

AGENTIC ARMOR

THE ATLAS - FEDERAL REGISTER WATCH

FEDERAL CHANGE, WORKED ALL THE WAY DOWN

A Federal Records Match Between Medicare and the VA

What the CMS matching-program notice of October 21, 2026 requires, what it touches in a state Medicaid agency, and what it leaves alone, level by level

General Edition - prepared for state Medicaid agencies

Washington published a notice. This packet does the reading - all the way down to what your agency actually has to check.

The document	Privacy Act of 1974; Matching Program
Issued by	Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services
Published	Wednesday, October 21, 2026 - 91 FR 66560-66561 - FR Doc. 2026-21491
Of record	Filed October 20, 2026, 8:45 a.m. - Billing Code 4120-03-P

What landed

On October 21, 2026, the Centers for Medicare & Medicaid Services (CMS) published a short notice - two pages - announcing a new computer matching program between Medicare and the Department of Veterans Affairs' health system. The two agencies will compare their records to find people enrolled in both Medicare and VA health care, and to find medical services that both agencies paid for. Where both paid for the same service, the money is recovered. The results also feed the two agencies' work against fraud, waste, and abuse.

THE ASSESSMENT, PLAINLY - Read against the Medicaid provider enrollment rules at 42 CFR Part 455, this notice changes none of them - no screening rule, no enrollment duty, no provider requirement moves. It creates no state report, no state filing, and no deadline of any agency's own. What it genuinely touches in a Medicaid agency is narrower and real: members who are Veterans enrolled in both Medicare and VA care; the third-party-liability picture the agency works from; program-integrity awareness; and one open public comment window that closes November 20, 2026. This binder works those connections all the way down, and states plainly, at every level, where the notice does not reach.

The clocks, up top

Clock	Date	What it is
Published	Wednesday, October 21, 2026	The notice appears at 91 FR 66560. Every clock below runs from this date or from the program's own start date.
Comments close	Friday, November 20, 2026	Written comments on the matching program itself - its purpose, its data, its protections. By mail or email to the CMS Privacy Officer, or on the notice's comment page at regulations.gov (docket CMS_FRDOC_0001-4472). The address is on Card 2.
Earliest start	Friday, November 20, 2026	The program may begin no sooner than 30 days after publication, and only if no comment received warrants a change to the notice.
Term	18 months from the start date	Counted from the day the program actually begins. If it begins at the earliest date the notice allows - November 20, 2026 - the term runs to Saturday, May 20, 2028.
Renewal point	Before the term ends	The HHS Data Integrity Board may renew the agreement for 12 more months, only if the program will run with no change and each agency certifies it was run as agreed.
Ending early	At any time, in writing	Either agency may ask the other, in writing, to end or change the agreement.



The notice's own dates on one line. The term is drawn at the earliest start the notice allows; every later date moves with the actual start, day for day.

Built from public information: the notice itself, published in the Federal Register; the published structure of a typical state Medicaid agency (the archetype described in Sources); and the federal regulations the notice connects to, at 42 CFR Part 455 (Medicaid provider enrollment) and 42 CFR Part 433, Subpart D (third party liability).

PART 1 - WHAT THE NOTICE DOES, POINT BY POINT

Every material point in the notice, as a card of its own. A reader who reads only the cards has the whole document.

Card 1 - A new federal match between Medicare and VA health records

91 FR 66560

Card 1 - A new federal match between Medicare and VA health records

In plain words: CMS and the Veterans Health Administration (VHA) - the VA's health care system - will run a computer matching program together. The VA sends CMS a file of every Veteran enrolled in VA health care. CMS compares it against Medicare's records to identify the people enrolled in both. For those people, the two agencies then exchange paid-claims records and compare them, service by service, to find where both agencies paid for the same care.

What it requires: Nothing is required of any state by this card. The match runs between two federal agencies, on federal records. This binder exists because the population and the payments the match touches overlap every Medicaid agency's own work - the levels in Part 2 and the map in Part 3 work that overlap out, and Card 8 states what does not change.

Source: 'Privacy Act of 1974; Matching Program,' Centers for Medicare & Medicaid Services, Federal Register, October 21, 2026, 91 FR 66560 - the Summary and Participating Agencies sections. CMS is named the source agency; the Veterans Health Administration is the other party.

How its date is set: The notice was published Wednesday, October 21, 2026. The program's own start is a separate clock - see Card 3 and the clocks page.

Card 2 - The comment clock - written comments close November 20, 2026

5 U.S.C. 552a(e)(12)

In plain words: Federal law requires advance public notice before a matching program runs, and this notice is that announcement. Anyone - including your agency - may write to CMS about the program itself: what it is for, what records it uses, and what protections ride with it. Comments that warrant a change can change the program before it starts; the program cannot start until the comment window has closed.

What it requires: Anyone who wants a voice in whether this program proceeds as written has until Friday, November 20, 2026. Comments go, 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 Boulevard, Baltimore, MD 21244-1850 - email barbara.demopulos@cms.hhs.gov - or through the notice's comment page on [regulations.gov](https://www.regulations.gov) (docket CMS_FRDOC_0001-4472). Questions about the program go to Richard Mazur, Government Technical Lead, Division of Medicare Secondary Payer Operations, Office of Financial Management, CMS, at (410) 786-1418 or Richard.Mazur2@cms.hhs.gov. In your agency, the decision to comment or not sits at agency leadership - Part 2, Level 3.

Source: The notice's DATES and ADDRESSES sections, 91 FR 66560. The advance-notice duty the notice discharges is the Privacy Act's, at 5 U.S.C. 552a(e)(12).

How its date is set: The notice states the deadline outright: 'The deadline for comments on this notice is November 20, 2026.' November 20, 2026 is 30 days after publication - the same 30 days that set the program's earliest start.

Card 3 - An 18-month run, with one 12-month renewal path

91 FR 66560 - DATES

Card 3 - An 18-month run, with one 12-month renewal path

In plain words: The matching agreement is not permanent. It runs for 18 months from the day it starts. It can be renewed once, for 12 more months, by the HHS Data Integrity Board - and only if nothing about the program changes and both agencies certify it was run exactly as agreed. Either agency can also ask, in writing, to end or change it at any time.

What it requires: Any agency routine built around this match - the awareness items in Part 3 - is built on an 18-month authority, not a permanent one. The agency's federal-change calendar should carry the term and the renewal point so the spring of 2028 is not a surprise (Part 3, Step 6).

Source: The notice's DATES section, 91 FR 66560.

How its date is set: The notice sets the length, not the end date: 18 months 'from its effective date.' The end date is worked out from the start date once the start date is known. At the earliest start the notice allows - November 20, 2026 - the term would run to Saturday, May 20, 2028. If the program starts later, the end moves with it, day for day.

Card 4 - Who is matched, and what records move

91 FR 66560-66561

In plain words: The people in the match are Veterans enrolled in VA health care, and within them, the Medicare beneficiaries enrolled in both systems. The VA's finder file carries each Veteran's VA identifier, Social Security number, Medicare claim number (if there is one), date of birth, name, sex, VA enrollment dates, and date of death if applicable. CMS answers with a file carrying the Medicare identifier (the MBI), Medicare enrollment dates, and the same identity fields. For the people found in both systems, the claims exchange follows: claim and line numbers, service dates, types and places of service, revenue codes, procedure and diagnosis codes, the billing and rendering providers' names and National Provider Identifiers, and the payment dates, amounts, and units - from both agencies, for the same services.

What it requires: Nothing of any state directly - no state file is an input and no state system is a destination. What this card fixes is the population: a Medicaid member who is a Veteran enrolled in Medicare and VA care is inside this match, in every state. That is the fact the third-party-liability and member-services levels in Part 2 rest on.

Source: The notice's Categories of Individuals and Categories of Records sections, 91 FR 66560-66561 - the finder-file, response-file, and claims-file field lists are printed there in full.

How its date is set: No date rides on this card. The records move while the program runs - inside the term on Card 3.

