participants will be asked to install the app, use of the app after the initial install will be optional.

For Aim 2 of the study, a subset (30 total) of the YMSM participants will be invited to participate in an in-depth interview. The interview will take approximately 90 minutes to complete. For the Aim 3 healthcare provider training, we will enroll a total of 20 healthcare providers. Over the 3-year data collection period, the estimated annual enrollment will be 7. It is expected that 50% of healthcare providers screened will meet study eligibility criteria and agree to join the study. Thus, we expect to screen 14 providers annually. The collection of initial screening information from the 14 providers will take approximately 10 minutes to complete. The collection of locator information from the 7 providers enrolled each year will take approximately 10 minutes to complete. Healthcare provider participants will be asked to complete an assessment before and after the PrEP training. The pre-training assessment and the post-training assessment are expected to take 30 minutes each to complete. Providers will also be asked to take part in a 60-minute interview.

In addition to the training and provider-level assessments, every 6 months during the 36-month data collection period, each of the four participating clinic sites will complete the clinic assessment tool to describe PrEP services implementation at the facility level. The clinic assessment will be completed by a single member of the clinic staff at each clinic (four respondents total). Clinic-level assessments at baseline and study end are estimated to take 120 minutes to complete. Clinic-level assessments conducted at six-month intervals between the baseline and study end points are expected to take 90 minutes to complete.

The total number of burden hours is 2,210 across 36 months of data collection. The total estimated annualized burden hours are 551. There are no costs to the participants other than their time to participate.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondent	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hrs)	Total burden (in hrs)
General Public—Adults	Patient Screener (English/Spanish)	267	1	10/60	45
General Public—Adults	Patient Locator Form (English/Spanish)	134	1	10/60	23
General Public—Adults	Patient Baseline Assessment (English/Spanish).	134	1	45/60	101
General Public—Adults	Patient Quarterly Assessment (English/Spanish).	134	3	45/60	302
General Public—Adults	CleverCap App Setup (English/Spanish).	134	1	10/60	23
General Public—Adults	Patient Interview Guide (English/Spanish).	10	1	90/60	15
Health Practitioners	Provider Screener	14	1	10/90	3
Health Practitioners	Provider Locator Form	7	1	10/90	2
Health Practitioners	Provider Pre-Training Assessment	7	1	30/60	4
Health Practitioners	Provider Post-Training Assessment	7	1	30/60	4
Health Practitioners	Provider Interview	7	1	60/60	7
Health Practitioners	Clinic Assessment Baseline and Final	4	1	130/60	9
Health Practitioners	Clinic Assessment Every Six Months	4	2	100/60	13
Total					551

Jeffrey M. Zirger,

Lead, Information Collection Review Office, Office of Public Health Ethics and Regulations, Office of Science, Centers for Disease Control and Prevention.

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BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

Privacy Act of 1974; Matching Program

AGENCY: Centers for Medicare & Medicaid Services, Department of Health and Human Services

ACTION: Notice of a new matching program.

SUMMARY: In accordance with subsection (e)(12) of the Privacy Act of 1974, as amended, the Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS) is providing notice of a new matching program between CMS and the Department of Veterans Affairs (VA), ''Verification of Eligibility for Insurance Affordability Programs Under the Patient Protection and Affordable Care Act.''

DATES: The deadline for comments on this notice is August 5, 2026. The re-established matching program will commence not sooner than 30 days after publication of this notice, provided no comments are received that warrant a change to this notice. The matching program will be conducted for an initial term of 18 months (from approximately May 15, 2026 to November 15, 2027) and within 3 months of expiration may be renewed for one additional year if the parties make no change to the matching program and certify that the program has been conducted in compliance with the matching agreement.

ADDRESSES: Interested parties may submit written comments on this notice, by mail or email, to the CMS Privacy Officer, Division of Security, Privacy Policy & Oversight, Information Security & Privacy Group, Office of Information Technology, Centers for Medicare & Medicaid Services, Location: N1–14–56, 7500 Security Blvd., Baltimore, MD 21244–1850, to *barbara.demopulos@cms.hhs.gov.*

FOR FURTHER INFORMATION CONTACT: If you have questions about the matching program, you may contact Terrence Kane, Director, Division of Automated Verifications and SEP Policy, Marketplace Eligibility and Enrollment

Group, Center for Consumer Information and Insurance Oversight, CMS, at (301) 492–4449 or by email at *terrenc.kane@cms.hhs.gov.*

