enrollment Attestation Form; *Use:* The collection consists of three forms used by Medicare providers and suppliers to register for EDI services with Medicare contractors. The updated collection includes the revised CMS EDI Registration Form (10164A) and CMS EDI Enrollment Agreement Form (10164B), both serving as model forms. The collection also introduces the CMS EDI Enrollment Attestation Form (10164C), a new mandatory attestation form requiring formal compliance verification from all participating entities.

The forms collect essential information necessary to identify Medicare providers and suppliers during electronic transactions, authorize requested EDI functions, and establish appropriate access privileges for healthcare entities. These forms ensure compliance with HIPAA transaction standards while implementing strengthened security requirements for billing vendors and clearing houses that handle Medicare data. The information collected by the forms will be uploaded into Medicare contractor computer systems. Medicare contractors will store this information in a database accessed at the time of provider connection to the Medicare Data Contractor Network (MDCN). When authentication is successful and connectivity is established, transactions may be exchanged. *Form Number:* CMS–10164 (OMB control number 0938–0983); *Frequency:* Yearly; *Affected Public:* Business or other-for-profits and not-for-profits; *Number of Respondents:* 229,767; *Total Annual Responses:* 229,767; *Total Annual Hours:* 153,178. (For questions regarding this collection contact Charlene Parks at 410–786–8684.)

William N. Parham, III,

Director, Division of Information Collections and Regulatory Impacts, Office of Strategic Operations and Regulatory Affairs.

[FR Doc. 2026–02874 Filed 2–12–26; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–1771, CMS–10488, CMS–10407 and CMS–R–284]

Agency Information Collection Activities: Submission for OMB Review; Comment Request

AGENCY: Centers for Medicare & Medicaid Services, Health and Human Services (HHS).

ACTION: Notice.

SUMMARY: The Centers for Medicare & Medicaid Services (CMS) is announcing an opportunity for the public to comment on CMS' intention to collect information from the public. Under the Paperwork Reduction Act of 1995 (PRA) federal agencies are also required to publish notice in the **Federal Register** concerning each proposed collection of information before the agency's request is submitted to OMB for approval.

DATES: Comments on the collection(s) of information must be received by the OMB desk officer by April 14, 2026.

ADDRESSES: Written comments and recommendations for the proposed information collection should be sent within 60 days of publication of this notice to *www.reginfo.gov/public/do/PRAMain.* Find this particular information collection by selecting ''Currently under 60-day Review—Open for Public Comments'' or by using the search function.

To obtain copies of a supporting statement and any related forms for the proposed collection(s) summarized in this notice, please access the CMS PRA website by copying and pasting the following web address into your web browser: *https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing.*

FOR FURTHER INFORMATION CONTACT: William Parham at (410) 786–4669.

SUPPLEMENTARY INFORMATION: Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501–3520), federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. The term ''collection of information'' is defined in 44 U.S.C. 3502(3) and 5 CFR 1320.3(c) and includes agency requests or requirements that members of the public submit reports, keep records, or provide information to a third party.

Interested persons are invited to send comments regarding our burden estimates or any other aspect of this collection of information, including the necessity and utility of the proposed information collection for the proper performance of the agency's functions, the accuracy of the estimated burden, ways to enhance the quality, utility, and clarity of the information to be collected, and the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

Information Collection

1. *Type of Information Collection Request:* Reinstatement without change of a previously approved collection; *Title:* Emergency and Foreign Hospital Services and Supporting Regulation in *42 CFR 424.103; Use:* Section 1866 of the Social Security Act states that any provider of services shall be qualified to participate in the Medicare program and shall be eligible for payments under Medicare if it files an agreement with the Secretary to meet the conditions

outlined in this section of the Act. Section 1814(d)(1) of the Social Security Act and *42 CFR 424.100,* allows payment of Medicare benefits for a Medicare beneficiary to a nonparticipating hospital that does not have an agreement in effect with the Centers for Medicare and Medicaid Services. These payments can be made if such services were emergency services and if CMS would be required to make the payment if the hospital had an agreement in effect and met the conditions of payment. This form is used in connection with claims for emergency hospital services provided by hospitals that do not have an agreement in effect under Section 1866 of the Social Security Act.

42 CFR 424.103 (b) requires that before a non-participating hospital may be paid for emergency services rendered to a Medicare beneficiary, a statement must be submitted that is sufficiently comprehensive to support that an emergency existed. Form CMS–1771 contains a series of questions relating to the medical necessity of the emergency. The attending physician must attest that the hospitalization was required under the regulatory emergency definition (*42 CFR 424.101* attached) and give clinical documentation to support the claim. A photocopy of the beneficiary's hospital records may be used in lieu of the CMS–1771 if the records contain all the information required by the form.; *Form Number:* CMS–1771 (OMB Control Number: 0938–0023); *Frequency:* Annually; *Affected Public:* Private Sector, Business or other for-profit and not-for-profit institutions; *Number of Respondents:* 100*; Number of Responses:* 200; *Total Annual Hours:* 50. (For policy questions regarding this collection contact Shauntari Cheely at 410–786–1818.)