Card 5 - The work the match produces - duplicate payments recovered, improper payments pursued

42 U.S.C. 1320a-7k - 1395y(a)(3)

In plain words: Three things come out of the match, in the notice's own order: beneficiaries enrolled in both systems are identified; payments both agencies made for the same service are identified so the duplicate money can be recovered and improper payments repaid; and the results support the two agencies' detection of fraud, waste, and abuse. The authorities the notice stands on match that work: the Privacy Act itself; section 1128J of the Social Security Act, the program-integrity authority; section 1862(a)(3), the rule that makes Medicare the secondary payer where another payer is responsible first; the VA's own care authorities at 38 U.S.C. 1703 and 1725; and 38 CFR 1.481.

Card 5 - The work the match produces - duplicate payments recovered, improper payments pursued

What it requires: The recoveries run between the federal parties - no state funds move under this notice, and no recovery duty is assigned to any state. The state's connection is the information picture: whether Medicare or the VA paid for a dual member's care is exactly the 'other coverage' picture third party liability works from, because Medicaid pays last. A running federal match makes that picture more current. Part 2, Level 4 carries what the TPL and program-integrity seats do with that - awareness, not new duties.

Source: The notice's Purpose(s) and Authority sections, 91 FR 66560. Medicaid as payer of last resort: 42 CFR Part 433, Subpart D.

How its date is set: The work runs inside the program's term - Card 3. No separate clock.

Card 6 - The systems the records come from

91 FR 66561 - Systems of records

In plain words: The notice names the official record systems on both sides. On the CMS side: the Common Working File (System No. 09-70-0526), the Medicare Beneficiary Database (09-70-0536), the Integrated Data Repository (09-70-0571), and the National Claims History (09-70-0558). On the VA side: Enrollment and Eligibility Records-VA (147VA10) and Non-VA Care (Fee) Records-VA (23VA10NB3). Records move between these systems under the routine uses published for each of them.

What it requires: Nothing of any state. The card is in the binder for the systems reader: no state system - not the Medicaid management information system, not any eligibility or enrollment system, in any state - is named as a source or a destination anywhere in this notice. No state data flows in this program in either direction.

Source: The notice's System(s) of Records section, 91 FR 66561.

How its date is set: No date rides on this card.

Card 7 - The protections that ride with the match

5 U.S.C. 552a(o) - (p) - (e)(12)

In plain words: The Privacy Act sets five conditions on a program like this, and the notice states, one by one, that the program meets them. First, a written agreement, approved by each agency's Data Integrity Board, provided to Congress and the Department of the Treasury, and available to the public. Second, the people whose records are matched must be told their information is subject to verification through matching. Third - the protection with teeth - match findings must be verified before anyone's benefits or payments are suspended, terminated, reduced, or finally denied: a match by itself takes nothing away from anyone. Fourth, the program is reported to Congress and the Office of Management and Budget in advance, and then every year. Fifth, advance notice in the Federal Register - which is this document.

What it requires: No new duty falls on any state. The working point for state staff is the third condition's shape: if a finding from this match ever reaches state work - a liability determination, a program-integrity lead - it arrives as something to verify, not as a conclusion. That is the same standard states already apply to matches they run themselves, and Part 3 writes it into the program-integrity step so it is standing practice, not memory.

Card 7 - The protections that ride with the match

Source: The notice's Supplementary Information, 91 FR 66560, citing 5 U.S.C. 552a(o), (u)(3)(A), (u)(4) (the agreement), 552a(o)(1)(D) (notice to individuals), 552a(p) (verification before adverse action), 552a(o)(2)(A)(i), (r), and (u)(3)(D) (reporting), and 552a(e)(12) (this notice).

How its date is set: The conditions run for the life of the program - the term on Card 3.

Card 8 - What this notice does not change

42 CFR Part 455

In plain words: This card is in the binder because the most useful sentence in it may be this one: nothing about Medicaid provider enrollment changes. The notice amends no regulation text anywhere. No screening level moves, no disclosure duty changes, no application fee, no revalidation cycle, no moratorium, no termination ground - the whole of 42 CFR Part 455 reads on October 22, 2026 exactly as it read on October 20. The notice enrolls and disenrolls no one. It does not change what any state's Medicaid pays, whom it pays, or what a provider must do to enroll or bill. It creates no state report, no state filing, and no state deadline; the only date that touches a state at all is the public comment deadline on Card 2, which belongs to anyone who wishes to write.

What it requires: Nothing. This card requires no action by any bureau, in any state, and no bureau should build one from this notice beyond the awareness and calendar items in Part 3.

Source: The notice read against 42 CFR Part 455, Medicaid provider enrollment. The notice is a Privacy Act matching-program announcement; it carries no regulatory text and amends no part of the Code of Federal Regulations.

How its date is set: No date rides on this card.

PART 2 - WHAT IT MEANS IN A MEDICAID AGENCY, LEVEL BY LEVEL

The same notice, walked down the structure of a typical Medicaid agency. The seats below are the archetype described in Sources - named by function, the shape nearly every state agency shares, no one state's names. Every level is answered, including the ones this notice does not reach - an untouched level is information, stated in one place, not an absence a reader has to guess at.

Level 1 - Federal rule

The notice itself - CMS and the Veterans Health Administration

What the federal text does: it establishes a matching program between two federal agencies under the Privacy Act's matching rules, on the authorities listed on Card 5. It writes no regulation and leaves states no discretion to exercise - there is no state option, election, or implementation choice anywhere in it. The federal decisions inside it (the written agreement, both Data Integrity Board approvals, the reports to Congress) belong to the federal parties and are stated in the notice as already provided for.

Action line - None. This level is the record the rest of the binder works from.

Level 2 - State plan / state regulation

The agency's Policy seat

Nothing to conform. No state plan amendment and no state regulation change is triggered, in any state: the state duties this notice runs alongside - Medicaid as payer of last resort under the state plan and 42 CFR Part 433, Subpart D - read exactly as they did before October 21. This binder is the documentation of that absence, so the question 'did we need a plan amendment for the CMS-VA match?' has a written answer instead of a memory.

Action line - None required. No state plan amendment; no regulation filing.

Level 3 - Agency leadership

The Agency Director and the deputy directors

An awareness item with one decision inside it. The awareness: a federal match now runs over a population that includes the agency's own members - Veterans dually enrolled in Medicare and VA care - and its findings concern payments for their care. The decision: whether the agency files a public comment on the program before the window closes on November 20, 2026 (Card 2). No approval, signature, or submission of any other kind is created for agency leadership by this notice.

Action line - Decide, by Friday, November 20, 2026, whether the agency comments. Silence is also a decision - the program proceeds as written if no comment warrants a change.

Level 4 - Bureau

Third-Party Liability and Program Integrity, in the main

Two functions are genuinely reached, in this order. Third-Party Liability (carried in the Finance line in many agencies) is the closest seat: whether Medicare or the VA paid for a dual member's service is the core fact TPL works from, and this match exists to make that fact more accurate on the federal side - duplicate payments identified and recovered, enrollment overlaps named. No TPL duty, form, report, or deadline changes; the seat should simply know the match is running and why (Part 3, Step 4). Program Integrity: the match is a standing federal fraud, waste, and abuse detection activity for its 18-month term, run between Medicare and the VA; it creates no new referral route into any state, and any finding that reaches a state through the existing federal channels is worked under the verification standard on Card 7 (Part 3, Step 5). Finance beyond the TPL line: no state funds move under this notice; recoveries run between the federal parties. The functions this notice does not reach: Provider Services & Enrollment, Managed Care, Policy (beyond Level 2's written answer), Systems / MMIS, Eligibility & Member Services beyond Step 3's readiness line, Pharmacy, Quality, Long-Term Services & Waivers, and CHIP - no duty, system, contract, or member process in any of them is touched.

Action line - TPL and Program Integrity: awareness seated at the program's start (Part 3, Steps 4 and 5). Every other function: no action.

Level 5 - Program / unit operations

TPL case work - program-integrity intake - member services

Level 5 - Program / unit operations

Inside the units, three small things and no big ones. TPL case work runs as it runs today - same intake, same systems, same recovery practice; the only change in its world is that the federal other-coverage picture for dually enrolled Veterans is being actively reconciled upstream for the next 18 months. Program-integrity intake adds one line to its source awareness: this match, for its term, with the standing rule that a match finding is verified before it is acted on. Member services carries the one genuinely new operational item: the Privacy Act requires the federal parties to tell the people in the match that their information is subject to verification through matching, so some members will receive or hear about a federal notice concerning a Medicare-VA records match and may ask the agency what it means. A member who asks should get a straight, short answer: it is a federal records match between Medicare and the VA; it does not change their Medicaid, their enrollment, or anything they must do (Part 3, Step 3). No state system sends or receives match data at this level or any other.

