## Addendum XIV: Medicare-Approved Bariatric Surgery Facilities (April through June 2026)

Addendum XIV includes a listing of Medicare-approved facilities that meet minimum standards for facilities modeled in part on professional society statements on competency. All facilities must meet our standards in order to receive coverage for bariatric surgery procedures. On February 21, 2006, we issued our decision memorandum on bariatric surgery procedures. We determined that bariatric surgical procedures are reasonable and necessary for Medicare beneficiaries who have a body-mass index greater than or equal to 35, have at least one co-morbidity related to obesity and have been previously unsuccessful with medical treatment for obesity. This decision also stipulated that covered bariatric surgery procedures are reasonable and necessary only when performed at facilities that are: (1) certified by the American College of Surgeons (ACS) as a Level 1 Bariatric Surgery Center (program standards and requirements in effect on February 15, 2006); or (2) certified by the American Society for Bariatric Surgery as a Bariatric Surgery Center of Excellence (program standards and requirements in effect on February 15, 2006).

There were no additions, deletions, or editorial changes to Medicare-approved facilities that meet CMS' minimum facility standards for bariatric surgery that have been certified by ACS and/or American Society for Metabolic and Bariatric Surgery in the 3-month period. This information is available at *www.cms.gov/MedicareApprovedFacilitie/BSF/list.asp#TopOfPage.*

For questions or additional information, contact Sarah Fulton, MHS (410-786-2749).

## Addendum XV: Fluorodeoxyglucose (FDG)-PET for Dementia and Neurodegenerative Diseases Clinical Trials (April through June 2026)

There were no FDG-PET for Dementia and Neurodegenerative Diseases Clinical Trials published in the 3-month period.

This information is available on our website at *www.cms.gov/MedicareApprovedFacilitie/PETDT/list.asp#TopOfPage.*

For questions or additional information, contact David Dolan, MBA (410-786-3365).

[FR Doc. 2026–15124 Filed 7–24–26; 8:45 am]
BILLING CODE 4169–69–C

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Medicare & Medicaid Services

**[CMS–4216–FN]**

### Medicare Program; Approved Renewal of Deeming Authority of the National Committee for Quality Assurance (NCQA) for Medicare Advantage Health Maintenance Organizations and Preferred Provider Organizations

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

**ACTION:** Notice.

**SUMMARY:** This notice announces our decision to approve the National Committee for Quality Assurance's renewal application for Medicare Advantage ''deeming authority'' of Health Maintenance Organizations and Preferred Provider Organizations for a term of 6 years.

**DATES:** The notice is published on July 27, 2026.

*Applicability Date:* The approval communicated in this notice is applicable May 18, 2026 through May 18, 2032.

**FOR FURTHER INFORMATION CONTACT:** Dawn Johnson Scott, (410) 786–3159 or Katie Schenck, (410) 786–0628.

**SUPPLEMENTARY INFORMATION:**

### I. Background

Under the Medicare program, eligible beneficiaries may receive covered services through a Medicare Advantage (MA) organization that contracts with the Centers for Medicare & Medicaid Services (CMS). The regulations specifying the Medicare requirements that must be met for a Medicare Advantage Organization (MAO) to enter into a contract with CMS are located at 42 CFR 422.503(b). These regulations implement Part C of Title XVIII of the Social Security Act (the Act), which specifies the services that an MAO must provide and the requirements that the organization must meet to enter into an MA contract with CMS. Generally, for an entity to be an MAO, the organization must be licensed under State law, or otherwise authorized to operate under State law, as a risk bearing organization, as set forth in 42 CFR 422.400.

As a method of assuring compliance with certain Medicare requirements, an MAO may choose to become accredited by a CMS-approved accrediting organization (AO). By virtue of its accreditation by a CMS-approved AO, the MAO may be ''deemed'' compliant

in one or more requirements set forth in section 1852(e)(4)(B) of the Act. For CMS to recognize an AO's accreditation program as establishing an MA plan's compliance with our requirements, the AO must, as set forth in § 422.157(a)(1), prove to CMS that their standards are at least as stringent as Medicare requirements for MAOs. MAOs that are licensed as health maintenance organizations (HMOs) or preferred provider organizations (PPOs) and are accredited by an approved AO may receive, at their request, ''deemed'' status for CMS requirements for the deemable areas. These areas include Quality Improvement, Anti-Discrimination, Confidentiality and Accuracy of Enrollee Records, Information on Advance Directives, and Provider Participation Rules.

At this time, CMS does not recognize accreditation of the following areas: Access to Services set out in § 422.156(b)(3) or the Part D areas of review set out at § 423.165(b) as part of the MA deeming program. AOs that apply for MA deeming authority are generally recognized by the health care industry as entities that accredit HMOs and PPOs. As we specify at § 422.157(b)(2)(ii), the term for which an AO may be approved by CMS may not exceed 6 years. For continuing approval, the AO must apply to CMS to renew their deeming authority for a subsequent approval period.

