Need and Use: The information requested is required by the Export-Import Bank Act of 1945, as amended, 12 U.S.C. 635g–1 (see Section 8A(a)(1) of EXIM's charter) and enables EXIM to evaluate and assess its competitiveness with the programs and activities of official export credit agencies and to report on the Bank's status in this regard.

Affected Public: EXIM plans to survey exporters and lenders that have engaged with EXIM on medium- and long-term support over the previous calendar year or responded to at least one of EXIM's last two surveys.

The number of respondents: 100.

Estimated time per respondent: 10 minutes.

The frequency of response: Annually.

Annual hour burden: 17 total hours.

Dated: September 14, 2026.

Andrew Smith,

Records Officer.

[FR Doc. 2026–19014 Filed 9–15–26; 8:45 am]

BILLING CODE 6690–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[Docket No. CDC–2026–0892]

Order Under Sections 362 and 365 of the Public Health Service Act Continuing the Suspension of the Right To Introduce Certain Persons From Countries Where a Quarantinable Communicable Disease Exists

AGENCY: Centers for Disease Control and Prevention (CDC), Department of Health and Human Services (HHS).

ACTION: Notice with comment period.

SUMMARY: The Centers for Disease Control and Prevention (CDC), a component of the Department of Health and Human Services (HHS), announces it is issuing an Order under Sections 362 and 365 of the Public Health Service Act, and associated implementing regulations, continuing the suspension of the right to introduce certain persons from countries where an outbreak of a quarantinable communicable disease exists. This Order was issued on September 11 and shall remain in effect through 4:59 p.m. Eastern Daylight Time (EDT) on Sunday, October 11, 2026. This Order may be amended or rescinded prior to that time at the discretion of the Director.

DATES: This action took effect September 11, 2026, at 5:00 p.m. EDT.

Written comments must be received on or before October 1, 2026.

ADDRESSES: You may submit comments, identified by Docket No. CDC–2026–0892 by either of the methods listed below. Do not submit comments by email. CDC does not accept comments by email.

- *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the instructions for submitting comments.
- *Mail:* Division of Global Migration Health, Centers for Disease Control and Prevention, 1600 Clifton Road NE, MS H16–4, Atlanta, GA 30329.

Instructions: All submissions received must include the agency name and Docket Number. All relevant comments received will be posted without change to *http://regulations.gov,* including any personal information provided. For access to the docket to read background documents or comments received, go to *http://www.regulations.gov.*

FOR FURTHER INFORMATION CONTACT: Jordan Faircloth, Deputy Chief of Staff, Centers for Disease Control and Prevention, 1600 Clifton Road NE, MS V18–2, Atlanta, GA 30329. Phone: 404–639–7000. Email: *cdcregulations@cdc.gov.*

SUPPLEMENTARY INFORMATION: On May 18, 2026, the Acting Director of the Centers for Disease Control and Prevention signed an Order prohibiting the introduction of certain persons who have departed from, or were otherwise present within, specified countries during the last 21 days. On May 22, 2026, the Assistant Secretary for Health (ASH), HHS, signed an Amended Order that reflected updates to 42 CFR 71.40 (f), which no longer provides an exemption for lawful permanent residents (LPRs) from such orders. CDC accepted comments on both the original Order and Amended Order through June 22, 2026. On June 21, 2026, the ASH signed a new 30-day Order continuing the previous Order, without change, and provided a 15-day comment period. On July 13, 2026, the ASH signed a new order continuing the previous Order without change and that responded to public comments as well as provided updates on the epidemiologic situation and status of the outbreak. On August 12, 2026, the ASH signed a new 30-day Order continuing the previous Order, without change, and provided a 15-day comment period. During the comment period for the August 12, 2026, Order, CDC received three comments, which are addressed below. With this notice, CDC is announcing the issuance of an Order that continues the suspension of the right to introduce certain persons who have departed from, or were otherwise present within, specified countries during the last 21 days. This Order is effective for a period of 30 days.