Action line - Member-services readiness line seated before the program starts (Step 3). TPL and program-integrity awareness at the start (Steps 4 and 5). No system work, no form changes, no new reports.

Level 6 - Provider-facing process

What a provider or applicant sees

Nothing changes. A provider applying to enroll, revalidating, billing, or appealing in any state sees the same application, the same screening, the same notices, and the same timelines as before this notice. No provider bulletin issues from it, and no provider communication is owed. The one thing a provider may experience sits entirely on the federal side: a provider who billed both Medicare and the VA for the same service may see a duplicate-payment recovery from one of them. That is federal payment work under authorities that predate this notice; the match is how the duplicates are found.

Action line - None. No bulletin, no notice, no change to any provider-facing process.

PART 3 - THE WORK, MAPPED

The map shows the work as it runs around this notice in a Medicaid agency. Two honesties govern it. First, the match itself runs between CMS and the VA; no step on this map sends state data anywhere, and no step gives any state a new duty. Second, the steps marked NEW are the only steps this notice adds. Everything else is the standing work the notice touches, shown so the new steps sit in their real context instead of floating beside it.

The standing work the notice touches

Standing work	As it runs today	Standing
A dual member receives care	A member who is a Veteran, enrolled in Medicare and VA care, receives a service. Medicare, the VA, or both may pay; Medicaid stands as payer of last resort where the member is Medicaid-eligible.	Standing - unchanged by this notice
TPL works the other-coverage picture	Third Party Liability learns of other coverage from its standing sources and cost-avoids or recovers, as it does today.	Standing - unchanged

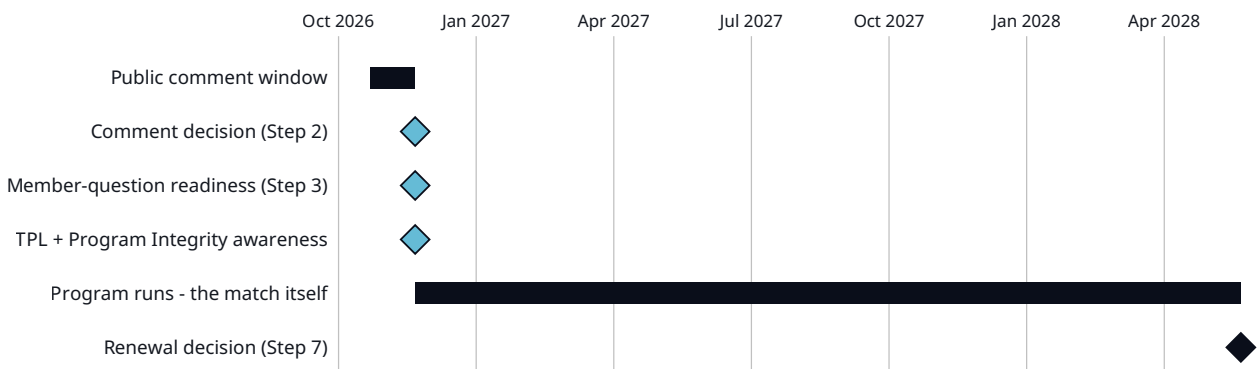
Standing work	As it runs today	Standing
Program Integrity works its leads	Findings and leads arrive through the existing federal and state channels and are verified before anything is acted on.	Standing - unchanged
Members ask about letters they receive	Member services answers questions about federal notices from the standing guidance it already uses.	Standing - one line added (Step 3)

The steps, current to future

Step	What happens	Owner	Depends on
Step 1	The federal match runs. The VA sends its finder file; CMS identifies the dually enrolled; the claims exchange runs; duplicate payments are identified for recovery and results feed fraud, waste, and abuse detection. Recurring, for the program's term.	CMS and the Veterans Health Administration (federal)	The comment window closing (Card 2) with no change warranted
Step 2 (NEW)	The comment decision. Leadership decides whether the agency files a public comment on the matching program, and if it does, the comment is filed with the CMS Privacy Officer inside the window.	Agency leadership - the Director's office	The clock only - the window closes November 20, 2026
Step 3 (NEW)	Member-question readiness. One line of guidance is added where member questions are answered: what the federal matching notice is, and that it does not change the member's Medicaid. Staff answering a Veteran member's question about a Medicare-VA match letter use it.	Eligibility & Member Services	Seated by the program's start (Step 1)
Step 4 (NEW)	Third Party Liability awareness seated. The TPL seat is briefed, once, that the federal Medicare-VA match is running: what it identifies, what it recovers, and its term. Standing TPL case work then proceeds unchanged, on a federal other-coverage picture that is being actively reconciled upstream.	Third-Party Liability (Finance line, in many agencies)	Step 1 - the program running

Step	What happens	Owner	Depends on
Step 5 (NEW)	Program Integrity awareness seated. Program-integrity intake notes the match as a standing federal fraud, waste, and abuse source for its term. If a finding involving a provider who also serves the state's Medicaid program arrives through the existing federal channels, it is worked as leads are worked today - verified before any action, the standard the Privacy Act itself sets for match findings.	Program Integrity	Step 1 - the program running
Step 6 (NEW)	The term goes on the calendar. The program's 18-month term and its renewal point are entered on the agency's federal-change calendar, counted from the actual start date once it is known, so the renewal window in 2028 arrives expected rather than discovered.	Agency leadership - the Director's office	Step 1 - the program's actual start date
Step 7	The renewal point. Before the term ends, the HHS Data Integrity Board decides whether the program renews for 12 more months. Renewal requires that the program run with no change and that each party certify it was run in compliance with the agreement. If it renews, the awareness steps above continue for the renewal term; if it lapses, they end with it.	HHS Data Integrity Board (federal) - watched by agency leadership	Step 1 - the term running to its end

The steps on the notice's own dates



Dates are shown only where the notice itself sets them: the comment window and the program's term. The agency's steps carry no durations of their own, so they stand as points at the program's start, where they belong. The dark line is the chain the notice's own dates set - the comment window must close before the program can start, and the term must run before renewal can be decided. Program dates are drawn at the earliest start the notice allows (November 20, 2026); if the start moves, the term moves with it.

PART 4 - THE MAP, STEP BY STEP (COMPANION GUIDE)

Every step on the map in Part 3, carded in full, so the map never travels without its guide.

Step 1 - The federal match runs

Owner: CMS and the Veterans Health Administration (federal) **Depends on:** The comment window closing (Card 2) with no change warranted

In plain words: Two federal agencies compare their records to find people enrolled in both Medicare and VA care, and services both of them paid for.

What it requires: Nothing of any state. The step is on the map because every state step below hangs from it: it is the event the awareness, readiness, and calendar steps respond to.

Source: The notice, Summary and Purpose(s), 91 FR 66560.

How its date is set: Starts no sooner than November 20, 2026 - 30 days after publication - and runs 18 months from its actual start (Card 3).

Step 2 - The comment decision NEW

Owner: Agency leadership - the Director's office **Depends on:** The clock only - the window closes November 20, 2026

In plain words: The one decision this notice puts in front of an agency's leadership: speak on the federal program, or let it proceed as written.

What it requires: A decision, made once, before the deadline. Filing is by mail or email to the CMS Privacy Officer, or on the notice's regulations.gov comment page (Card 2 carries the addresses).

Source: The notice, DATES and ADDRESSES, 91 FR 66560.

How its date is set: Set by the notice outright: comments close Friday, November 20, 2026.

Step 3 - Member-question readiness NEW

Owner: Eligibility & Member Services **Depends on:** Seated by the program's start (Step 1)

In plain words: Members in the match will be told their records are subject to verification through matching. Some will ask their state agency what that means. This step makes sure the answer is ready, short, and true.