2. *Type of Information Collection Request:* Revision of currently approved collection; *Title of Information Collection:* Consumer Experience Survey Data Collection; *Use:* Section 1311(c)(4) of the Affordable Care Act requires the Department of Health and Human Services (HHS) to develop an enrollee satisfaction survey system that assesses consumer experience with qualified health plans (QHPs) offered through an Exchange. It also requires public display of enrollee satisfaction information by the Exchange to allow individuals to easily compare enrollee satisfaction levels between comparable plans. HHS established the QHP Enrollee Experience Survey (QHP Enrollee Survey) to assess consumer experience with the QHPs offered through the Marketplaces. The survey includes topics to assess consumer experience with the health care system such as communication with providers and ease of access to health care services.

CMS developed the survey using the Consumer Assessment of Health Providers and Systems (CAHPS®) principles (*https://www.ahrq.gov/cahps/about-cahps/principles/index.html*) and established an application and approval process for survey vendors who want to participate in collecting QHP enrollee experience data. The QHP Enrollee Survey, which is based on the CAHPS® Health Plan Survey, will be used to (1) help consumers choose among competing health plans, (2) provide actionable information that the QHPs can use to improve performance, (3) provide information that regulatory and accreditation organizations can use to regulate and accredit plans, and (4) provide a longitudinal database for consumer research. To develop the QHP Enrollee Survey, CMS completed developmental testing, including psychometric testing and beta testing. Additional changes made the survey since its development have been informed by focus groups with consumers and QHP issuers, cognitive testing with consumers, and input CMS received from interested parties. CMS previously obtained clearance for the 2016–2026 administrations of the QHP Enrollee Survey. At this time, CMS is requesting to renew approval for the information collection related to the QHP Enrollee Experience Survey in 2027–2029. These activities are necessary to ensure that CMS fulfills legislative mandates established by section 1311(c)(4) of the Affordable Care Act to develop an ''enrollee satisfaction survey system'' and provide such information on Marketplace websites. CMS is also seeking approval to revise the QHP Enrollee Survey beginning with 2027 to improve response rates, reduce burden on QHP enrollees and improve overall instrument alignment with the Consumer Assessment of Healthcare Providers and Systems (CAHPS) 5.1 Survey. To accomplish this, CMS is proposing to remove four questions related to tobacco-usage that are used to calculate the Medical Assistance with Smoking and Tobacco Use Cessation measure. CMS is also proposing to replace the two demographic questions related to race and ethnicity with one question aligned with the Office of Management and Budget (OMB) Revisions to OMB's Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity. CMS is further proposing to refine the survey instrument to align questions related to telehealth with the CAHPS 5.1 Survey. CMS is also proposing to add 5 gate questions to allow participants to screen out of detailed follow-up questions that do not apply to them (see the Crosswalk of Changes to the QHP Enrollee Survey). CMS proposes allowing the customization of the mail and internet survey instruments to replace ''Qualified Health Plan (QHP)'' with the QHP issuer's name on the cover page. CMS is also proposing to update the QHP Enrollee Survey sampling protocol to allow oversampling at any level. CMS is also seeking to add a third email reminder on Day 40 of the fielding timeline and to extend the telephone dialing period by one week to begin on Day 48 of the fielding timeline. Finally, CMS is proposing revisions to the survey instrument, prenotification letter, reminder letter, survey cover letter, and notification/reminder emails for plain language to reduce repetition and improve readability. *Form Number:* CMS–10488 (OMB control number: 0938–1221); *Frequency:* Annually; *Affected Public Sector:* (Individuals and Households), Private sector (Business or other for-profits and Not-for-profit institutions); *Number of Respondents:* 72,008 respondents; *Total Annual Responses:* 72,008; *Total Annual Hours:* 12,013. (For policy questions regarding this collection contact Preeti Hans 301–492–5114).

3. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Summary of Benefits and Coverage and Uniform Glossary; *Use:* The Affordable Care Act amends the Public Health Service Act (PHS Act) by adding section 2715 ''Development and Utilization of Uniform Explanation of Coverage Documents and Standardized Definitions.'' This section directs the Secretary, in consultation with the National Association of Insurance Commissioners (NAIC) and a working group composed of stakeholders, to develop standards for use by a group health plan and a health insurance issuer in compiling and providing to applicants, enrollees, and policyholders and certificate holders a summary of benefits and coverage (SBC) explanation that accurately describes the benefits and coverage under the applicable plan or coverage. Section 2715 also requires 60-days advance notice of any material modification in any of the terms of the plan or coverage that is not reflected in the most recently provided summary

and the development of standards for the definitions of terms used in health insurance coverage.