SUPPLEMENTARY INFORMATION: The Privacy Act of 1974, as amended (5 U.S.C. 552a) provides certain protections for individuals applying for and receiving federal benefits. The law governs the use of computer matching by federal agencies when records in a system of records (meaning, federal agency records about individuals retrieved by name or other personal identifier) are matched with records of other federal or non-federal agencies. The Privacy Act requires agencies involved in a matching program to:

1. Enter into a written agreement, which must be prepared in accordance with the Privacy Act, approved by the Data Integrity Board of each source and recipient federal agency, provided to Congress and the Office of Management and Budget (OMB), and made available to the public, as required by 5 U.S.C. 552a(o), (u)(3)(A), and (u)(4).

2. Notify the individuals whose information will be used in the matching program that the information they provide is subject to verification through matching, as required by 5 U.S.C. 552a(o)(1)(D).

3. Verify match findings before suspending, terminating, reducing, or making a final denial of an individual's benefits or payments or taking other adverse action against the individual, as required by 5 U.S.C. 552a(p).

4. Report the matching program to Congress and the OMB, in advance and annually, as required by 5 U.S.C. 552a(o) (2)(A)(i), (r), and (u)(3)(D).

5. Publish advance notice of the matching program in the **Federal Register** as required by 5 U.S.C. 552a(e)(12).

This matching program meets these requirements.

Barbara Demopulos,

CMS Privacy Act Officer, Division of Security, Privacy Policy & Oversight, Information Security and Privacy Group,Office of Information Technology, Centers for Medicare & Medicaid Services.

Participating Agencies: The Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS) is the recipient agency, and the Department of Veterans Affairs (VA), is the source agency.

Authority for Conducting the Matching Program: The matching program is authorized under 42 U.S.C. 18001.

Purpose(s): The purpose of this matching program is to assist CMS in determining individuals' eligibility for Insurance Affordability Programs (IAPs). In this matching program, VHA provides CMS with data when State Administering Entities (AE) request it and VHA is authorized to release it, verifying whether an individual is enrolled in Minimum Essential Coverage (MEC) through a VHA Health Care Program. CMS makes the data provided by VHA available to the requesting AE through a data services hub (Hub) to verify an Applicant's enrollment in MEC to use in determining the enrollee's eligibility for financial assistance, Medicaid, the Children's Health Insurance Program (CHIP) and the Basic Health Program. CMS and AEs will use the VA's disability data for determining eligibility for advance payments of the premium tax credit (APTC) and cost-sharing reductions (CSRs). VHA health plans provide minimum essential coverage, and eligibility for such plans usually precludes eligibility for financial assistance in paying for private coverage. The data provided by VHA under this matching program will be used by CMS and AEs to authenticate identity, determine eligibility for financial assistance, and determine the amount of the financial assistance.

Categories of Individuals: The categories of individuals whose information is involved in the matching program are:

- Veterans whose records at VHA match data provided to VHA by CMS (submitted by AEs) about individuals who are applying for or are enrolled in an insurance coverage plan through a federally-facilitated health insurance exchange.

Categories of Records: The categories of records used in this matching program are identity records and minimum essential coverage period records consisting of the following data elements:

Data provided by CMS to VHA:

a. First Name(required).

b. Middle Name/Initial (if provided by applicant).

c. Surname (Applicant's Last Name) (required).

d. Date of Birth (required).

e. Sex (required).

f. SSN (required).

g. Requested Qualified Health Plan (QHP) Coverage Effective Date (required).

h. Requested QHP Coverage End Date (required).

i. State Identification.

j. Transaction ID(required).

Data provided by VHA to CMS:

a. SSN (required).

b. Start/End Date{s) of enrollment period(s) (when match occurs).

c. A blank date response when a non-match occurs.

d. If CMS transmits request and a match is made, but VA's record contains a Date of Death, VA will respond in the same manner as a non-match response, with a blank date.

e. Enrollment period(s) is/are defined as the timeframe during which the individual was enrolled in a VHA Health Care Program.