What it requires: The line, in words a member can use: this is a federal records match between Medicare and the VA; it does not change your Medicaid coverage, your enrollment, or anything you have to do. Seated where call and member-services guidance lives, before matches begin.

Step 3 - Member-question readiness **NEW**

Source: The notice's Supplementary Information - the Privacy Act's notice-to-individuals condition, 5 U.S.C. 552a(o)(1)(D), 91 FR 66560.

How its date is set: By the program's start - earliest November 20, 2026. The federal notice to individuals rides with the program, so readiness belongs in place before the first members hear of it.

Step 4 - Third Party Liability awareness seated **NEW**

Owner: Third-Party Liability (Finance line, in many agencies) **Depends on:** Step 1 - the program running

In plain words: The people who work out who else should have paid for a dual member's care are told that Washington is now reconciling Medicare and VA payments for exactly that population, for 18 months.

What it requires: One briefing, recorded. No new intake, form, report, system change, or recovery practice follows from it.

Source: The notice, Purpose(s), 91 FR 66560; Medicaid payer of last resort, 42 CFR Part 433, Subpart D.

How its date is set: At the program's start - earliest November 20, 2026 - and the awareness stands for the term on Card 3.

Step 5 - Program Integrity awareness seated **NEW**

Owner: Program Integrity **Depends on:** Step 1 - the program running

In plain words: The fraud-and-abuse picture between Medicare and the VA gets a new federal feed for 18 months. The state's rule for anything that arrives from it is the rule already in force: a match is a lead, not a conclusion.

What it requires: One intake note, recorded. The notice creates no new referral route, no new reporting duty, and no new data feed into any state.

Source: The notice, Purpose(s) and Supplementary Information, 91 FR 66560 - the verification-before-adverse-action condition is 5 U.S.C. 552a(p).

How its date is set: At the program's start - earliest November 20, 2026 - standing for the term.

Step 6 - The term goes on the calendar **NEW**

Owner: Agency leadership - the Director's office **Depends on:** Step 1 - the program's actual start date

In plain words: An 18-month federal program that nobody calendared becomes a surprise at month 17. This step is the un-surprising.

What it requires: Two calendar entries: the term (start date plus 18 months) and the renewal point before it. If the start date moves, the entries move with it, day for day.

Source: The notice, DATES, 91 FR 66560.

Step 6 - The term goes on the calendar NEW

How its date is set: Set by working out from the actual start: 18 months from the day the program begins. At the earliest start, the term ends Saturday, May 20, 2028.

Step 7 - The renewal point

Owner: HHS Data Integrity Board (federal) - watched by agency leadership **Depends on:** Step 1 - the term running to its end

In plain words: The federal program's own fork in the road, 18 months out: one more year exactly as agreed, or the end of the agreement.

What it requires: Nothing of any state but attention: the agency's calendar (Step 6) carries the point, and the outcome decides whether Steps 4 and 5 stand for another 12 months.

Source: The notice, DATES, 91 FR 66560.

How its date is set: Before the term ends - at the earliest-start reckoning, before Saturday, May 20, 2028. The renewed term, if granted, runs 12 months from the renewal.

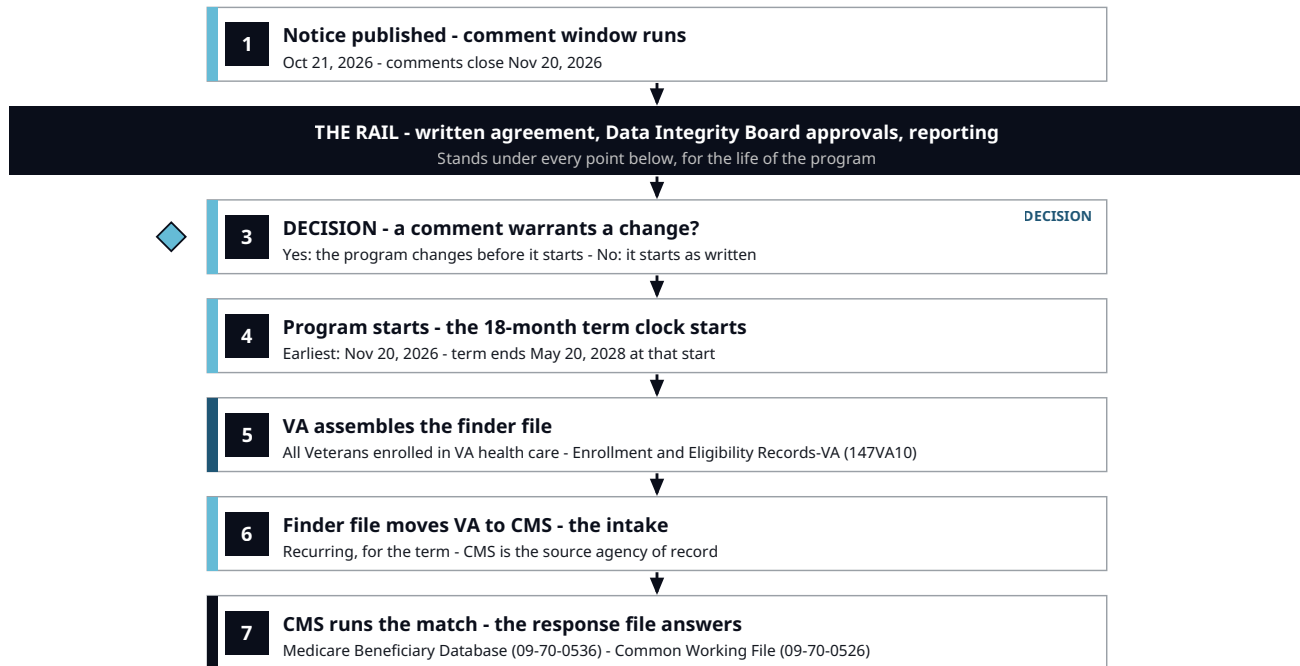
PART 5 - THE PROCESS MAP: THE MATCH, END TO END

Parts 1 through 4 worked the notice down: what it requires, where it lands in a Medicaid agency's structure, and the steps it adds. This part draws the same material as a process - the matching program's life as a flow, from the day the notice appeared to the day the agreement ends. The flow runs through the two federal parties and the six record systems the notice names. A state agency appears the way the notice puts it there: at the touchpoints, where the program's life reaches the agency's members and the agency's standing work - never in the data path. Arrows are drawn only where the notice's own stated sequence carries one: the finder file before the match, the response file before the claims exchange, the findings before anything is done with them. Decisions are drawn as decisions and the Privacy Act's safeguard points as gates, because that is what they are. The companion guide in Part 6 cards every point on this map in full.

The registry read - the systems this program is allowed to touch

The notice's Systems of Records section is the program's registry: it names the official record systems the match draws from and answers into, and it states that records move between them under the routine uses published for each. Six systems, no others. On the CMS side: the Common Working File (09-70-0526), the Medicare Beneficiary Database (09-70-0536), the Integrated Data Repository (09-70-0571), and the National Claims History (09-70-0558). On the VA side: Enrollment and Eligibility Records-VA (147VA10) and Non-VA Care (Fee) Records-VA (23VA10NB3). Every point on the map below carries the system it touches, taken from that list. No state system appears in it - not any state's Medicaid management information system, not any eligibility or enrollment system - and so no state system appears on the map. A state reader checking whether state data flows anywhere in this program can check it here, against the notice's own list.