This information collection will ensure that over 30 million consumers shopping for or enrolled in private, individually purchased, or non-federal governmental group health plan coverage receive the consumer protections of the Affordable Care Act. Employers, employees, and individuals will use this information to compare coverage options prior to selecting coverage and to understand the terms of, and extent of medical benefits offered by, their coverage (or exceptions to such coverage or benefits) once they have coverage. *Form Number:* CMS–10407 (OMB control number 0938–1146); *Frequency:* Annually; *Affected Public:* Private Sector—Business or other for-profits and Not-for-profit institutions; *Number of Respondents:* 90,805; *Number of Responses:* 10,507,165; *Total Annual Hours:* 204,140. (For policy questions regarding this collection contact Daniel Kidane at *daniel.kidane@cms.hhs.gov.*)

4. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Transformed—Medicaid Statistical Information System (T–MSIS); *Use:* The data reported in T–MSIS are used by federal, state, and local officials, as well as by private researchers and corporations to monitor past and projected future trends in the Medicaid and CHIP programs. The data provide the only national level information available on enrollees, beneficiaries, and expenditures. It also provides the only national level information available on Medicaid utilization. The information is the basis for analyses and for cost savings estimates for the Department's cost sharing legislative initiatives to Congress. The collected data are also crucial to our actuarial forecasts.

This iteration proposes to: (1) add a new valid value that will enable CMS to obtain A-Number, I–94 Number, SEVIS ID, and I–797 Receipt Number for Medicaid and CHIP beneficiaries, (2) add a new valid value to identify state-specific managed care program codes, (3) remove the collection of SOGI data, (4) remove the active Records Layouts file, and (5) update certain T–MSIS Data Dictionary documents. We are not proposing any burden changes.

Form Number: CMS–R–284 (OMB control number: 0938–0345); *Frequency:* Quarterly and monthly; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 54; *Total Annual Responses:* 648; *Total Annual Hours:* 7,290. (For policy questions regarding this collection contact Connie Gibson at 410–786–0755.)

William N. Parham, III,

Director, Division of Information Collections and Regulatory Impacts, Office of Strategic Operations and Regulatory Affairs.

[FR Doc. 2026–02871 Filed 2–12–26; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10945]

Agency Information Collection Activities: Submission for OMB Review; Comment Request

AGENCY: Centers for Medicare & Medicaid Services, Health and Human Services (HHS).

ACTION: Notice.

SUMMARY: The Centers for Medicare & Medicaid Services (CMS) is announcing an opportunity for the public to comment on CMS' intention to collect information from the public. Under the Paperwork Reduction Act of 1995 (PRA) federal agencies are also required to publish notice in the **Federal Register** concerning each proposed collection of information before the agency's request is submitted to OMB for approval.

DATES: Comments on the collection(s) of information must be received by the OMB desk officer by April 14, 2026.

ADDRESSES: Written comments and recommendations for the proposed information collection should be sent within 60 days of publication of this notice to *www.reginfo.gov/public/do/PRAMain.* Find this particular information collection by selecting ''Currently under 60-day Review—Open for Public Comments'' or by using the search function.

To obtain copies of a supporting statement and any related forms for the proposed collection(s) summarized in this notice, please access the CMS PRA website by copying and pasting the following web address into your web browser: *https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing.*

FOR FURTHER INFORMATION CONTACT: William Parham at (410) 786–4669.

SUPPLEMENTARY INFORMATION: Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501–3520), federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. The term ''collection of information'' is defined in 44 U.S.C. 3502(3) and 5 CFR 1320.3(c) and includes agency requests or requirements that members of the public submit reports, keep records, or provide information to a third party.

Interested persons are invited to send comments regarding our burden estimates or any other aspect of this collection of information, including the necessity and utility of the proposed information collection for the proper performance of the agency's functions, the accuracy of the estimated burden, ways to enhance the quality, utility, and clarity of the information to be collected, and the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

Information Collection

1. *Type of Information Collection Request:* New collection (Request for a new OMB control number); *Title of Information Collection:* Administrative Procedures for Chronic and Post-Acute Care Quality Programs; *Use:* This is a request for a new information collection for certain procedural requirements associated with the Centers for Medicare & Medicaid Services' (CMS') quality reporting programs (QRPs) and value-based purchasing (VBP) programs. CMS' QRPs and VBP programs promote higher quality, more efficient healthcare for Medicare beneficiaries by collecting and reporting on quality-of-care metrics. This information is made available to consumers, both to empower Medicare beneficiaries and inform decision-making, as well as to incentivize providers to make continued quality improvements.

Specifically, CMS has implemented QRPs for multiple settings, including for the home health (HH), hospice, inpatient rehabilitation facility (IRF), long-term acute care hospital (LTCH), and skilled nursing facility (SNF) settings, to achieve its overarching priorities and initiatives. Any Hospice, HH Agency (HHA), IRF, LTCH, or SNF—collectively referred to as providers—that does not meet the reporting requirements for their respective program may be subject to a payment reduction in its annual payment update (APU).

CMS has also implemented value-based purchasing (VBP) programs to provide incentive payments to providers who deliver high quality care to patients, as measured by their performance on specific quality metrics.

These QRPs and SNF VBP Program include quality measures calculated using data collected through claims,