posted on the website for the PACCARB at *http://www.hhs.gov/paccarb* when this information becomes available.

ADDRESSES: The meeting will be held virtually at *www.hhs.gov/live.*

FOR FURTHER INFORMATION CONTACT: Sarah Mcclelland, M.P.H., Designated Federal Officer, Presidential Advisory Council on Combating Antibiotic-Resistant Bacteria, Office of the Assistant Secretary for Health, U.S. Department of Health and Human Services, Email: *CARB@hhs.gov.*

SUPPLEMENTARY INFORMATION: The Presidential Advisory Council on Combating Antibiotic-Resistant Bacteria (PACCARB), established by Executive Order 13676, is continued by Section 505 of Public Law 116–22, the Pandemic and All-Hazards Preparedness and Advancing Innovation Act of 2019 (PAHPAIA). Activities and duties of the PACCARB are governed by the provisions of the Federal Advisory Committee Act (FACA), Public Law 92–463, as amended (5 U.S.C. App.), which sets forth standards for the formation and use of federal advisory committees.

The PACCARB shall advise and provide information and recommendations to the Secretary of Health and Human Services (Secretary) regarding programs and policies intended to reduce or combat antibiotic-resistant bacteria that may present a public health threat and improve capabilities to prevent, diagnose, mitigate, or treat such resistance. The PACCARB shall function solely for advisory purposes.

Such advice, information, and recommendations may be related to improving: the effectiveness of antibiotics; research and advanced research on, and the development of, improved and innovative methods for combating or reducing antibiotic resistance, including new treatments, rapid point-of-care diagnostics, alternatives to antibiotics, including alternatives to animal antibiotics, and antimicrobial stewardship activities; surveillance of antibiotic-resistant bacterial infections, including publicly available and up-to-date information on resistance to antibiotics; education for health care providers and the public with respect to up-to-date information on antibiotic resistance and ways to reduce or combat such resistance to antibiotics related to humans and animals; methods to prevent or reduce the transmission of antibiotic-resistant bacterial infections; including stewardship programs; and coordination with respect to international efforts in order to inform and advance the United States capabilities to combat antibiotic resistance.

The focus of the December 2, 2026, meeting will assess the current State of the Threat that antimicrobial resistance possesses. It will include presentations, review, and analysis of recently released data and reports from the Centers for Disease Control (CDC), the American Veterinary Medical Association (AVMA), the Food and Drug Administration (FDA), and HHS. Written public comments can be emailed to *CARB@hhs.gov* by midnight December 30, 2026, and should be limited to no more than one page. All public comments received prior to December 30, 2026, will be provided to the subcommittee members.

Sarah Mcclelland,

Designated Federal Officer, Presidential Advisory Council on Combating Antibiotic-Resistant Bacteria, Office of the Assistant Secretary for Health.

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BILLING CODE 4150–44–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2027, Through September 30, 2028

AGENCY: Office of the Secretary, HHS.

ACTION: Notice.

SUMMARY: The Federal Medical Assistance Percentages (FMAP) and Enhanced Federal Medical Assistance Percentages (eFMAP) for fiscal year 2028 have been calculated pursuant to the Social Security Act (the Act). These percentages will be effective from October 1, 2027, through September 30, 2028. This notice announces the calculated FMAP rates, in accordance with the Act, that the U.S. Department of Health and Human Services (HHS) will use in determining the amount of Federal matching for State medical assistance (Medicaid), Temporary Assistance for Needy Families (TANF) Contingency Funds, Child Support collections, Child Care Mandatory and Matching Funds of the Child Care and Development Fund, Title IV–E Foster Care Maintenance payments, Adoption Assistance payments and Kinship Guardianship Assistance payments, and the eFMAP rates for the Children's Health Insurance Program (CHIP) expenditures. Table 1 gives figures for each of the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands. This notice reminds states of adjustments available for states meeting requirements for disproportionate employer pension or insurance fund contributions and adjustments for disaster recovery. At this time, no state qualifies for such adjustments, and territories are not eligible.