The flow - the opening points



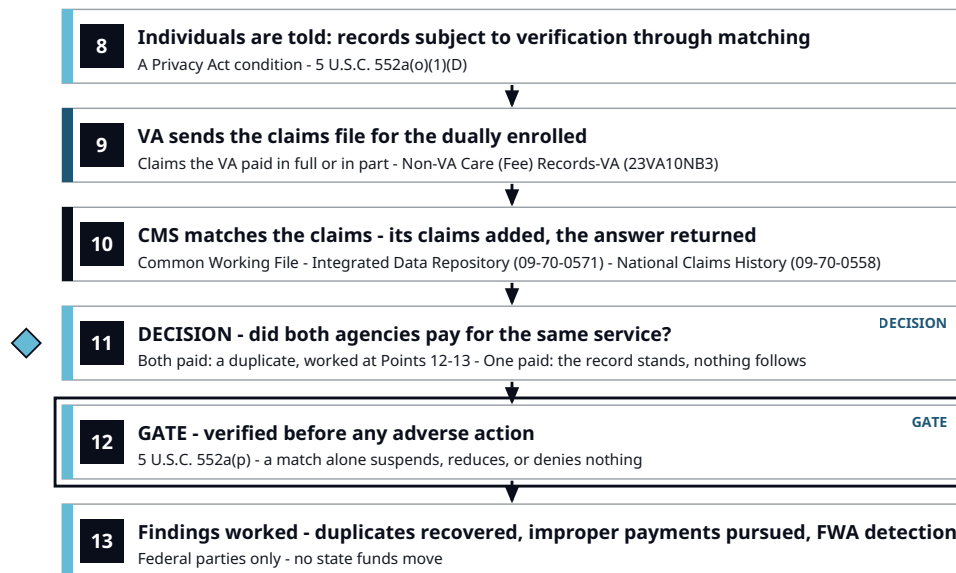
The left bar names the lane: VA, CMS, federal (both parties). Points 3 and every later decision wear the diamond; the rail (Point 2) stands under the whole flow. Arrows follow the sequence the notice itself states.

The points, as a table

Point	What happens	Who runs it	System of record	Follows from
1	The notice is published; the comment window runs	Federal - CMS publishes	The Federal Register - this notice	The start of the flow - nothing precedes it.
2	The rail - the agreement and its reporting, under every point that follows	Federal - both parties	All six systems named in the registry read	Stated in the notice as already provided for; not a step in the sequence.
3	Decision - a comment warrants a change, or none does	Federal - CMS determines; each agency decides for itself	None - a determination, not a system	Map Point 1 - the window must run before this decision can be made.
4	The program starts; the term clock starts with it	Federal - the program itself	None - the program's own clock	Map Point 3 - no change warranted.
5	The finder file is assembled - every Veteran enrolled in VA health care	Department of Veterans Affairs - Veterans Health Administration	Enrollment and Eligibility Records-VA (147VA10)	Map Point 4 - the program running.
6	The finder file moves to CMS - the match's intake	VA to CMS	From 147VA10 (VA) to the CMS matching systems (Map Point 7)	Map Point 5 - the file assembled.

Point	What happens	Who runs it	System of record	Follows from
7	The match runs - CMS answers with the response file	Centers for Medicare & Medicaid Services	Medicare Beneficiary Database (09-70-0536) - Common Working File (09-70-0526)	Map Point 6 - the finder file received.
8	The people in the match are told their records are subject to verification	Federal - both parties owe it	None - a notice duty, owed by the federal parties	Map Point 7 - there must be a match before anyone is in it to be told.
9	The claims file follows - what the VA paid for the dually enrolled	Department of Veterans Affairs - Veterans Health Administration	Non-VA Care (Fee) Records-VA (23VA10NB3)	Map Point 7 - 'based on the results in each response file,' in the notice's own words.
10	The claims are matched - CMS adds its own claims and answers	Centers for Medicare & Medicaid Services	Common Working File (09-70-0526) - Integrated Data Repository (09-70-0571) - National Claims History (09-70-0558)	Map Point 9 - the claims file received.
11	Decision - both agencies paid for the same service, or only one did	Federal - both parties, on the matched pairs	The matched claims pairs from Map Point 10	Map Point 10 - the matched pairs.
12	The gate - findings are verified before anyone acts on them	Federal - a Privacy Act gate, binding on both parties	None - a legal condition on the use of every finding	Map Point 11 - a duplicate identified is a finding, and findings pass here before use.
13	The work the findings do - recovery, accuracy, and fraud, waste, and abuse detection	Federal - both parties	The parties' own payment systems - no system named for this point in the notice	Map Point 12 - findings pass the verification gate before they are worked.
14	Touchpoint - a member asks the agency what the federal letter means	The agency - Eligibility & Member Services	No state system receives match data - the seat's own member-services guidance	Map Point 8 - the federal notification is what prompts the question.
15	Touchpoint - TPL works its standing picture while Washington reconciles it upstream	The agency - Third-Party Liability (Finance line)	TPL's standing sources and systems, unchanged - the notice names no state system	Map Point 13 - the federal work running is what the seat is briefed on.
16	Touchpoint - Program Integrity notes a new federal detection source for the term	The agency - Program Integrity	Program-integrity intake, unchanged - no new feed is created by the notice	Map Point 13 - the detection work running is what the note records.
17	The term ends - the renewal decision, or the end of the flow	Federal - HHS Data Integrity Board decides; agency leadership watches	None - a board decision	Map Point 4 - the term must be running, and running out, before renewal can be decided.

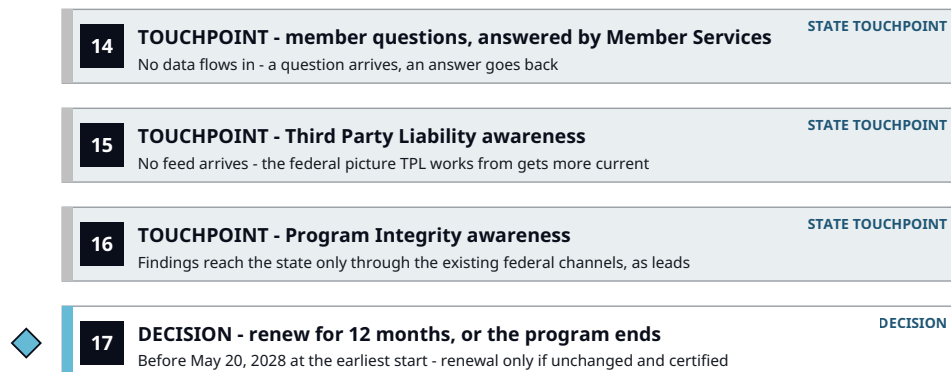
The flow - the findings



The gate at Point 12 is the Privacy Act's verification condition, drawn where it stands: between a finding and any use of it.

The state touchpoints, and the governing clock

The state touchpoints, and the clock that governs the whole flow. The three touchpoints carry no arrows into the flow, on purpose: nothing flows from the match into any state. They are drawn because the program's life reaches these seats in every Medicaid agency - a member's question, a more current other-coverage picture, a federal fraud-and-abuse feed running upstream - and each seat, named here by its function, should know which point of the flow it is standing next to. These are the checks an agency runs in its own house; the state summation sheet at the back of this packet keys them to a named state.



No arrows in this panel: nothing flows from the federal flow into these seats. Point 17 is the clock that governs the whole map - the term, and the renewal decision that ends or extends it.

Read whole, the map says one thing three ways. As a flow: a defined population's records move between two federal parties, through six named systems, behind a verification gate, for a fixed term. As a set of seats: the federal parties run every point of the data path; a state agency runs none of it and is touched at exactly three points, none of which carries data. And as a clock: everything on the map lives inside the term the notice sets - when the term ends, or is renewed, the map's life ends or extends with it. This edition's touchpoints are drawn on the archetypal agency's functional seats, so any Medicaid agency can read its own house into them; the summation sheet at the back keys the three touchpoints, and the two leadership checks beside them, to one named state at a time.

PART 6 - COMPANION GUIDE TO THE PROCESS MAP

Every point on the map in Part 5, carded in full: who runs it, what system it touches, what moves, and what its owner watches for. The map never travels without this guide.

Map Point 1 - The notice is published; the comment window runs

Runs at: Federal - CMS publishes **System of record:** The Federal Register - this notice

Follows from: The start of the flow - nothing precedes it.

In plain words: CMS publishes the advance notice the Privacy Act requires before a matching program runs. For 30 days, anyone - including your agency - may write to CMS about the program itself: its purpose, its records, its protections.

What moves: No program data moves yet. What moves is paper: written comments, by mail or email to the CMS Privacy Officer, or through the notice's comment page on regulations.gov (docket CMS_FRDOC_0001-4472). Card 2 carries the addresses.

What the owner watches for: Agency leadership watches this point for one thing: the agency's own decision, comment or not, belongs inside this window (the decision point is Map Point 3; the binder's Step 2 in Part 3).

