

AG, 2255 Glades Rd., Suite 324A, Boca Raton, FL 33431. Before FDA withdrew the approval of these ANDAs, Masuu Global Solutions LLC, U.S. Agent for Extrovis AG, informed FDA that they did not want the approval of the ANDAs withdrawn. Because Masuu Global Solutions LLC, U.S. Agent for Extrovis AG, timely requested that approval of their ANDAs not be withdrawn, the approvals are still in effect. This notice corrects that error.

FOR FURTHER INFORMATION CONTACT: Martha Nguyen, Center for Drug Evaluation and Research, Food and Drug Administration, 10903 New Hampshire Ave., Bldg. 75, Rm. 1676, Silver Spring, MD 20993–0002, 301–796–3471, Martha.Nguyen@fda.hhs.gov.

SUPPLEMENTARY INFORMATION: In the **Federal Register** of Friday, February 20, 2026 (91 FR 8242), appearing on page 8242 in FR Doc. 2026–03411, the following correction is made:

On page 8243, in the table, the entries for ANDA 078022 and ANDA 090665 are removed.

Grace R. Graham,

Deputy Commissioner for Policy, Legislation, and International Affairs.

[FR Doc. 2026–12044 Filed 6–15–26; 8:45 am]

BILLING CODE 4164–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Agency Information Collection Activities: Submission to OMB for Review and Approval; Public Comment Request; Health Resources and Services Administration Uniform Data System

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

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act of 1995, HRSA submitted an Information Collection Request (ICR) to the Office of Management and Budget (OMB) for review and approval. Comments submitted during the first public review of this ICR will be provided to OMB. OMB will accept further comments from the public during the review and approval period. OMB may act on HRSA's ICR only after the 30-day comment period for this notice has closed.

DATES: Comments on this ICR should be received no later than July 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 Review—Open for Public Comments” or by using the search function.

FOR FURTHER INFORMATION CONTACT: To request a copy of the clearance requests submitted to OMB for review, email Samantha Miller, the HRSA Information Collection Clearance Officer, at paperwork@hrsa.gov or call (301) 443–3983.

SUPPLEMENTARY INFORMATION: *Information Collection Request Title:* Health Resources and Services Administration Uniform Data System, OMB No. 0915–0193—Revision.

Abstract: The Health Center Program, administered by HRSA, is authorized under section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b). Health centers are community-based and patient-directed organizations that deliver affordable, accessible, quality, and cost-effective primary health care services to patients on a sliding fee based on income and family size. Nearly 1,400 health centers operate more than 16,200 service delivery sites that provide primary health care to over 32 million people in every U.S. state, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin.

HRSA uses the Uniform Data System (UDS) for required annual reporting of program-specific data by Health Center Program awardees (those funded under section 330 of the PHS Act), Health Center Program look-alikes (entities meeting requirements of, but not funded under, section 330 of the PHS Act), and Nurse Education, Practice, Quality and Retention (NEPQR) and Advanced Nursing Education (ANE) Program awardees (specifically those funded under the practice priority areas of sections 831(b) and 811 of the PHS Act).

Some NEPQR and ANE Program awardees establish and expand nursing practice arrangements in non-institutional settings to demonstrate methods to improve access to primary health care in medically underserved communities. Nursing grantees implementing nursing practice arrangements have historically used the same data collection system as the Health Center Program.

A 60-day notice published in the **Federal Register** on December 10, 2025, vol. 90, No. 235; pp. 57205–57208. There were 16 public comments. Below

is a summary of key themes raised in the comments and HRSA's responses:

- *Maintain COVID-related measures (Two comments):*

- Stakeholders recommended reconsideration of the proposed removal of several COVID-related measures in *Table 6A: Selected Diagnoses and Services Rendered*, including *Respiratory conditions related to COVID–19*, *Long COVID*, *Novel coronavirus (SARS-CoV–2) disease*, *Novel coronavirus (SARS-CoV–2) diagnostic test*, and *Novel coronavirus (SARS-CoV–2) antibody test*, emphasizing the importance of continued tracking for surveillance, resource allocation, and monitoring impacts on special medically underserved populations. Of the five COVID-related measures currently included in the 2025 UDS, HRSA will retain two measures in response to stakeholder feedback, while three measures will be removed as part of broader streamlining efforts.