Response to Comments on Previous Orders

Comment: All three commenters acknowledge that CDC has both the statutory authority and responsibility to protect public health and to take reasonable measures when there is a credible risk of introducing a serious communicable disease into the United States; the commenters also acknowledge the seriousness of the Ebola disease outbreak. Even considering the gravity of the situation, the commenters expressed concerns regarding the broad application of the Order, asserting that less restrictive measures would provide adequate public health protections.

Commenters suggested that CDC consider using narrower, risk-based criteria rather than applying blanket restrictions to all covered individuals. They suggested considering a variety of factors, including specific locations visited, length of stay, activities, interactions, precautions followed, and reasons for travel. They suggested that CDC distinguish actual exposure risk rather than broad nationality- or route-based assumptions. One commenter recommended screening, diagnostic testing, health monitoring, and, where appropriate, domestic isolation as alternatives to application of the Order. Commenters asserted that such targeted approaches can protect the public while minimizing unnecessary disruptions to lawful travel, family reunification, humanitarian activities, and other legitimate interests.

Response: CDC recognizes that individual risk may differ among persons who have been present in a designated country or place where the quarantinable communicable disease outbreak is occurring. However, CDC also considers the public health and other resources required to implement an Order issued under Sections 362 and 365 of the Public Health Service Act and the implementing regulation at 42 CFR 71.40. Based on such considerations, CDC has determined that a generally applicable threshold based on whether an individual was present in a designated country or place during the relevant period is both more protective of public health and more feasible to implement.

The Order does contain exception mechanisms that permit consideration of individual circumstances where appropriate. For example, a customs officer may, with supervisory approval, except an individual based on the totality of the circumstances, including

significant humanitarian and public health interests. In addition, a person may be provisionally granted an exception by CDC, the basis of which is subsequently confirmed following a public health assessment at the time of entry and supported through the implementation of appropriate public health mitigation protocols.

CDC does not agree that individualized exposure assessments, testing, symptom screening, or monitoring can presently be feasibly implemented and serve as a substitute for the Order for all covered persons. CDC is therefore making no changes in response to this comment.

Comment: One commenter expressed concern that use of the term ''presence'' within a covered country to include airside international transit passengers who did not clear host-nation customs, never entered local domestic infrastructure, and had zero exposure to local transmission clusters, violates the Administrative Procedure Act (APA), 5 U.S.C. 706(2)(A). The commenter noted that Ebola is not an airborne pathogen, nor is it contagious during its incubation period, and that symptomatic airside transit passengers cannot transmit the virus, rendering a blanket exclusion of airside transit counter to established scientific facts. The commenter asserted that there is no epidemiological data demonstrating that airside international airport transit carries a community transmission risk profile justifying a blanket 21-day entry prohibition.

Response: CDC agrees that Ebola disease is not transmitted through ordinary airborne exposure and that persons infected with Ebola virus generally do not transmit the virus before developing symptoms. The relevant public health concern under section 265, however, is not limited to whether an asymptomatic person can transmit Ebola virus while physically present in an airport. An infected person may travel internationally during the incubation period before developing symptoms and subsequently become symptomatic while in transit or after reaching another destination.

As discussed in the previous response, CDC recognizes that individual exposure circumstances may differ among persons who have been present in a designated country or place where the quarantinable communicable disease outbreak is occurring. Whether a traveler cleared immigration or customs does not necessarily resolve all public health considerations relevant to that person's physical presence in the designated country or place or potential exposure. Airport transit may occur under varying circumstances, including differences in duration, movement within airport facilities, interactions with other persons and travelers, itinerary changes, or unanticipated delays. Moreover, implementation of the proposed limitations based on individual exposure circumstances would be more difficult to operationalize considering the volume of travelers at issue, as well as restraints on resources and personnel in the highly fluid context of international air travel.

CDC therefore declines at this time to adopt the commenter's recommendation to categorically exclude all persons whose presence in a designated country or place consisted solely of airside airport transit.