Source: The notice, Summary and DATES, 91 FR 66560.

How its date is set: Set by the notice outright: published Wednesday, October 21, 2026; comments close Friday, November 20, 2026.

Map Point 2 - The rail - the agreement and its reporting, under every point that follows

Runs at: Federal - both parties **System of record:** All six systems named in the registry read

Follows from: Stated in the notice as already provided for; not a step in the sequence.

In plain words: A matching program does not run on a notice alone. Behind the notice stands a written agreement between CMS and the VA, approved by each agency's Data Integrity Board, provided to Congress and the Department of the Treasury, and available to the public. The program is reported to Congress and the Office of Management and Budget in advance, and then every year. And every disclosure the flow makes runs under the routine uses published for the system of records it leaves.

What moves: The agreement and the reports - federal paper, moving between the parties, Congress, the Treasury, and OMB. No beneficiary data moves on the rail.

What the owner watches for: Nothing for a state to watch directly. The rail is on the map because it is what makes the flow lawful - and because the renewal point (Map Point 17) is decided by one of the bodies named on it, the HHS Data Integrity Board.

Source: The notice, Supplementary Information, 91 FR 66560, citing 5 U.S.C. 552a(o), (u)(3)(A), (u)(4) (the agreement) and 552a(o)(2)(A)(i), (r), (u)(3)(D) (the reporting); the routine uses, notice, System(s) of Records, 91 FR 66561.

How its date is set: Stands for the life of the program - the term on Map Point 17.

Map Point 3 - Decision - a comment warrants a change, or none does

Runs at: Federal - CMS determines; each agency decides for itself **System of record:** None - a determination, not a system

Follows from: Map Point 1 - the window must run before this decision can be made.

In plain words: The fork the comment window exists for. If a comment received warrants a change to the notice, the program is changed before it starts. If none does, the program proceeds exactly as published. A state's part in this point is only its own: whether its agency is one of the commenters.

What moves: Nothing moves but the determination itself, and any revised notice CMS issues.

What the owner watches for: Agency leadership: the agency's comment-or-not decision (Part 3, Step 2) must be made before this point is reached, because after it, the window is closed and the program's shape is set.

Source: The notice, DATES, 91 FR 66560 - 'provided no comments are received that warrant a change to this notice.'

How its date is set: Reached when the window closes - Friday, November 20, 2026.

Map Point 4 - The program starts; the term clock starts with it

Runs at: Federal - the program itself **System of record:** None - the program's own clock

Follows from: Map Point 3 - no change warranted.

In plain words: Thirty days after publication, and only if no comment warranted a change, the matching program commences. Its 18-month term is counted from this day, whatever day it turns out to be - which is why the term's end date cannot be printed as a fixed date until the start is known.

What moves: Nothing moves at this point itself. It is the gate the recurring flow (Map Points 5 through 13) passes through, once.

What the owner watches for: Agency leadership: the agency's federal-change calendar takes its two entries from this date - the term and the renewal point (Part 3, Step 6). If the start moves, both entries move with it, day for day.

Source: The notice, DATES, 91 FR 66560.

How its date is set: Earliest Friday, November 20, 2026. At that start, the term runs to Saturday, May 20, 2028.

Map Point 5 - The finder file is assembled - every Veteran enrolled in VA health care

Runs at: Department of Veterans Affairs - Veterans Health Administration **System of record:** Enrollment and Eligibility Records-VA (147VA10)

Follows from: Map Point 4 - the program running.

In plain words: The VA builds the file the whole match runs on: one record for every Veteran enrolled in VA health care. Each record carries the VA unique person identifier, Social Security number, Medicare claim number if there is one, date of birth, first and last name, sex, VA enrollment time frames, and date of death if applicable.

Map Point 5 - The finder file is assembled - every Veteran enrolled in VA health care

What moves: Within the VA at this point - the file is assembled from the VA's enrollment and eligibility records. It moves at Map Point 6.

What the owner watches for: No state seat watches this point. It is on the map because the population it defines - Veterans in VA care - is the population every later point, and every state touchpoint, is about.

Source: The notice, Summary and Categories of Records (VHA Beneficiary Finder File Data), 91 FR 66560-66561; the system, System(s) of Records, 91 FR 66561.

How its date is set: Recurring, for the program's term - the notice says the file is provided 'on a recurring basis' and does not set the period.

Map Point 6 - The finder file moves to CMS - the match's intake

Runs at: VA to CMS **System of record:** From 147VA10 (VA) to the CMS matching systems (Map Point 7)

Follows from: Map Point 5 - the file assembled.

In plain words: The VA provides the finder file to CMS, again and again across the term. CMS is the source agency of record for this program and the Veterans Health Administration is the other party - the file's direction follows from that: enrollment records flow from the VA to CMS, and answers flow back.

What moves: The finder file itself - the nine data elements on Map Point 5, for every Veteran enrolled in VA health care, every state's Veteran members among them. No state system sends or receives anything at this point; the members' records move because they are federal beneficiaries, inside federal systems.

What the owner watches for: No state seat. The point matters to the state reader for one reason: this is the only intake the program has. There is no state file, no state feed, and no state submission anywhere in it.

Source: The notice, Summary and Participating Agencies, 91 FR 66560.

How its date is set: Recurring across the term; the first file follows the start (Map Point 4).

Map Point 7 - The match runs - CMS answers with the response file

Runs at: Centers for Medicare & Medicaid Services **System of record:** Medicare Beneficiary Database (09-70-0536) - Common Working File (09-70-0526)

Follows from: Map Point 6 - the finder file received.

In plain words: CMS compares the finder file against Medicare's enrollment records and answers, record for record, with a response file: the VA identifier, Social Security number, the Medicare identifier (MBI), date of birth, name, sex code, Medicare enrollment effective and termination dates, and date of death. The records that come back matched are the point of the exercise - the beneficiaries enrolled in both Medicare and VA health care, identified.

What moves: The response file, CMS to VA. And inside CMS, the identification itself: the dual-enrolled population now exists as a defined set, which is what the claims exchange (Map Points 9 and 10) is run against.

Map Point 7 - The match runs - CMS answers with the response file

What the owner watches for: No state seat. State readers should note what this point does not produce: no list, extract, or notice is created for any state. The identification lives and works inside the two federal parties.

Source: The notice, Categories of Records (CMS Response File Data), 91 FR 66561, and Purpose(s), 91 FR 66560; the systems, System(s) of Records, 91 FR 66561.

How its date is set: Recurring, with each finder file, for the term.

Map Point 8 - The people in the match are told their records are subject to verification

Runs at: Federal - both parties owe it **System of record:** None - a notice duty, owed by the federal parties

Follows from: Map Point 7 - there must be a match before anyone is in it to be told.

In plain words: One of the Privacy Act's five conditions, riding with the match: the individuals whose information is used must be notified that the information they provide is subject to verification through matching. It is a federal duty, performed by the federal parties - and it is the point of the flow most likely to be felt in a state, because some of the people told will be the agency's own members, and some of them will ask the agency what the letter means.

What moves: A federal notification, to the individual. No data moves to any state; what may move is a member's question - which is Map Point 14.

What the owner watches for: Member services watches this point: it is the reason the readiness line exists (Part 3, Step 3), seated before the program starts so the first question is answered from guidance, not improvised.

Source: The notice, Supplementary Information, 91 FR 66560, citing 5 U.S.C. 552a(o)(1)(D).

How its date is set: Rides with the match, from the program's start, for the term.

Map Point 9 - The claims file follows - what the VA paid for the dually enrolled

Runs at: Department of Veterans Affairs - Veterans Health Administration **System of record:** Non-VA Care (Fee) Records-VA (23VA10NB3)

Follows from: Map Point 7 - 'based on the results in each response file,' in the notice's own words.

In plain words: For the beneficiaries the response file identified as dually enrolled, the VA provides a file of the medical claims it paid in full or in part. Each claim carries the patient's identifying information, claim and claim line numbers, service date, type and place of service, revenue codes, the billing provider's name and National Provider Identifier, rendering and attending provider fields, procedure codes and modifiers, diagnosis codes and qualifiers, and the payment date, amount, units, and payment authority.