DATES: The percentages listed in Table 1 will be effective for each of the four quarter-year periods beginning October 1, 2027, and ending September 30, 2028.

FOR FURTHER INFORMATION CONTACT: Amelia Whitman, Office of Health Policy, Office of the Assistant Secretary for Planning and Evaluation, Room 447D—Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, DC 20201, (202) 578–1478.

SUPPLEMENTARY INFORMATION: The Secretary of HHS manages programs under titles IV, XIX and XXI of the Act in each jurisdiction of the United States. Programs under titles I, X, and XIV of the Act operate only in Guam and the Virgin Islands, and a program under title XVI of the Act (Aid to the Aged, Blind, or Disabled) operates only in Puerto Rico. The percentages in this notice apply to State expenditures for most medical assistance and child health assistance, and assistance payments for certain social services provided under these titles. The Act provides separate terms for Federal matching of administrative costs.

Sections 1905(b) and 1101(a)(8)(B) of the Act require the Secretary of HHS to publish the FMAP rates each year. The Secretary calculates the percentages, using formulas set out in sections 1905(b) and 1101(a)(8), and calculations from the Department of Commerce of average income per person in each State and for the United States (meaning, for this purpose, the fifty states). The final percentages are subject to upper and lower limits specified in section 1905(b) of the Act. The percentages for the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands are specified in statute, and thus are not based on the statutory formula that determines the percentages for the 50 states.

Federal Medical Assistance Percentage

Section 1905(b) of the Act, subject to statutory qualifications, specifies the formula for calculating FMAPs as follows:

''[T]he term 'Federal medical assistance percentage' for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum[.]''

Section 1905(b) further specifies that the FMAP for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be 55 percent. However, section 5101(b) of Division FF of the Consolidated Appropriations Act, 2023 (Pub. L. 117–328) amended section 1905(ff) of the Act to provide that the FMAP for the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be 83 percent permanently. We note that the Consolidated Appropriations Act, 2023 also amended section 1905(ff) of the Act to provide that the FMAP for Puerto Rico shall be 76 percent through September 30, 2027. Beginning October 1, 2027, the FMAP for Puerto Rico will be 55 percent under section 1905(b)(2) of the Act. In addition, we note that the rate that applies for Puerto Rico, the Virgin Islands, and Guam in certain other programs pursuant to section 1118 of the Act is 75 percent. Section 4725(b) of the Balanced Budget Act of 1997 (Pub. L. 105–33) amended section 1905(b) to provide that the FMAP for the District of Columbia, for purposes of titles XIX and XXI, shall be 70 percent. For the District of Columbia, we note under Table 1 that other rates may apply in certain other programs. The rates for the states, the District of Columbia, and the territories are set out in Table 1, Column 1.

Section 1905(y) of the Act, as added by section 2001(a)(3) of the Patient Protection and Affordable Care Act (''Affordable Care Act'') (Pub. L. 111–148), provides for an increase in the FMAP for medical assistance expenditures for newly eligible individuals described in section 1902(a)(10)(A)(i)(VIII) of the Act, as added by the Affordable Care Act (the adult group); ''newly eligible'' is defined in section 1905(y)(2)(A) of the Act. The FMAP for the adult group is 100 percent for Calendar Years 2014, 2015, and 2016, gradually declining to 90 percent for calendar quarters in 2020 and each year thereafter.[1] In addition, section 1905(z) of the Act, as added by section 10201 of the Affordable Care Act, provides that states that offered substantial health coverage to certain low-income parents and nonpregnant, childless adults on the date of enactment of the Affordable Care Act, referred to as ''expansion states,'' shall receive an enhanced FMAP beginning in 2014 for medical assistance expenditures for nonpregnant childless adults who may be required to enroll in benchmark coverage under section 1937 of the Act. Some of these provisions are discussed in more detail in the proposed rule, ''Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010,'' published on August 17, 2011 (76 FR 51148, 51172) and the final rule and interim final rule published on March 23, 2012 (77 FR 17144, 17194). This notice does not set forth the matching rates for the adult group as specified in section 1905(y) of the Act or the matching rates for nonpregnant, childless adults in expansion states as specified in section 1905(z) of the Act.