- *Recognize Psychiatric Mental Health Nurse Practitioners (PMHNP) distinctly (One comment):*

- One stakeholder requested to specify PMHNPs separately in *Table 5: Staffing and Utilization* due to their significant role in delivering mental health services and managing high patient volume. In response to this feedback, PMHNPs will be added to *Table 5*, line 20b, under *Other Licensed Mental Health Providers*.

- *Include additional case management codes (Two comments):*

- Commenters also requested enhancements to the Case Management codes under *Table 6A: Patient Support Services* to include Advance Primary Care Management codes (G0556, G0557, G0558) and T1016, to capture broader case management services beyond Medicare. Based on stakeholder feedback, these codes will be added to *Table 6A*, line 35, *Case Management*.

- *Adjust Substance Use Disorder Initiation/Engagement electronic clinical quality measure (eCQM) for health center realities (Two comments):*

- Commenters recommended reconsideration of the substance use disorder (SUD) measure, *Initiation and Engagement of SUD Treatment*, which was introduced in the 2025 UDS instrument. Stakeholders noted that the current eCQM does not align with health center data capabilities, resulting in misclassification of ongoing SUD treatment and understated health center performance. Commenters specifically

noted the reporting challenges with the measure's definition of a "new SUD episode," which does not account for care received outside the health center and may inadvertently include patients in the denominator. Commenters also expressed that due to scope-of-practice limitations and operational challenges, there may be constraints in meeting the initiation and engagement timeframes outlined in the measure.

As 2025 was the first year of implementation for the SUD eCQM, HRSA recognizes that health centers may require time to fully operationalize workflows and reporting processes. HRSA will continue to provide technical assistance, monitor implementation, and assess the measure's ongoing relevance as additional data becomes available. Regarding proposed changes to the specifications for a measure, reporting specifications are set by the measure steward and cannot be modified. Measure stewards for each UDS clinical quality measure are listed in Appendix G of the forthcoming 2026 UDS Manual, which HRSA plans to release in summer 2026.

• *General objection to proposed changes (One comment):*

- One commenter expressed the need for transparency regarding the rationale for proposed measurement changes. HRSA maintains open communication channels (e.g., all-programs webcasts, newsletters, tailored technical assistance calls) and will continue to provide technical assistance on UDS reporting to ensure stakeholders understand the rationale and best practices for implementing UDS instrument changes.

• *Support for overall UDS streamlining/burden reduction (Six comments):*

- Commenters conveyed broad approval and support for HRSA's proposed measurement alignment, elimination, and simplification efforts, noting that these changes are expected to meaningfully reduce administrative reporting burden.

• *Consideration regarding mental health and substance use disorder tracking (Three comments):*

- In response to the proposed removal of Table 5: *Selected Services Detail Addendum*, stakeholders requested that the decision be reconsidered, noting potential underreporting of integrated mental health and substance use disorder services that are delivered by non-psychiatric and non-licensed professional counselor

providers. Additionally, stakeholders expressed that the removal of the *Selected Services Detail Addendum* would impair accurate performance assessment and collaborative care tracking. HRSA maintains that the measures in this section are not used to assess compliance with grant performance requirements, and related reporting in the main part of Table 5 would remain unchanged. Given areas of duplication, HRSA is exploring ways to capture unduplicated data on integrated care for a future iteration of the UDS instrument.