What moves: The VA claims file, VA to CMS - only for the dually enrolled, only claims the VA actually paid. Claims for Veterans who are not in Medicare are never in this file, because the response file at Map Point 7 is what selects them.

What the owner watches for: No state seat. The provider identifiers in this file are federal payment records; a state's provider appears in it only if the VA paid them for a dual's care - which is federal payment history, not a state enrollment fact.

Map Point 9 - The claims file follows - what the VA paid for the dually enrolled

Source: The notice, Categories of Records (VHA Claims File Data Fields), 91 FR 66561; the system, System(s) of Records, 91 FR 66561.

How its date is set: Follows each response file, for the term.

Map Point 10 - The claims are matched - CMS adds its own claims and answers

Runs at: Centers for Medicare & Medicaid Services **System of record:** Common Working File (09-70-0526) - Integrated Data Repository (09-70-0571) - National Claims History (09-70-0558)

Follows from: Map Point 9 - the claims file received.

In plain words: CMS matches the VA's claims records against its own claims and payment systems and returns a response file: the VA's claim, with the CMS claims fields added for the claims CMS paid in full or in part for the same service - the same field list, mirrored: patient, claim and line, service, revenue codes, providers and their identifiers, procedures, diagnoses, and payment date, amount, and units. After this point, a service both agencies paid for is no longer a suspicion; it is a pair of payment records, side by side.

What moves: The claims response file, CMS to VA. Both parties now hold the matched pairs the rest of the flow works on.

What the owner watches for: No state seat - the exchange is closed between the two parties.

Source: The notice, Categories of Records (CMS Claims File Data Fields), 91 FR 66561; the systems, System(s) of Records, 91 FR 66561.

How its date is set: Recurring, with each claims file, for the term.

Map Point 11 - Decision - both agencies paid for the same service, or only one did

Runs at: Federal - both parties, on the matched pairs **System of record:** The matched claims pairs from Map Point 10

Follows from: Map Point 10 - the matched pairs.

In plain words: Each matched pair is read for the one question the program exists to answer: did both agencies pay for the same health care service? Where only one paid, the pair is simply the record of a single payment - the match has done its work and nothing follows from it. Where both paid, the pair is a duplicate payment identified, and it passes to the gate at Map Point 12 before anything is done with it.

What moves: The classification of each pair - duplicate, or not. No money moves at this point.

What the owner watches for: No state seat. Note, though, the shape of this point for state work: it is a finding about federal payments. It decides nothing about any state's Medicaid payment, claim, or provider.

Source: The notice, Purpose(s), 91 FR 66560 - 'identify duplicate payments made for the same health care services.'

How its date is set: With each claims exchange, for the term.

Map Point 12 - The gate - findings are verified before anyone acts on them

Runs at: Federal - a Privacy Act gate, binding on both parties **System of record:** None - a legal condition on the use of every finding

Follows from: Map Point 11 - a duplicate identified is a finding, and findings pass here before use.

In plain words: The safeguard with teeth, drawn as a gate because nothing passes it unexamined. Before an individual's benefits or payments may be suspended, terminated, reduced, or finally denied - or any other adverse action taken - on the strength of a match, the finding must be verified. A match is evidence to be checked, never a conclusion to be executed. Every use of a finding in the rest of this flow stands behind this gate.

What moves: Nothing moves through this point except findings that have been verified. What the gate stops is also part of the record: unverified action on a raw match.

What the owner watches for: Program Integrity watches this gate as the standing rule for state work: if a finding from this program ever reaches a state through the existing federal channels, it is worked the way the gate works it - verified before any action (Part 3, Step 5). The rule is printed here so it is practice, not memory.

Source: The notice, Supplementary Information, 91 FR 66560, citing 5 U.S.C. 552a(p).

How its date is set: Stands at every use of a finding, for the life of the program.

Map Point 13 - The work the findings do - recovery, accuracy, and fraud, waste, and abuse detection

Runs at: Federal - both parties **System of record:** The parties' own payment systems - no system named for this point in the notice

Follows from: Map Point 12 - findings pass the verification gate before they are worked.

In plain words: Past the gate, the findings do the program's stated work. Duplicate payments are recovered and improper payments repaid, between the federal parties, under the program-integrity authority and the rule that makes Medicare the secondary payer where another payer is responsible first. And the match results support both agencies' detection of fraud, waste, and abuse - a standing federal detection feed for the term. This is the last point of the data flow; everything after it on the map is a touchpoint or a clock.

What moves: Recovered money, between CMS and the VA. Detection results, inside the two agencies' integrity work. Nothing in this point moves to, from, or through any state - no state funds, no state recovery duty, no state report.

What the owner watches for: Third-Party Liability and Program Integrity each watch this point at one remove, and their touchpoints are Map Points 15 and 16. Finance notes the negative: recoveries under this program are federal money; no state ledger is touched.

Source: The notice, Summary and Purpose(s), 91 FR 66560; the authorities, Authority for Conducting the Matching Program, 91 FR 66560 - 42 U.S.C. 1320a-7k and 1395y(a)(3).

How its date is set: For the term, with each cycle of the flow.

Map Point 14 - Touchpoint - a member asks the agency what the federal letter means

Runs at: The agency - Eligibility & Member Services **System of record:** No state system receives match data - the seat's own member-services guidance

Follows from: Map Point 8 - the federal notification is what prompts the question.

In plain words: The one place the program's life touches an agency counter. A member who is a Veteran, told under Map Point 8 that his records are subject to verification through a Medicare-VA match, may ask the agency what it means. The answer is short and it is the whole answer: it is a federal records match between Medicare and the VA; it does not change his Medicaid coverage, his enrollment, or anything he has to do.

What moves: A question in, an answer out - conversation, not data. The member's records are not requested, received, or sent by the state at this touchpoint or any other.

What the owner watches for: The seat watches for volume and confusion, nothing more: if questions arrive in number, the readiness line (Part 3, Step 3) is doing its job or needs a plainer wording - a guidance question, not a program event.

Source: The binder's Step 3 (Part 3), seated on the notice's notification condition, 5 U.S.C. 552a(o)(1)(D), 91 FR 66560.

How its date is set: From the program's start, for the term - readiness seated before the start.

Map Point 15 - Touchpoint - TPL works its standing picture while Washington reconciles it upstream

Runs at: The agency - Third-Party Liability (Finance line) **System of record:** TPL's standing sources and systems, unchanged - the notice names no state system

Follows from: Map Point 13 - the federal work running is what the seat is briefed on.

In plain words: Medicaid pays last: whether Medicare or the VA paid for a dual member's service is the core fact third party liability works from. This program reconciles exactly that fact on the federal side, for exactly that population, for 18 months. TPL's work does not change - same intake, same sources, same recovery practice. What changes is the currency of the federal picture behind it. The seat is briefed once, at the program's start, and the briefing is the whole of this touchpoint.

What moves: One briefing, inside the agency. No file, feed, extract, or report arrives from the match - if TPL's picture of a member's other coverage improves during the term, it improves through TPL's standing sources, as it does today.

What the owner watches for: The TPL seat watches its own casework for the upstream effect and expects nothing on any schedule: the match publishes nothing to states, on no cycle (What Is Not Settled carries that as an open item).

Source: The binder's Step 4 (Part 3), seated on the notice, Purpose(s), 91 FR 66560, and 42 CFR Part 433, Subpart D - Medicaid as payer of last resort.

How its date is set: Briefed at the program's start - earliest November 20, 2026 - standing for the term.

Map Point 16 - Touchpoint - Program Integrity notes a new federal detection source for the term

Runs at: The agency - Program Integrity **System of record:** Program-integrity intake, unchanged - no new feed is created by the notice

Follows from: Map Point 13 - the detection work running is what the note records.

In plain words: For 18 months, a federal fraud, waste, and abuse detection activity runs between Medicare and the VA over a population that includes the agency's members and, at the edges, providers who also serve Medicaid. The notice creates no referral route into any state and no feed to subscribe to. What the seat does is one recorded intake note: the match exists, its term, and the standing rule for anything that ever arrives from it through the channels that already exist - it is a lead, verified before any action, the gate at Map Point 12 applied at the state's own desk.