Comment: One commenter stated concern about Fifth Amendment Due Process protection of LPRs. Unlike non-resident aliens, returning LPRs possess robust Fifth Amendment Due Process protections (Landon v. Plasencia, 459 U.S. 21 (1982)). Sweeping LPRs into a total 21-day entry exclusion under 42 U.S.C. 265—while processing U.S. Citizens present in the exact same outbreak zones under 42 U.S.C. 264 domestic isolation protocols—violates Fifth Amendment Procedural Due Process and Equal Protection principles (*Bolling* v. *Sharpe,* 347 U.S. 497 (1954)).

Response: This comment is outside the scope of the continued Order. The Order is consistent with CDC's foreign quarantine regulations, including 42 CFR 71.40, which exclude U.S. citizens and U.S. nationals from the suspension authority. Changes to § 71.40 (f) to remove LPRs from the types of individuals to whom orders issued under such authority do not apply were properly promulgated pursuant to notice and comment rulemaking (91 FR 31362 (May 27, 2026)). Additionally, CDC notes that this approach helps conserve public health resources by attempting to limit the overall number of individuals arriving into the United States. CDC is therefore making no changes in response to this comment.

Comment: All commenters urged CDC to continue monitoring the situation, and to make public health decisions based on the most recent epidemiological data and current circumstances. Commenters urged CDC to be mindful of its authorities and the importance of maintaining public trust.

Response: CDC appreciates the comment and agrees that public health measures should be based on current epidemiological evidence and periodically reassessed as relevant conditions change. CDC will continue to evaluate the epidemiological conditions underlying the Order, the risk of international introduction, the effectiveness and availability of public health mitigation measures, and relevant information concerning implementation of the Order. If changing circumstances warrant modification of the geographic scope, covered populations, exceptions, or other provisions of the Order, CDC will consider such modifications consistent with 42 U.S.C. 265 and 42 CFR 71.40.

The Order also is temporary and subject to continuing reassessment. The current Order is effective for 30 days and is intended to facilitate an ongoing public health assessment and risk profile of the outbreak. CDC continues to evaluate epidemiological conditions, the risk of importation, the effectiveness and availability of mitigation measures, and other relevant public health information in determining whether the statutory and regulatory criteria remain satisfied. If those circumstances materially change, CDC will consider whether the Order should be modified, narrowed, or discontinued.

CDC agrees that transparency regarding both the public health rationale for the Order and the limits of CDC's authority is important to maintaining public trust. CDC will continue to provide information concerning the epidemiological basis for its actions and to reassess whether continued exercise of the authority under 42 U.S.C. 265 remains necessary in light of evolving public health conditions.

CDC carefully considered all comments and determined that they did not warrant changes to the requirements of the Order issued August 12, 2026. The new Order, issued on September 11, 2026, provides updated information regarding the status of the Ebola disease outbreak and CDC response efforts and maintains the previous travel restrictions.

CDC will accept comments for this Order using docket CDC–2026–0892. A copy of the Order is provided below and a copy of the signed Order can be found at *https://www.cdc.gov/port-health/legal-authorities/evdorder.html.*

U.S. Department of Health and Human Services Centers for Disease Control and Prevention (CDC)

Order Under Sections 362 & 365 of the Public Health Service Act (42 U.S.C. 265, 268) and 42 CFR § 71.40

Continuing the Suspension of the Right To Introduce Certain Persons From Countries Where a Quarantinable Communicable Disease Exists

I. Executive Summary

The Centers for Disease Control and Prevention (CDC), a component of the U.S. Department of Health and Human Services (HHS), issues this Order pursuant to Sections 362 and 365 of the Public Health Service (PHS) Act, 42 U.S.C. 265 and 268, and their implementing regulations. This Order continues the suspension of the right to introduce ''covered aliens,'' as defined herein, into the United States for a period of thirty days, subject to the outcome of an ongoing comprehensive public health risk assessment. This Order is necessary to protect public health in the United States from the serious risk posed by the introduction of Ebola disease into the United States by covered aliens based on the outbreak of Ebola disease caused by the Bundibugyo virus confirmed present in the Democratic Republic of the Congo (DRC) and, until recently, in Uganda.