Data provided from CMS to VBA:

a. First Name (required).

b. Last Name (required).

c. Date of Birth (required)..

d. Sex (required).

e. Social Security Number (required unless address is provided).

f. Street Address (required unless SSN is provided).

g. City (required unless SSN is provided).

h. State (required unless SSN is provided).

i. Country (required unless SSN is provided).

j. Zip Code (required unless SSN is provided).

k. Middle Name (optional).

l. Sex (optional).

m. Mother's Maiden Name (optional).

n. Home Phone Number (optional).

o. Birth Place City (optional).

p. Birth Place State (optional).

q. Birth Place Country (optional) Data provided by VBA to CMS:

a. Combined disability rating.

b. Effective date for combined disability rating.

c. Individual disability rating(s).

d. Individual disability rating decision(s).

e. Individual disability rating effective date(s).

f. Individual disability rating end date(s).

g. Individual disability rating percentage(s).

h. Indicator of whether individual disability rating is static.

i. Permanent and total service-connected status.

j. Total Disability status individual unemployability status.

System(s) of Records: The data used in this matching program will be disclosed from the following systems of records, based on the routine uses identified:

- Health Insurance Exchanges System (HIX), CMS System No. 09–70–0560, last published in full at 78 FR 63211 (Oct. 23, 2013), as amended at 83 FR 6591 (Feb. 14, 2018).
- Veterans and Beneficiaries Purchased Care Community Health Care Claims, Correspondence, Eligibility, Inquiry and Payment Files-VA,'' System No. 54VA10, last fully published at 90 FR 4447354 (September 15, 2025).

• Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records—VA (58VA21/22/28), last published at 88 FR 61858.

[FR Doc. 2026–13572 Filed 7–2–26; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10949 and CMS–10717]

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 required to publish notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension or reinstatement of an existing collection of information, and to allow a second opportunity for public comment on the notice. Interested persons are invited to send comments regarding the burden estimate 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.

DATES: Comments on the collection(s) of information must be received by the OMB desk officer by August 5, 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.

Information Collection

1. *Type of Information Collection Request:* New collection (Request for a new OMB control number); *Title of Information Collection:* Rural Health Transformation Program Reporting; *Use:* On July 4, 2025, President Trump signed Public Law 119–21 which the Centers for Medicare & Medicaid Services (CMS) refers to as the ''Working Families Tax Cut'' (WFTC) legislation, into law. The legislation authorized the Rural Health Transformation (RHT) Program, marking a significant federal investment of up to $50 billion over five years and is designed to empower as many as 50 State awardees to catalyze transformative improvements within their rural healthcare ecosystems. The principal objective is to enhance healthcare access, quality, and outcomes through innovative, system-wide change, thereby investing in the health of rural communities for future generations.

Funding for approved State awardees is determined through a formal scoring and allocation process. The financial architecture of the program is composed of two primary streams: baseline funding, distributed equally among all awardees, and performance-based workload funding, which is allocated based on the scoring of specific rural and technical score factors within each State's application and their subsequent annual performance.

To ensure continued eligibility and funding, State awardees must adhere to key program requirements, including the submission of annual and quarterly reports. CMS will re-calculate each approved State's technical score and corresponding Workload funding amount for each subsequent budget period based on the information and data the approved State provides in the required annual reporting each year. In these reports, States will provide updates on programmatic milestones, report on performance and evaluation metrics, and detail the expenditure of funds. *Form Number:* CMS–10949 (OMB control number: 0938–TBD); *Frequency:* Quarterly and yearly; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 50; *Total Annual Responses:* 200; *Total Annual Hours:* 20,000. (For policy questions regarding this collection contact Anthony (Tony) DiFondi at 215–861–4318.)

2. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Medicare Part C and Part D Program Audit and Industry-Wide Part C Timeliness Monitoring Project (TMP) Protocols; *Use:* CMS is responsible for overseeing the Medicare Advantage (MA) and Part D programs to ensure that beneficiaries receive appropriate and timely benefits, services, and drugs. Under Sections 1857(d) and 1860D–12 of the Social Security Act, and related regulations at 42 CFR 422.503, 422.504, 422.516, 423.504, and 423.505, CMS has the authority to inspect, evaluate, and monitor the benefits provided by Sponsoring organizations. To carry out this oversight, Sponsoring organizations must provide CMS with access to relevant records, documentation, and systems. They are also required to report information on service utilization and other data as requested by CMS to confirm ongoing compliance with program requirements. CMS uses the data collected by way of these audit protocols to thoroughly assess whether Sponsoring organizations are meeting specific federal requirements.

The information gathered during this program audit will be used by the Medicare Parts C and D Oversight and Enforcement Group (MOEG) within the Center for Medicare (CM) to assess Sponsoring organizations' compliance