What moves: One intake note, inside the agency. If a finding ever travels, it travels the existing federal channels exactly as findings travel today - the notice builds no new road.

What the owner watches for: The seat watches for a finding involving a provider who also serves the state's Medicaid program, and works it as leads are worked today. It does not watch for, request, or expect match data.

Source: The binder's Step 5 (Part 3), seated on the notice, Purpose(s) and Supplementary Information, 91 FR 66560 - the verification condition is 5 U.S.C. 552a(p).

How its date is set: Noted at the program's start - earliest November 20, 2026 - standing for the term.

Map Point 17 - The term ends - the renewal decision, or the end of the flow

Runs at: Federal - HHS Data Integrity Board decides; agency leadership watches **System of record:** None - a board decision

Follows from: Map Point 4 - the term must be running, and running out, before renewal can be decided.

In plain words: The flow's last point is a decision, and it is not automatic. Before the 18 months run out, the HHS Data Integrity Board may renew the agreement for 12 more months - only if the program will be conducted without any change and each party certifies it was conducted in compliance with the agreement. If it renews, every recurring point on this map runs for the renewal term and the state touchpoints stand for 12 more months. If it does not, the flow stops at the term's end and the touchpoints end with it. Separately, at any time, either party may ask the other in writing to terminate or modify the agreement - the flow can end early, and the map says so rather than presenting the term as guaranteed.

What moves: The board's decision, and either a renewed agreement or a closed one. No data moves at this point.

What the owner watches for: Agency leadership: the calendar entries from Map Point 4 exist so this point arrives expected. When the decision lands, the touchpoints' standing - another 12 months, or ended - is the agency's only follow-up.

Source: The notice, DATES, 91 FR 66560.

How its date is set: Before the term ends - at the earliest-start reckoning, before Saturday, May 20, 2028. A granted renewal runs 12 months from the renewal.

WHAT IS NOT SETTLED

The program's actual start date

The notice sets the earliest date (November 20, 2026) and the condition (no comment warrants a change). The actual date settles when the comment window closes, or when CMS states it. The term's end date, the calendar entries in Step 6, and the renewal point in Step 7 all move with it.

Whether comments change the program

The window is open until November 20, 2026. A changed program would be announced by CMS; until the window closes, the program as published is the program to plan against.

Whether anything about the match's results is published for states to use

The notice creates no state reporting and sends states nothing. The Privacy Act reporting it describes runs to Congress and the Office of Management and Budget, between the federal parties. If CMS publishes results or guidance touching dual enrollment, it would arrive as a new federal document - and it would be worked the way this one was.

The renewal decision

Settles at the HHS Data Integrity Board before the term ends in 2028, on the two conditions on Card 3. The agency's calendar carries the point (Step 6).

SOURCES, IN ORDINARY LANGUAGE

The notice itself. 'Privacy Act of 1974; Matching Program,' Centers for Medicare & Medicaid Services, Federal Register, Vol. 91, No. 202, Wednesday, October 21, 2026, pages 66560-66561. FR Doc. 2026-21491. Every date, field list, system name, and authority in this binder is taken from its text.

The law it stands on. The Privacy Act of 1974, 5 U.S.C. 552a - in particular (e)(12), (o), (p), (r), and (u). Social Security Act sections 1128J (42 U.S.C. 1320a-7k) and 1862(a)(3) (42 U.S.C. 1395y(a)(3)). 38 U.S.C. 1703 and 1725; 38 CFR 1.481.

The agency structure. The archetype this edition is built on: a composite of the structures state Medicaid agencies publish - an Agency Director (the Medicaid Director) and deputy directors over the program and administration lines; Provider Services & Enrollment; Managed Care; Policy; Finance, with Third-Party Liability carried in the Finance line in many agencies; Program Integrity; Eligibility & Member Services; Systems / MMIS; Pharmacy; Quality; Long-Term Services & Waivers; and CHIP seated as its own program line. It is a composite, not any state's actual structure, and it is labeled as one wherever it carries weight in this binder. The systems named for the archetype are functional descriptions only - the Medicaid management information system, the eligibility and enrollment system, the enrollment portal, the provider call center; no vendor product is named anywhere in this edition.

The rules it was read against. 42 CFR Part 455 (Medicaid program integrity and provider enrollment) - read to confirm the notice changes none of it (Card 8). 42 CFR Part 433, Subpart D (third party liability; Medicaid as payer of last resort).

PART 7 - THE STATE SUMMATION SHEET

Everything before this page is the same for every state - the federal flow does not change at a state line. What changes is the name over the door and the seats inside it. This sheet is the whole of the per-state adaptation, at summation level: one page that keys the packet to a named state and its Medicaid agency, and summarizes the five checks the packet asks that agency to run in its own house.

State	[STATE]
Agency of record	[THE STATE'S MEDICAID AGENCY, AS IT NAMES ITSELF]
Director's office	[THE MEDICAID DIRECTOR'S OFFICE - SEAT AND NAME OF RECORD]
Packet	CMS-VA Matching Program, General Edition (FR Doc. 2026-21491)

1 - The comment decision

The seat: Agency leadership - the Director's office

Decide by Friday, November 20, 2026 whether the agency files a public comment on the matching program (packet Card 2, Step 2, Map Point 3). Silence is also a decision: the program proceeds as written.

2 - Member-question readiness

The seat: Member services - [THE AGENCY'S MEMBER-FACING SEAT]

Seat one line of guidance before the program starts: a federal records match between Medicare and the VA; it does not change a member's Medicaid, enrollment, or anything they must do (Step 3, Map Point 14).

3 - Third-Party Liability awareness

The seat: Third-Party Liability - [THE AGENCY'S TPL SEAT, AND THE LINE IT SITS IN]

One recorded briefing at the program's start: Washington is reconciling Medicare and VA payments for the dual population for 18 months. No new intake, form, or report (Step 4, Map Point 15).

4 - Program Integrity awareness

The seat: Program Integrity - [THE AGENCY'S PROGRAM-INTEGRITY SEAT]

One recorded intake note: the match is a standing federal detection source for its term; anything that ever arrives is a lead, verified before action - the gate at Map Point 12 (Step 5, Map Point 16).

5 - The term on the calendar

The seat: Agency leadership - the federal-change calendar

Enter the 18-month term, counted from the program's actual start, and the renewal point before it ends (Step 6, Map Points 4 and 17). At the earliest start the term ends Saturday, May 20, 2028.

What does not change

What does not change, in every state: 42 CFR Part 455 reads exactly as it read before this notice (Card 8). No state system is a source or a destination in this program (Card 6). No state report, filing, or deadline is created; the only date that touches a state is the comment deadline above.

Basis: the notice itself (91 FR 66560-66561) and the named agency's published structure, in the public record. A filled sheet names its sources; a seat the public record does not name is printed as not documented, never filled in by inference.

About this binder

This binder works one federal document all the way down: what it says, what it requires, where it lands in a Medicaid agency's structure, and where it does not reach. It was built from the public information listed above. This is the general edition, and 'general' describes its knowledge, not its standard: the construction and finish are the full master-binder standard the house builds to. What is general is the agency it is drawn on - the archetype in Sources, a typical Medicaid agency's shape - because this edition is written before any one agency's structure and systems are documented to us. As each agency's structure and systems are documented, that agency's own edition, built on its real seats and systems, succeeds this general one. The binder is a working briefing document - it states the notice's requirements and an agency's standing practice in plain terms; it is not a compliance determination, it changes no policy, and where a question is open, it is printed as open (What Is Not Settled, following Part 6).

The service, standing

This packet is one piece of a standing service. The Atlas watches the Federal Register for what touches Medicaid, and works each release the way this one is worked: the clocks up top, the document carded point by point, the walk down through an agency level by level, the process map and its companion guide, and a plain statement of what the release does not change - assembled as a master binder a team can run from, on the day the release lands. Subscribers receive every pack at the tier they hold; the edition built on their own agency's structure and systems is the subscriber's edition. This general edition is free, and it is yours to keep and use either way.

Two piles of paper. One bridge.

Agentic Armor LLC - The Atlas, Federal Register Watch. This binder is published as the general edition: one federal document, operationalized for any Medicaid agency.