This Order applies to covered aliens who have departed from, or were otherwise present within, DRC, Uganda, or South Sudan during the last 21 days (regardless of their country of origin). This Order is based on an assessment of the most recently available data and current conditions regarding the Ebola disease outbreak.

This Order is time-limited and shall be in effect for 30 days from the date of issuance. This Order is intended to address the serious risk of introduction of Ebola disease into the United States, while allowing the U.S. Government to continue an ongoing assessment of the current and evolving conditions of the Ebola disease outbreak in consultation with other stakeholders.

This Order is severable from previously issued Orders under Sections 362 and 365 of the Public Health Service (PHS) Act, 42 U.S.C. 265 and 268, and their implementing regulations under 42 CFR part 71. Any provision of this Order held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to continue to give the maximum effect to the provision permitted by law, unless such holding shall be one of utter invalidity or unenforceability.

II. Authority, Scope, and Purpose

I issue this Order pursuant to Sections 362 and 365 of the Public Health Service (PHS) Act, 42 U.S.C. 265 and 268, and their implementing regulations under 42 CFR part 71,[1] which authorize the CDC Director to suspend the right to introduce [2] persons into the United States when the Director determines that the existence of a quarantinable communicable disease in a foreign country or place creates a serious danger of the introduction of such disease into the United States and the danger is so increased by the introduction of persons from the foreign country or place that a temporary suspension of the right of such introduction is necessary to protect public health.

This Order applies to persons who have departed from, or were otherwise present within, DRC, Uganda, and South Sudan during the last 21 days (regardless of their country of origin), including lawful permanent residents of the United States, subject to the exceptions detailed below. For purposes of this Order, I refer to persons covered by the Order as ''covered aliens.''

This Order does *not* apply to the following:

- U.S. citizens and U.S. nationals; [3]
- Members of the armed forces of the United States and associated personnel, U.S. government personnel serving overseas, associated personnel, and their spouses and children, subject to required assurances; [4]
- Persons whom customs officers determine, with approval from a supervisor, should be excepted from this Order based on the totality of the circumstances, including consideration of significant law enforcement, officer and public safety, humanitarian, and public health interests. The U.S. Department of Homeland Security (DHS) will consult with CDC regarding the standards for such exceptions to help ensure consistency with current CDC guidance and public health recommendations; and
- Persons who would otherwise be subject to this Order, who are permitted to enter the United States based on an exception provisionally granted by CDC with confirmation based on a public health assessment at time of entry under a DHS-approved process documented and shared with CDC which includes appropriate public health mitigation protocols, per CDC guidance.

The purpose of this Order is twofold. First, this Order aims to continue minimizing the number of covered aliens entering the United States who have been within countries experiencing or that have recently experienced a known or suspected outbreak of Ebola disease and thereby reduce the risk of introduction of Ebola disease into the United States. Second, this Order is intended to facilitate an ongoing public health assessment and risk profile of the Ebola disease outbreak. Thirty days is the amount of time necessary for CDC to continue monitoring the situation and determine if there has been a material change to the risk of importation and whether this Order would remain in effect or requires modification. Such information will enable the CDC Director to make an informed determination regarding what restrictions are necessary going forward and provide the opportunity for the development of a comprehensive mitigation and containment plan in consultation with stakeholders.

III. Factual Basis

A. Ebola Disease

Viral hemorrhagic fever refers to a group of severe illnesses caused by certain viruses that damage the body's blood vessels and affect the ability of the blood to clot properly. Viral hemorrhagic fevers include diseases such as Ebola, Marburg, Lassa fever, and dengue hemorrhagic fever.