• *Patient support services and upstream drivers of health reporting implications: (Two comments):*

- Commenters applauded the transition of patient support services and upstream drivers of health measures from the appendices to Table 6A: *Selected Services and Diagnosis Rendered* but identified potential challenges of these additions if certified health information technology cannot automate extraction, leading to an increase in administrative and operational burden. As with any new reporting requirement, HRSA anticipates an initial transition period and will continue to provide technical assistance and guidance to support implementation. HRSA will monitor early reporting experience to assess burden and inform future refinements in 2027.

• *Lifestyle Medicine proposals (One comment):*

- One commenter recommended incorporating lifestyle measures into the UDS instrument to strengthen preventative care and whole-person health. The stakeholder specifically proposed a variety of related measures reflecting upstream risks and outcomes, standardized lifestyle medicine assessments, Type 2 diabetes remission, deprescribing outcomes, and community support. HRSA appreciates the thoughtful suggestion and will evaluate these recommendations for alignment with Administration and HRSA priorities for a future UDS instrument.

• *Financial and Service Reporting Transparency (Two comments):*

- Commenters requested reconsideration of the removal of grant-level reporting in Table 9E: Other Revenue and the consolidation of line items in Table 8A: Financial Costs. Commenters noted that maintaining grant-level reporting is necessary to promote transparency

and accountability by demonstrating how federal resources are used to support health centers. Further, it was noted that the proposed consolidation and removal of Table 8A line items will reduce visibility into critical health center services. HRSA notes that these removals reflect an effort to reduce reporting burden by modernizing and streamlining the instrument and eliminating redundancies where comparable data may be collected in other grant financial reporting forms, including Health Center Program Forms (OMB No. 0915-0285-Revision).

• *Desire to retain multiple Table 6A clinical measures (One comment):*

- One stakeholder expressed a desire to retain several Table 6A: *Selected Diagnoses and Services Rendered* measures, including abnormal breast cancer and cervical cancer findings, contact dermatitis and other eczema, mammograms, Pap tests, sealants, and oral surgery. HRSA is removing these measures from Table 6A due to redundancies where similar information is captured elsewhere in the UDS instrument. For example, the abnormal breast cancer findings measure is also similarly reflected in Table 6B's Breast Cancer Screening measure (CMS125v13).¹

• *Clarifications on Tables 8A/9D/9E (Three comments):*

- Commenters also expressed the need for additional reporting guidance clarification across multiple tables, including tables 8A, 9D, and 9E, particularly related to managed care dynamics, including treatment of insured patient copays in payer mix. HRSA will provide detailed reporting instructions for the relevant tables, consistent with standard practice, in the forthcoming 2026 UDS Manual release, which HRSA plans to release in summer 2026.

Need and Proposed Use of the Information: HRSA requires the collection of information through UDS to monitor and evaluate the performance of health centers under section 330 and select NEPQR and ANE recipients under sections 831(b) and 811 of the PHS Act. These data support program compliance, inform quality improvement initiatives, guide the delivery of technical assistance, and shape federal health program decisions. To keep this instrument relevant and

¹ eCQI Resource Center. (2025). *Breast cancer screening (CMS125v13)*. U.S. Department of Health and Human Services, Office of the National Coordinator for Health Information Technology. <https://ecqi.healthit.gov/ecqm/ec/2025/cms0125v13>.

responsive to the Health Center Program's needs and Administration priorities, periodic updates are essential. This includes adjustments to the proposed measures made during the internal HRSA review and approval process used to finalize the proposed measures for submission to OMB. The purpose of these updates is to capture the breadth of integrated primary care services offered by health centers. Measures that were added during the internal HRSA review and approval process are signified by an asterisk (*) in the list below.

HRSA proposes to make the following updates for the performance year 2026 UDS data collection (note: measures to be removed refer to the line in the 2025 UDS):

Table 4: Selected Patient Characteristics

Removal

- *Managed Care Utilization*—UDS measures associated with managed care member months, *Capitated Member Months*, *Fee-for-Service Member Months*, and *Total Member Months* (Lines 13a—13c) will be removed to reduce the reporting burden, given the variations in payer structures and payment arrangements across health centers.