The National Committee for Quality Assurance (NCQA) was previously approved by CMS as an AO for MA deeming of HMOs and PPOs for a 6 year term beginning December 30, 2020 to December 30, 2026. On December 19, 2025, NCQA submitted its initial application to renew its deeming authority, including materials requested by CMS that included information intended to address the requirements set out in regulations at § 422.158(a) and (b) that are prerequisites for receiving approval of its accreditation program from CMS, and the renewal application was determined to be complete on January 8, 2026.

## II. Provisions of the Proposed Notice

In a proposed notice that appeared in the March 10, 2026, **Federal Register** (91 FR 46), we announced NCQA's request to renew its MA deeming authority for HMOs and PPOs. In the March 10, 2026, proposed notice, we detailed our evaluation criteria. Under section 1852(e)(4) of the Act and § 422.158, we conducted a review of NCQA's application in accordance with the criteria specified by our regulations which include, but are not limited to the following:

- The types of MA plans that it would review as part of its accreditation process.
- A detailed comparison of NCQA's accreditation requirements and standards with the Medicare requirements (for example, a crosswalk) in the following five deemable areas: Quality Improvement, Anti-Discrimination, Confidentiality and Accuracy of Enrollee Records, Information on Advance Directives, and Provider Participation Rules.
- Detailed information about the organization's survey process, including—

++ Frequency of surveys and whether surveys are announced or unannounced;

++ Copies of survey forms, and guidelines and instructions to surveyors;

++ Descriptions of—

— The survey review process and the accreditation status decision making process;

— The procedures used to notify accredited MAOs of deficiencies and to monitor the correction of those deficiencies; and

— The procedures used to enforce compliance with accreditation requirements.

- Detailed information about the individuals who perform surveys for the AO, including—

++ The size and composition of accreditation survey teams for each type of plan reviewed as part of the accreditation process;

++ The education and experience requirements surveyors must meet;

++ The content and frequency of the in-service training provided to survey personnel;

++ The evaluation systems used to monitor the performance of individual surveyors and survey teams; and

++ The organization's policies and practice for participation, in surveys or in the accreditation decision process, by an individual who is professionally or financially affiliated with the entity being surveyed.

- A description of the organization's data management and analysis system for its surveys and accreditation decisions, including the kinds of reports, tables, and other displays generated by that system.
- A description of the organization's procedures for responding to and investigating complaints against accredited organizations, including policies and procedures regarding coordination of these activities with appropriate licensing bodies and ombudsmen programs.
- A description of the organization's policies and procedures for the withholding or removal of accreditation for failure to meet the AO's standards or requirements, and other actions the organization takes in response to noncompliance with its standards and requirements.
- A description of all types (for example, full, partial) and categories (for example, provisional, conditional, temporary) of accreditation offered by the organization, the duration of each type and category of accreditation and a statement identifying the types and categories that would serve as a basis for accreditation if CMS approves the AO.
- A list of all currently accredited MAOs and the type, category, and expiration date of the accreditation held by each of them.
- A list of all full and partial accreditation surveys scheduled to be performed by the AO.
- The name and address of each person with an ownership or control interest in the AO.
- CMS will also consider NCQA's past performance in the deeming program and results of recent deeming validation reviews or equivalency reviews conducted as part of continuing Federal oversight of the deeming program under § 422.157(d).

In accordance with section 1865(a)(3)(A) of the Act, the March 10, 2026 proposed notice solicited public comments regarding NCQA's request to renew its MA deeming authority for HMOs and PPOs.

## III. Analysis of and Responses to Public Comments on the Proposed Notice

A few commenters supported CMS' renewal of NCQA's deeming authority. Another comment raised issues that were outside of the scope of the proposed notice.

## IV. Provisions of the Final Notice

### *A. Differences Between NCQA's Standards and Requirements for Accreditation and Medicare's Conditions and Survey Requirements*

We compared the standards and survey process contained in NCQA's application with the Medicare conditions for accreditation. Our review and evaluation of NCQA's application for our continued approval were conducted as described in section II. of this final notice, and yielded the following:

- Under § 422.158(a)(2), NCQA submitted a crosswalk and standards that clearly crosswalked to our regulations, and any applicable oversight protocols, in each of five deemable areas: (1) Quality Improvement; (2) Anti-discrimination;

(3) Confidentiality and Accuracy of Enrollee Records; (4) Information on Advance Directives: and (5) Provider Participation rules.

• NCQA submitted additional information/documentation regarding its survey process to address our regulations at §§ 422.158(a)(1) through (11), and (b)(1) through (3).