Bundibugyo virus disease (BVD) is a severe and often fatal illness caused by one of the viruses in the Ebola family. Ebola disease outbreaks occur mainly in parts of sub-Saharan Africa and can spread rapidly in communities with limited healthcare resources. Ebola disease caused by the Bundibugyo virus is a rare form of Ebola first identified during an outbreak in Bundibugyo District, Uganda, in 2007. Bundibugyo virus is one of several species within the orthoebolavirus family and causes symptoms similar to other forms of Ebola, including fever, weakness, vomiting, diarrhea, and, in severe cases, hemorrhagic complications and organ failure. The disease spreads through direct contact with infected bodily fluids or contaminated materials.

The incubation period for Ebola disease caused by the Bundibugyo virus is typically between 2 and 21 days, with

[1] Control of Communicable Diseases; Foreign Quarantine: Suspension of the Right to Introduce and Prohibition of Introduction of Persons into United States from Designated Foreign Countries or Places for Public Health Purposes, 85 FR 56424 (Sept. 11, 2020), as amended by 91 FR 31362 (May 27, 2026); 42 CFR 71.40.

[2] *Suspension of the right to introduce* means to cause the temporary cessation of the effect of any law, rule, decree, or order pursuant to which a person might otherwise have the right to be introduced or seek introduction into the United States. 42 CFR 71.40(b)(5).

[3] 42 CFR 71.40(f).

[4] 42 CFR 71.40(e)(1) and (2).

most people developing symptoms within 4 to 10 days after exposure. During this incubation period, infected persons do not spread the virus until symptoms begin.

Screening for Bundibugyo virus disease focuses on identifying symptoms and possible exposure history, such as recent travel to affected areas or contact with infected aliens. Suspected patients are evaluated for symptoms including fever, weakness, vomiting, diarrhea, and bleeding, and laboratory confirmation is performed using specialized tests such as PCR (polymerase chain reaction) to detect the virus in blood and other body fluid samples. Health authorities also use temperature checks, contact tracing, and isolation procedures to prevent transmission.

There are currently no widely approved vaccines or specific antiviral treatments for the Bundibugyo strain of Ebola disease. Treatment mainly consists of supportive care, including intravenous fluids, electrolyte replacement, oxygen support, pain and fever management, and treatment of secondary infections. Early medical care significantly improves survival chances. Robust public health measures such as early detection, rapid isolation, strong infection prevention measures (*i.e.,* use of personal protective equipment [PPE]), and monitoring of contacts are critical to controlling outbreaks and reducing deaths. A clinical trial of monoclonal antibodies is presently underway in DRC.[5] However, experts expect it will be several months before these therapeutics are potentially available for wider use.

B. Ongoing Bundibugyo Virus Disease Outbreak

The ongoing outbreak of Ebola virus disease caused by the Bundibugyo virus in DRC continues to escalate in intensity and expand geographically. The outbreak is now the largest and deadliest Ebola outbreak in DRC's history, as well as the second largest Ebola outbreak on record.[6] The outbreak remains centered in eastern DRC's Ituri Province, although cases have been identified in North Kivu, South Kivu, Haut-Uele, Tshopo, and Bas-Uélé provinces. This geographic expansion is concerning, particularly given that response efforts are still not at the scale required for outbreak containment. On August 9, prior to the issuance of the last Order, DRC reported 4,318 confirmed cases and 2,011 deaths across 41 health zones. Cases and deaths have continued to increase and as of September 9, DRC reports 6,779 confirmed cases and 3,267 deaths across 61 health zones.

As recently as September 10, 2026, the ongoing Bundibugyo Ebola virus outbreak in DRC continues to spread despite response efforts. Although contact tracing for confirmed cases has risen to approximately 87% nationwide, these efforts are still well below the operational threshold of 95% needed to successfully slow the spread of this outbreak.[7] Recent assessments indicate that the true magnitude of the outbreak may be two to four times greater than reported surveillance data suggest. Surveillance challenges persist in the most heavily affected areas, with conflict and insecurity, weak health infrastructure, and relatively porous borders in the region complicating containment efforts. These conditions increase the likelihood that cases will remain undetected and that infected persons may travel outside affected areas before being identified by public health authorities.