Table 5: Staffing and Utilization and Selected Service Detail Addendum *

Removal

- *Selected Service Detail Addendum*—Detailed reporting elements related to integrated mental health and substance use disorder service delivery (Lines 20a01—21h) will be removed to streamline reporting and reduce burden on health centers. Mental health and substance use disorder services will continue to be reported in the core part of Table 5.

Addition

- *Staffing and Utilization*—Specific mental health personnel types, including PMHNPs, will be added as drop-down options to Line 20b, *Other Licensed Mental Health Providers*. This addition will allow for more accurate classification of licensed mental health providers and better reflect the composition of the behavioral health workforce.

Table 6A: Selected Diagnoses and Services Rendered

Removals

- *Various Clinical Measures*—Clinical measures associated with various diagnoses and selected services rendered are being removed from Table

6A to streamline reporting, reduce burden, and eliminate potential redundancies where similar information is captured elsewhere in the UDS. The specific measures proposed for removal are indicated below:

- Respiratory conditions related to COVID-19 (Line 6a)
- Abnormal breast findings, female (Line 7)
- Abnormal cervical findings (Line 8)
- Contact dermatitis and other eczema (Line 12)
- Novel coronavirus (SARS-CoV-2) diagnostic test (Line 21c)
- Novel coronavirus (SARS-CoV-2) antibody test (Line 21d)
- Mammogram (Line 22)
- Pap test (Line 23)
- Sealants (Line 30)
- Oral surgery (extractions and other surgical procedures) (Line 33)
- Rehabilitative services (Endo, Perio, Prostho, Ortho) (Line 34)

As mentioned above, because of feedback received during the 60-day comment period, HRSA added “Novel coronavirus (SARS-CoV-2) disease (Line 4c)” and “Long COVID (Line 4d)” back into Table 6A.

Additions

- *Type 1 Diabetes*—A new measure is being added as line 9a to identify the number of patients with Type 1 Diabetes. This addition will help address key data gaps and improve HRSA's understanding of the distinct care and resource needs of patients with Type 1 Diabetes.

- *Intellectual and Developmental Disabilities*—A new measure is being added as line 20g to capture the number of patients with intellectual and developmental disabilities. Available data indicate that this population may experience lower rates of access to preventive and chronic care, including fewer screenings, lower utilization of dental care, and higher rates of undiagnosed or unmanaged conditions. Capturing this information will improve understanding of the prevalence of persons with intellectual and developmental disabilities in the Health Center Program and support efforts to enhance health care access and quality of care for individuals who require complex, coordinated services.

- *Autism Spectrum Disorder Screening*—A new measure is being added as line 26g to capture the number of patients screened for autism spectrum disorder. This measure will help assess the extent to which health centers are implementing recommended developmental screening practices and connecting children and families to needed support services.

- *Patient Support Services*—Four new measures are being added as lines 35–38 to capture the number of patients receiving case management, eligibility assistance, transportation, and language assistance services to better understand the range of non-clinical services that facilitate access to care and contribute to improved patient outcomes.

- *Upstream Drivers of Health*—Four new measures are being added as lines 39–42, transitioning from Appendix D to the UDS core tables, to identify the number of patients who are screened for, and who receive, services addressing upstream drivers of health. These or similar measures are now being elevated to the core reporting set to support standardized data collection. Integrating these measures within the core tables will enhance the ability to monitor how health centers identify and address patients' access to and utilization of services.

Table 6B: Quality of Care Measures *

Additions

- *Fall Risk Screenings*—One new measure is being added as line 24 to capture the number of patients 65 years of age and older who were screened for future fall risk, in alignment with eCQM CMS139v14.² Incorporating a fall risk screening measure aligns the UDS with national quality and preventive care efforts, including routine fall risk assessments conducted during Medicare Initial and Annual Wellness Visits.³ This alignment supports harmonization across federal programs, enables HRSA to better understand the needs and resources required to support the growing aging population served by the Health Center Program and inform technical assistance for health centers.