*B. Term of Approval*

Based on the review and observations described in section II. of this final notice, we have determined that NCQA's accreditation program requirements meet or exceed our requirements. Therefore, we approved NCQA as a national AO with deeming authority for MA HMOs and PPOs on May 18, 2026 for a term of approval to continue through May 18, 2032. We informed NCQA of their renewal via a letter dated May 18, 2026.

**V. Collection of Information Requirements**

This document does not impose information collection requirements, that is, reporting, recordkeeping or third-party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

The Administrator of the Centers for Medicare & Medicaid Services (CMS), Mehmet Oz, having reviewed and approved this document, authorizes Trenesha Fultz-Mimms, who is the Federal Register Liaison, to electronically sign this document for purposes of publication in the **Federal Register**.

**Trenesha Fultz-Mimms,**

*Federal Register Liaison, Centers for Medicare & Medicaid Services.*

[FR Doc. 2026–15116 Filed 7–24–26; 8:45 am]

**BILLING CODE 4169–69–P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Administration for Children and Families

**[Office of Management and Budget #: 0970–0509]**

### Proposed Information Collection Activity; Mental Health Assessment Form and Onsite Health Intervention Form

**AGENCY:** Office of Refugee Resettlement, Administration for Children and Families, U.S. Department of Health and Human Services.

**ACTION:** Request for public comments.

**SUMMARY:** The Administration for Children and Families (ACF) Office of Refugee Resettlement (ORR) is requesting a 3-year extension with changes of the Mental Health Assessment Form and Onsite Health Intervention Form (formerly Public Health Investigation Form: Non-TB Illness, and Public Health Investigation Form: Active TB, OMB # 0970–0509, expiration 9/30/2026). Proposed revisions include merging two forms (Public Health Investigation Forms, Active TB and Non-TB Illness) into the single Onsite Health Intervention (OHI) Form. The proposed restructuring and revisions will improve transparency, lessen burden, improve data quality, and ensure alignment with ORR requirements. In addition, to ensure continuity of care, the request has been revised to include the sharing of health information with the Department of Homeland Security (DHS) in specific circumstances.

**DATES:** *Comments due* September 25, 2026.

**ADDRESSES:** In compliance with the requirements of the Paperwork Reduction Act of 1995, ACF is soliciting public comment on the specific aspects of the information collection described above. You can obtain copies of the proposed collection of information and submit comments by emailing *infocollection@acf.hhs.gov.* Identify all requests by the title of the information collection.

**SUPPLEMENTARY INFORMATION:**

*Description:* Unaccompanied alien children in ORR custody are placed in care provider programs until unification with a qualified sponsor. Care providers ensure children receive a range of services including routine and emergency medical, dental, and mental health care. Care provider staff are expected to implement all recommended treatment plans (*e.g.,* referrals to specialists, medication administration, accommodation for physical or mental impairments that impact daily living activities) as directed by the evaluating healthcare provider. Care provider staff are also expected to respond to reported or observed non-emergency healthcare concerns (including exposures to specific reportable communicable illnesses) through triage with a licensed healthcare professional or administration of over-the-counter medications as indicated by the child's primary healthcare provider's standing orders. If a child with a health condition that requires daily management or accommodation (*e.g.,* medication, durable medical equipment) is identified for repatriation by DHS, relevant information from their established treatment plan must be shared with DHS to ensure continuity of care. See ''Proposed Changes'' for more information.

Data from scheduled mental health assessments and onsite health interventions is captured through the following forms under OMB # 0970–0509:

• Mental Health Assessment Form.

• Onsite Health Intervention Form (Formerly, Public Health Investigation Form: Active TB, and Public Health Investigation Form: Non-TB Illness).

The Mental Health Assessment Form (MHAF) has a corresponding instructional ''Dear Colleague'' letter that healthcare providers are expected to read at the initial visit with the child. The forms are used as worksheets by healthcare providers and care provider staff to compile information that would otherwise have been collected during the health assessment or onsite health intervention. Once completed, care provider staff transcribe the information from the form into ORR's secure, electronic system of record. Although the MHAF is not completed during emergency or urgent care visits, hospitalizations, or admissions to an out-of-network facility (*e.g.,* residential treatment center), care providers are required to complete the respective form in ORR's electronic system of record by extracting relevant data from health records.

Data is used by ORR to monitor and support the health of unaccompanied alien children while in care, for case management of identified illnesses/conditions, and to ensure care provider compliance with ORR requirements. Finally, ORR has updated the stated uses of data sharing to include providing relevant health information to DHS when a child with healthcare needs is identified by DHS for repatriation.

**Proposed Changes**

ORR is proposing updates to streamline and strengthen health documentation by combining the two Public Health Investigation Forms into a single expanded Onsite Health Intervention Form that would cover quarantine for communicable disease exposure, triage with a licensed healthcare professional, and medication-related standing orders. The MHAF would also be revised to:

• Reduce duplicate documentation by removing the History section