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:* Extension without change of a currently approved collection; *Title of Information Collection:* Application for Participation in the Intravenous Immune Globulin (IVIG) Demonstration; *Use:* Traditional fee-for-service (FFS) Medicare covers some or all components of home infusion services depending on the circumstances. By special statutory provision, Medicare Part B covers intravenous immune globulin (IVIG) for persons with primary immune deficiency disease (PIDD) who wish to receive the drug at home. However, Medicare does not separately pay for any services or supplies to administer it if the person is not homebound and otherwise receiving services under a Medicare Home Health episode of care. As a result, many beneficiaries have chosen to receive the drug at their doctor's office or in an outpatient hospital setting.

The Medicare IVIG Demonstration application requests basic demographic information necessary to determine eligibility for participation in the demonstration. This information is used by CMS' implementation support contractor to determine eligibility for the demonstration and to set up a demonstration eligibility record that is used by the Medicare claims system when processing claims for demonstration services.

The application also includes some questions about how and where the beneficiary is currently receiving immunoglobulin and related services. This data is being used by the evaluation contractor to conduct its evaluation and to better understand which beneficiaries are electing to enroll in the demonstration. *Form Number:* CMS–10518 (OMB control number: 0938–1246); *Frequency:* Annually; *Affected Public:* Individuals and Households; *Number of Respondents:* 6,500; *Total Annual Responses:* 6,500; *Total Annual Hours:* 1,625. (For policy questions regarding this collection contact Debra K. Gillespie at 410–786–4631.)

Dated: April 20, 2021.

William N. Parham, III,

Director, Paperwork Reduction Staff, Office of Strategic Operations and Regulatory Affairs.

[FR Doc. 2021–08515 Filed 4–22–21; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Privacy Act of 1974; Matching Program

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

ACTION: Notice of a new matching program.

SUMMARY: In accordance with 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 re-established matching program between CMS and each State-Based Administering Entity (AE), titled ''Determining Eligibility for Enrollment in Applicable State Health Subsidy Programs Under the Patient Protection and Affordable Care Act.''

DATES: The deadline for comments on this notice is May 24, 2021. 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 2021 to November 2022) and within three months of expiration may be renewed for one additional year if the parties make no changes 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 as follows:

1. Electronically. You may send your comments electronically to *http://www.regulations.gov.* Follow the instructions for ''Comment or Submission'' or ''More Search Options'' to find the information collection document(s) that are accepting comments.

2. By Regular Mail. You may mail written comments to the following address: Centers for Medicare & Medicaid Services, Division of Security, Privacy Policy & Governance, Information Security & Privacy Group, Office of Information Technology, Location: N1–14–56, 7500 Security Blvd., Baltimore, MD 21244–1850.

FOR FURTHER INFORMATION CONTACT: If you have questions about the matching program, you may contact: Robert Yates, State Operations Division, State Marketplace and Insurance Programs Group, Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services, 7501 Wisconsin Avenue, Bethesda, MD 20814, by phone at 301–492–5151 or email to *Robert.Yates@cms.hhs.gov,* or Jenny Chen, Director, Division of State Technical Assistance, State Marketplace and Insurance Programs Group, Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services, 7501 Wisconsin Avenue, Bethesda, MD 20814, by phone at 301–492–5156 or email to *Jenny.Chen@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 payments under federal benefit programs. 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,

Privacy Advisor, Division of Security, Privacy Policy and Governance, Office of Information Technology, Centers for Medicare & Medicaid Services.

Participating Agencies

Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS), and the AE in each state. Each party (CMS and each AE) is both a source agency, and each AE is a recipient agency, in this matching program, as explained in the Purpose(s) section below.

AEs administer insurance affordability programs, and include Medicaid/Children's Health Insurance Program (CHIP) agencies, state-based exchanges (SBEs), and basic health programs (BHPs). In states that operate a SBE, the AE would include the Medicaid/CHIP agency. Additionally, there are two states—Minnesota and New York—where the AE operates as both a SBE and BHP. In states that have elected to utilize the federally-facilitated exchange (FFE), the AE would include only the Medicaid/CHIP agency.