Table 6B: Quality of Care Measures and Table 7: Health Outcomes

Updates

- *Clinical Quality Measures*—Tables 6B and 7 collect UDS clinical quality measures, and where applicable, clinical quality measures will be updated in alignment with specifications of the issued performance year 2026 electronic clinical quality measures. These specifications were

² eCQI Resource Center. (2026). *Falls: Screening for future fall risk (CMS0139v14)*. U.S. Department of Health and Human Services, Office of the National Coordinator for Health Information Technology. <https://ecqi.healthit.gov/ecqm/ec/2026/cms0139v14>.

³ Centers for Medicare & Medicaid Services. (2026). *Initial preventive physical exam*. U.S. Department of Health and Human Services. <https://www.cms.gov/medicare/coverage/preventive-services/medicare-wellness-visits/initial-preventive-physical-exam>.

released by the Centers for Medicare & Medicaid Services on May 8, 2025, for use by eligible providers. Aligning clinical performance measures across national programs promotes data standardization, quality, and transparency, and decreases the reporting burden for providers and organizations participating in multiple federal programs.

Table 8A: Financial Costs

Removals

- *Allocation of Facility and Non-Clinical Support Services—Allocation of Facility and Non-Clinical Support Services*, Column B, and the requirement to report overhead costs on Table 8A will be removed.

- *Enabling Services*—Costs of each type of enabling service (Lines 11a, 11b, 11c, 11d, 11e, 11f, 11g, and 11h) will be removed. These costs will be consolidated into a single line to reflect all *Patient Support Services* costs (Line 11) (previously known as Enabling Services).

- *Donations*—Line 18, *Value of Donated Facilities, Services, and Supplies (specify)*, will be removed.

These updates are being made to reduce the reporting burden and address stakeholder feedback.

Table 9D: Accrued Patient Service Revenue

Removals

- *Retroactive Settlements, Receipts, and Paybacks*—revenue associated with Columns c1—c4 for classification of types of collections will be removed:

- Collection of Reconciliation/ Wraparound Current Year (c1)
- Collection of Reconciliation/ Wraparound Previous Years (c2)
- Collection of Other Payments: Pay for Performance, Risk Pools, etc. (c3)
- Penalty/Payback (c4)

These collections will be consolidated into a single column to reflect all Collections (Column B).

- *Payer Category*—Form of payment (non-managed care, capitated managed care, and fee-for-service managed care) lines have been collapsed into a single total line by the third-party payer. *Total Medicaid* (Line 3), *Total Medicare* (Line 6), *Total Other Public (specify)* (Line 9), and *Total Private* (Line 12) will be reported, and the following lines will be removed as a result:

- Medicaid Non-Managed Care (Line 1)
- Medicaid Managed Care (capitated) (Line 2a)
- Medicaid Managed Care (fee-for-service) (Line 2b)
- Medicare Non-Managed Care (Line 4)

- Medicare Managed Care (capitated) (Line 5a)
- Medicare Managed Care (fee-for-service) (Line 5b)
- Other Public, including Non-Medicaid Children's Health Insurance Program (CHIP), Non-Managed Care (Line 7)
- Other Public, including Non-Medicaid CHIP, Managed Care (capitated) (Line 8a)
- Other Public, including Non-Medicaid CHIP, Managed Care (fee-for-service) (Line 8b)
- Private Non-Managed Care (Line 10)
- Private Managed Care (capitated) (Line 11a)
- Private Managed Care (fee-for-service) (Line 11b)

- *Sliding Fee **—Sliding fee associated with Line 13, Column E for classification of sliding fee discounts provided to patients has been collapsed into the existing single total Self-Pay line (Line 13) and will be reported as Adjustments (Column D).

- *Patient Bad Debt **—Bad debt write-off associated with patients previously reported in Line 13, Column F has been removed and will be reported with all third-party payer bad debt write-offs and allowances (Line 15, Column G).