Other Adjustments to the FMAP

For purposes of title XIX (Medicaid) of the Act, the FMAP, defined in section 1905(b) of the Act, for each State beginning with fiscal year 2006, may be subject to an adjustment pursuant to section 614 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law 111–3.

First, the FMAP is adjusted if a State experiences no growth or positive growth in total personal income and an employer in that State has made a significantly disproportionate contribution to an employer pension or insurance fund. The adjustment involves disregarding the significantly disproportionate employer pension or insurance fund contribution in computing the per capita income for the State (but not in computing the per capita income for the United States). Employer pension and insurance fund contributions are significantly disproportionate if the increase in contributions exceeds 25 percent of the total increase in personal income in that State. A **Federal Register** Notice with comment period was published on June 7, 2010 (75 FR 32182) announcing the methodology for calculating this adjustment; a final notice was published on October 15, 2010 (75 FR 63480).

The second situation arises if a State experiences negative growth in total personal income. Beginning with fiscal year 2006, section 614(b)(3) of CHIPRA specifies that, for the purposes of calculating the FMAP for a calendar year in which a State's total personal income has declined, the portion of an employer pension or insurance fund contribution that exceeds 125 percent of the amount of such contribution in the previous calendar year shall be disregarded in computing the per capita income for the State (but not in computing the per capita income for the United States).

No Federal source of reliable and timely data on pension and insurance contributions by individual employers and states is currently available. We request that states report employer pension or insurance fund contributions to help determine potential FMAP adjustments for states experiencing significantly disproportionate pension or insurance contributions and states experiencing a negative growth in total personal income. See also the information described in the January 21, 2014 **Federal Register** notice (79 FR 3385).

Section 1905(aa) of the Act, as amended by section 2006 of the Affordable Care Act, specifies that notwithstanding section 1905(b) of the Act, the FMAP for a ''disaster-recovery FMAP adjustment State'' is adjusted as described in section 1905(aa)(1) of the Act. The statute defines a ''disaster-recovery FMAP adjustment State'' as one of the 50 states or District of Columbia for which, at any time during the preceding 7 fiscal years, the President has declared a major disaster under section 401 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, under which every county or parish in the State warrant individual and public assistance or public assistance from the Federal Government, and for which the regular FMAP [2] as determined for succeeding fiscal years is less than the FMAP for the preceding fiscal year by an amount outlined under sections 1905(aa)(2)(A) and (aa)(2)(B) of the Act. This notice does not contain disaster recovery adjustments since no state qualifies as a ''disaster-recovery FMAP adjustment State.'' See more information described in the December 22, 2010 **Federal Register** notice (75 FR 80501).

[1] Section 1905(kk) of the Act, as added by section 71110 of Public Law 119–21, provides that, notwithstanding sections 1905(y) and (z), beginning October 1, 2026, the FMAP for payments for care and services described in section 1903(v)(2) furnished to an alien described in section 1903(v)(1) may not exceed the FMAP determined under section 1905(b).

[2] Section 1905(aa)(3) of the Act defines a State's ''regular FMAP'' to be the FMAP that would otherwise apply to the State for the fiscal year, as determined under section 1905(b) and without regard to section 1905(aa), (y), and (z), and section 10202 of the Affordable Care Act.

Enhanced Federal Medical Assistance Percentage (eFMAP) for CHIP

Section 2105(b) of the Act specifies the formula for calculating the eFMAP rates as follows:

[T]he ''enhanced FMAP'', for a State for a fiscal year, is equal to the Federal medical assistance percentage (as defined in the first sentence of section 1905(b)) for the State increased by a number of percentage points equal to 30 percent of the number of percentage points by which (1) such Federal medical assistance percentage for the State, is less than (2) 100 percent; but in no case shall the enhanced FMAP for a State exceed 85 percent.