Authority for Conducting the Matching Program

The principal authority for conducting the matching program is 42 U.S.C. 18001, *et seq.*

Purpose(s)

The matching program will enable CMS to provide information (including information CMS receives from other federal agencies under related matching agreements) to AEs, to assist AEs in verifying applicant information as required by the Patient Protection and Affordable Care Act of 2010 (PPACA) to determine applicants' eligibility for enrollment in applicable state health subsidy programs, including exemption from the requirement to maintain minimum essential coverage (MEC) or from the individual responsibility payment. In addition, to avoid dual enrollment, information will be shared between CMS and AEs, and among AEs, for the purpose of verifying whether applicants and enrollees are currently eligible for or enrolled in a Medicaid/CHIP program. All information will be shared through a data services hub (Hub) established by CMS to support the federally-facilitated health insurance exchange (which CMS operates) and state-based exchanges.

Categories of Individuals

The individuals whose information will be used in the matching program are consumers who apply for eligibility to enroll in applicable state health subsidy programs through an exchange established under ACA and other relevant individuals (such as, applicants' household members).

Categories of Records

The categories of records that will be used in the matching program are identifying records; minimum essential coverage period records; return information (household income and family size information); citizenship status records; birth and death information; disability coverage and income information; and imprisonment status records.

The data elements CMS will receive from AEs may include:

1. Social security number (if applicable).
2. Last name.
3. First name.
4. Date of birth.

The data elements the AEs will receive from CMS may include:

1. Validation of SSN.
2. Verification of citizenship or immigration status.
3. Incarceration Status.
4. Eligibility and/or enrollment in certain types of MEC.
5. Income, based on Federal Tax Information (FTI), Title II benefits, and current income sources.
6. Quarters of Coverage.
7. Death Indicator.

System of Records

The records that CMS will disclose to AEs will be disclosed from the following system of records, as authorized by routine use 3 published in the System of Records Notices (SORN) cited below:

CMS 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).

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Community Living

Award of a Single-Source Supplement for the National Center for Benefits Outreach and Enrollment

ACTION: Announcing the Intent to Award a Single-Source Supplement for the National Center for Benefits Outreach and Enrollment (NCBOE).

SUMMARY: The Administration for Community Living (ACL) announces the intent to award a single-source supplemental to the current cooperative agreement held by the National Council on Aging (NCOA) for the National Center for Benefits Outreach and Enrollment (NCBOE). The purpose of the NCBOE is to provide technical assistance to states, Area Agencies on Aging, Aging and Disability Resource Centers and service providers who conduct outreach and low-income benefits enrollment assistance, particularly to older individuals with greatest economic need for federal and state programs. The administrative supplement for FY 2021 will be for $3,009,007, bringing the total award for FY 2021 to $14,509,007.

FOR FURTHER INFORMATION CONTACT: For further information or comments regarding this program supplement, contact Margaret Flowers, U.S. Department of Health and Human Services, Administration for Community Living, Center for Integrated Programs, Office of Healthcare Information and Counseling; telephone (202) 795–7315; email *Margaret.flowers@acl.hhs.gov.*

SUPPLEMENTARY INFORMATION: This supplemental funding will expand the NCBOE's outreach and education efforts targeting older adults with the greatest economic need, especially people from underserved communities. The NCBOE will build on current efforts to reach and assist beneficiaries, including expanding the work of the Benefits Enrollment Centers, making enhancements to the benefits eligibility and screening tool, and expanding the capacity of the benefits call center. As part of this work, the NCBOE should consider specific strategies to reach and enroll beneficiaries in rural communities, who are under 65, with limited English proficiency, from tribal communities, from communities of color, and/or from other historically underserved and marginalized communities. In its role as the Medicare Improvements for Patients and Providers Act (MIPPA) Resource Center, the NCBOE should expand their support for the MIPPA grantees to develop technical assistance materials for the Older Americans Act Title VI Tribal grantees. Materials may include educational content on Medicare and the Indian Health Service, and training on enrollment assistance for low income beneficiaries. Additionally, the NCBOE should build on the work previously done to support the aging and disability networks (including the Area Agencies on Aging, Centers for Independent Living, and Aging and Disability