These updates are being made to reduce the reporting burden and address stakeholder feedback.

Additions

- *Bad Debt Write-Offs and Allowances **—A new line will be added as an offset to *Net Patient Service Revenue* for accrued *Bad Debt Write-Offs and Allowances* (Line 15, Column G).

- *Net Patient Services Revenue*—A new column and line will be added for *Net Patient Service Revenue (Charges Less Adjustments)* (Line 16, Column G).

- *Pharmacy Net Patient Service Revenue*—A new line will be added to reflect all *Pharmacy Net Patient Service Revenue* (Line 17, Column G).

- *Third-Party Incentive Revenue*—A new line will be added to reflect all *Third-Party Incentive Revenue* (Line 18, Column G).

These updates are being made to reduce reporting burden and to better assess financials in alignment with generally accepted accounting principles and health centers' financial statements.

Table 9E: Other Accrued Revenue

Removals

- *HRSA's Bureau of Primary Health Care (BPHC) Grants*—Health Center Program grant funding sources (formerly Lines 1a—1e) and other BPHC funding

detail lines (formerly Lines 1k—1q) will be removed. Grants with active funding will be aggregated and reported on a single, total line: *Total Health Center BPHC Grants* (Line 1).

- *Other Federal Grants*—Specific federal grant funding sources (formerly Lines 2, 3, and 3a) will be removed. All non-BPHC federal grants will be reported on Line 5, *Total Other Federal Grants (specify)*.

These updates are being made to align with supplemental funding being rolled into the base Health Center Program funding, remove outdated supplemental funding lines, reduce the reporting burden, and to better assess financials in alignment with generally accepted accounting principles and health centers' financial statements.

Appendix D: Health Center Information Technology (Health IT) Capabilities and Appendix E: Other Data Elements

Removals

- *Appendix D: Health IT Capabilities*—Several questions specific to Electronic Health Records implementation (Questions 1a, 1a2, 1a3, 1c, 1c1, and 10) will be removed from Appendix D.

- *Appendix D: Health IT Capabilities*—Upstream drivers of health screening questions (Questions 11, 11a, 12, 12a, and 12b) will be removed from Appendix D.

- *Appendix E: Other Data Elements*—Appendix E will be removed, and certain data elements will be combined with Appendix D. Outreach and enrollment assists (formerly Appendix E, Question 3) will be removed (aspects will be incorporated in the Table 6A Patient Support Services addition).

These updates are being made to reduce the reporting burden and address stakeholder feedback.

Additions

- *Appendix D: Health Center IT Capabilities and Other Data Elements*—Three questions on Alternative Payment Models (APM) will be added to Appendix D (Questions 17—19), to include:

- What payor arrangements do you have for value-based purchasing contracts?
- Please list the types of APMs your health center is involved in.
- What percentage of your health center's revenue during the year is tied to value-based payment contracts?

HRSA is adding new data elements to capture health centers' participation in APMs to improve understanding of the evolving payment landscape within the Health Center Program. As health centers increasingly engage in payment arrangements that emphasize value, care coordination, and outcomes, collecting information on APM participation will provide valuable insight into the range and scope of these models and inform technical assistance to support health centers' adoption of APMs.

- *Appendix D: Health IT Capabilities **—One question addressing the provision of sex rejecting services and procedures in health

centers will be added to Appendix D (Question 20), to include:

- For individuals under 19 years of age, does your health center provide services that use puberty blockers, sex hormones, or surgical procedures for the purpose of transforming their physical appearance to align with an identity that differs from their sex? *Puberty blockers may include GnRH agonists and other interventions, to delay the onset or progression of normally timed puberty in an individual. Sex hormones may include androgen blockers, estrogen, progesterone, or testosterone. Surgical procedures may include alteration or removal of an individual's sex organs.*

HRSA is making these updates to Appendix D based on internal agency review and approval processes to capture the breadth of integrated primary care services offered by health centers.

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.