The eFMAP rates are used in the Children's Health Insurance Program under title XXI and in the Medicaid program for expenditures for medical assistance provided to certain children as described in sections 1905(u)(2) and 1905(u)(3) of the Act. There is no specific requirement to publish the eFMAP rates. We include them in this notice for the convenience of the states (Table 1, Column 2).

(Catalog of Federal Domestic Assistance Program Nos. 93.558: TANF Contingency Funds; 93.563: Child Support Services; 93.596: Child Care Mandatory and Matching Funds of the Child Care and Development Fund; 93.658: Foster Care Title IV–E; 93.659: Adoption Assistance; 93.769: Ticket-to-Work and Work Incentives Improvement Act (TWWIIA) Demonstrations to Maintain Independence and Employment; 93.778: Medical Assistance Program; 93.767: Children's Health Insurance Program)

Robert F. Kennedy, Jr.,

Secretary, Department of Health and Human Services.

TABLE 1—FEDERAL MEDICAL ASSISTANCE PERCENTAGES AND ENHANCED FEDERAL MEDICAL ASSISTANCE PERCENTAGES, EFFECTIVE OCTOBER 1, 2027–SEPTEMBER 30, 2028

[Fiscal year 2028]

State	Federal medical assistance percentages	Enhanced federal medical assistance percentages
Alabama	72.81	80.97
Alaska	51.23	65.86
American Samoa *	83.00	85.00
Arizona	64.16	74.91
Arkansas	70.88	79.62
California	50.00	65.00
Colorado	50.00	65.00
Connecticut	50.00	65.00
Delaware	63.93	74.75
District of Columbia ***	70.00	79.00
Florida	53.56	67.49
Georgia	67.45	77.22
Guam *	83.00	85.00
Hawaii	56.91	69.84
Idaho	68.77	78.14
Illinois	52.54	66.78
Indiana	66.28	76.40
Iowa	64.95	75.47
Kansas	63.78	74.65
Kentucky	71.84	80.29
Louisiana	68.77	78.14
Maine	61.05	72.74
Maryland	50.00	65.00
Massachusetts	50.00	65.00
Michigan	65.75	76.03
Minnesota	52.96	67.07
Mississippi	77.62	84.33
Missouri	63.08	74.16
Montana	60.77	72.54
Nebraska	55.54	68.88
Nevada	58.78	71.15
New Hampshire	50.00	65.00
New Jersey	50.00	65.00
New Mexico	71.46	80.02
New York	50.00	65.00
North Carolina	64.75	75.33
North Dakota	54.27	67.99
Northern Mariana Islands *	83.00	85.00
Ohio	65.36	75.75
Oklahoma	66.83	76.78
Oregon	59.15	71.41
Pennsylvania	57.22	70.05
Puerto Rico **	55.00	68.50
Rhode Island	57.08	69.96
South Carolina	69.45	78.62
South Dakota	52.79	66.95
Tennessee	63.67	74.57
Texas	58.86	71.20
Utah	62.50	73.75
Vermont	56.80	69.76
Virgin Islands *	83.00	85.00

TABLE 1—FEDERAL MEDICAL ASSISTANCE PERCENTAGES AND ENHANCED FEDERAL MEDICAL ASSISTANCE PERCENTAGES, EFFECTIVE OCTOBER 1, 2027–SEPTEMBER 30, 2028—Continued

[Fiscal year 2028]

State	Federal medical assistance percentages	Enhanced federal medical assistance percentages
Virginia	50.17	65.12
Washington	50.00	65.00
West Virginia	74.67	82.27
Wisconsin	61.45	73.02
Wyoming	50.00	65.00

* The Consolidated Appropriations Act, 2023 set the FMAP for American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, and the Virgin Islands permanently at 83 percent. For purposes of section 1118 of the Act, the percentage used under titles I, X, XIV, and XVI will be 75 per centum for the Virgin Islands and Guam.