In 2026, the estimated total burden hours for this ICR are approximately 304,616 hours, compared to 2025, when the burden was estimated at 377,317 hours—a decrease of approximately 72,701 hours collectively across health centers or an average of 42 hours per health center. This decrease is primarily attributable to HRSA's streamlining efforts, which were undertaken to reduce provider burden.

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 ours)	Total burden hours
UDS—Universal Report	1,596.00	1.00	1,596.00	184.20	293,983.20
UDS Grant Report	419.00	1.22	511.18	20.80	10,632.54
Total	2,015.00		2,107.18		304,615.74

* The estimated number of respondents for the Universal Report consists of 1,356 Health Center Program recipients, 170 Health Center Look-alikes, and 70 NEPQR and ANE recipients. The estimated number of respondents for the “Grant Report” is based on the number of reports submitted by health centers in 2025: 337 (one report), 71 (two reports), 11 (three reports).

Amy P. McNulty,
Deputy Director, Executive Secretariat.
[FR Doc. 2026–12046 Filed 6–15–26; 8:45 am]
BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Announcement of Solicitation of Written Comments on Proposed Healthy People 2030 Objectives and Request for Information on Screen Time To Inform Healthy People

AGENCY: Office of Disease Prevention and Health Promotion, Office of the Assistant Secretary of Health, Office of the Secretary, Department of Health and Human Services.

ACTION: Notice.

SUMMARY: The U.S. Department of Health and Human Services (HHS), Office of Disease Prevention and Health Promotion (ODPHP) solicits written comments from the public on new objectives to be added to Healthy People 2030 and gather input to refine or expand the existing screen time objectives.

DATES: Written comments will be accepted through 11:59 p.m. ET, July 16, 2026.

ADDRESSES: Written comments should be submitted by email to HP2030Comment@hhs.gov.

FOR FURTHER INFORMATION CONTACT: Yen Lin, Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services, 1101 Wootton Parkway, Suite 420, Rockville, MD 20852; Email: HP2030@hhs.gov.

SUPPLEMENTARY INFORMATION: Since 1980, Healthy People has provided science-based, measurable 10-year objectives to improve the nation’s health and well-being, established national priorities, and monitored progress throughout each subsequent decade. Shaped by input from individuals and organizations across all sectors and all levels of government, Healthy People solicits annual public comment to reflect current public health priorities.

ODPHP seeks written public comments on three new objectives to be added to Healthy People 2030. These new objectives were developed by federal Healthy People topic area workgroup agencies and have been reviewed by the Healthy People 2030 Federal Interagency Workgroup (FIW). They are:

1. *Access to Health Services (New Objective–10):* Reduce the proportion of persons who are unable to obtain or who delay obtaining mental health care due to cost. Data source: National Health Interview Survey, Centers for Disease Control and Prevention/ National Center for Health Statistics.
2. *Early and Middle Childhood (New Objective–05):* Increase the proportion of children who are developmentally ‘on

track’ and healthy and ready to learn at school. Data source: National Survey of Children’s Health, Health Resources and Services Administration/Maternal and Child Health Bureau.

3. *Social Determinants of Health (New Research Objective–03):* Explore the impact of referrals to non-clinical activities (e.g., art, music, movement, nature, and community service) on improving health outcomes. Data source: No known reliable national data source is currently available.

Note: Research objectives highlight critical emerging public health issues that lack the research or reliable national data needed to establish 10-year targets.

Recently, HHS released the Surgeon General’s Advisory on the Harms of Screen Use which warns of adverse health outcomes associated with screen time. Concerns at various age groups are discussed, beginning with exposure in young children through teenage years, and highlighting concerns with mental, cognitive, and behavioral health. Given the information cited in the advisory, ODPHP is seeking public comments to refine or expand two existing Healthy People 2030 objectives:

1. *Physical Activity–13:* Increase the proportion of children aged 2 to 5 years who get no more than 1 hour of screen time a day. Data Source: National Survey of Children’s Health, Health Resources and Services Administration.