** The Consolidated Appropriations Act, 2023 set the FMAP for Puerto Rico at 76 percent through September 30, 2027. Beginning October 1, 2027, the FMAP for Puerto Rico will be 55 percent under section 1905(b)(2) of the Act. For purposes of section 1118 of the Act, the percentage used under titles I, X, XIV, and XVI will be 75 per centum for Puerto Rico.

*** The values for the District of Columbia (DC) in the table were set for the state plan under titles XIX and XXI and for capitation payments and disproportionate share hospital (DSH) allotments under those titles. For other purposes, the percentage for DC is 50.00, unless otherwise specified by law.

[FR Doc. 2026–23741 Filed 11–20–26; 8:45 am]

BILLING CODE 4150–28–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Agency Information Collection Activities: Proposed Collection; Comment Request

In compliance with section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 concerning opportunity for public comment on proposed collections of information, the Substance Abuse and Mental Health Services Administration (SAMHSA) will publish periodic summaries of proposed projects. To request more information on the proposed projects or to obtain a copy of the information collection plans, call the SAMHSA Reports Clearance Officer at: *samhsapra@samhsa.hhs.gov.*

Comments are invited on: (a) Whether the proposed collections of information are necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology.

Proposed Project: National Survey on Drug Use and Health (OMB No. 0930–0110)

The National Survey on Drug Use and Health (NSDUH) is a survey of the U.S. civilian, non-institutionalized population aged 12 years old or older within the 50 states and the District of Columbia. Consistent with NSDUH designs since 1991, the 2027 NSDUH will include residents of noninstitutional group quarters (*e.g.,* shelters, rooming houses, dormitories) and civilians residing on military bases. Excluded from the NSDUH are those without fixed household address (*e.g.,* homeless people not in shelters) and residents of institutional group quarters, such as jails and hospitals.

The 2027 sampling frame will exclude U.S. territories. Although data collection pilots were conducted to assess operational feasibility in Puerto Rico (2023—2025) and in the U.S. Virgin Islands (2024), SAMHSA determined that additional testing and discussions with other statistical agencies are needed before expanding full-scale NSDUH data collection to Puerto Rico and the U.S. Virgin Islands.

The 2027 NSDUH will continue to use both in-person and web-based modes of data collection. Consistent with all NSDUH surveys conducted since 2002, each respondent who completes the full interview will be given a $30 incentive. The delivery method will depend on the interview mode: in-person respondents will receive a $30 cash incentive, while web-based respondents will receive either an electronic gift card by email or a physical gift card by mail, based on their preference.

The data provide nationally representative data on the use of tobacco, alcohol, and drugs; substance use disorders; mental health issues; recovery from substance use disorders and mental health issues; and receipt of substance use and mental health treatment at the national, state, and substate levels. NSDUH data also help to identify the extent of substance use and mental illness among different population subgroups, estimate trends over time, and determine the need for treatment services. Substance use topics covered include lifetime, past-year, and past-month use; age at first use; substance use treatment history; perceived need for treatment; and substance use disorders. Mental health topics include major depressive episodes; suicidal ideation and attempts; general mental illness; and use of mental health care. NSDUH estimates allow researchers, clinicians, policymakers, and the general public to better understand and improve the nation's behavioral health.

The NSDUH questionnaire must be updated periodically to reflect changing substance use and mental health issues and to continue producing current data. For the 2027 NSDUH, planned changes from the 2026 questionnaire include: (1) revisions and additions to the Special Drugs module to prevent inconsistent reporting of last use of specific drugs with earlier modules; (2) revisions to the Risk/Availability module to ask about using marijuana rather than smoking marijuana; (3) addition to the Mental Health Services Utilization module to capture past 12-month use of a Crisis Line service; (4) reinstatement of a question in the Youth Experiences module about perceived attitudes of close friends; (5) revisions to the Consumption of Alcohol module to ask about polysubstance use in the past 30 days rather than the last time the