As of August 27, 2026, the 42-day enhanced monitoring period—defined as twice the maximum incubation period for Ebola (21 days) per international guidance has been completed in Uganda.[8] Over the course of the outbreak in Uganda, the country reported 20 confirmed cases of Ebola disease and two confirmed deaths, as well as one probable case and one probable death. The last confirmed case was reported on June 21, 2026. Of the confirmed cases, 15 were imported cases and 5 were secondary cases linked to imported cases from DRC.[9] All cases in Uganda have been epidemiologically linked to the ongoing outbreak in DRC, with cross-border importations having occurred, resulting in secondary transmission among family members and caregivers.[10] Ugandan authorities activated emergency response systems, expanded surveillance, and strengthened screening at borders and health facilities. Although the country has achieved successful containment of the outbreak, continued overland travel from DRC poses an ongoing risk of cross-border transmission, particularly among healthcare workers and in western Ugandan districts that serve as points of entry for travelers seeking medical care.

To date, South Sudan has not reported any confirmed Ebola disease cases in the current outbreak.[11] However, it is considered at high risk because of its close border with affected areas in eastern DRC, limited healthcare infrastructure, and cross-border population movement. Regional and international agencies, including WHO and Africa CDC, are supporting preparedness measures, surveillance, and coordination among the three countries to prevent wider spread. Despite these efforts, there continues to be a risk that the outbreak in DRC could spread to South Sudan through cross-border travel by infected individuals during the virus's incubation period, when they have been exposed but are not yet showing symptoms.

Travelers moving between affected countries and major international transit hubs could unknowingly carry the Bundibugyo virus before becoming ill. Such travelers may spread the outbreak beyond the affected countries and ultimately reach the United States. DRC, Uganda, and South Sudan are connected to the global aviation network through a series of regional and international transit hubs that provide pathways into the United States. Travelers departing from outbreak-affected regions frequently transit through densely populated metropolitan airports such as Addis Ababa Bole International Airport (ADD), Jomo Kenyatta International Airport (NBO) in Nairobi, Brussels Airport (BRU), Hamad International Airport (DOH) in Doha, Dubai International Airport (DXB), and Istanbul Airport (IST), all of which maintain extensive passenger connectivity to major U.S. gateway airports including John F. Kennedy International Airport (JFK), Washington Dulles International Airport (IAD), Hartsfield-Jackson Atlanta International

[5] WHO, *Patient enrolment begins in a scientific trial to identify the first effective treatments for Bundibugyo virus disease, https://www.who.int/news/item/02-07-2026-patient-enrolment-begins-in-a-scientific-trial-to-identify-the-first-effective-treatments-for-bundibugyo-virus-disease* (last accessed September 10, 2026).

[6] Kabasele D, Meyer E, Kabore I, et al. Notes from the Field: Characteristics and Monitoring of the 2026 Outbreak of Ebola Disease Caused by Bundibugyo Virus—Democratic Republic of the Congo, August 2026. MMWR Morb Mortal Wkly Rep 2026;75:554–556. DOI: *http://dx.doi.org/10.15585/mmwr.mm7535e1*.

[7] Ministry of Public Health, Hygiene and Social Welfare, *Situation Report on the 17th Ebola Virus Outbreak Disease/DRC—August 6, 2026, https://insp.cd/category/activite-cousp/* (last accessed September 10, 2026).

[8] World Health Organization, Uganda ends Ebola outbreak following completion of 42-day countdown, *https://www.afro.who.int/countries/uganda/news/uganda-ends-ebola-outbreak-following-completion-42-day-countdown* (last accessed September 10, 2026).

[9] WHO, *Disease Outbreak News: Ebola disease caused by Bundibugyo virus, Democratic Republic of the Congo & Uganda, https://www.who.int/emergencies/disease-outbreak-news/item/2026-DON613* (last accessed September 10, 2026).

[10] CDC internal data.

[11] CDC, *Ebola Outbreak: Current Situation, https://www.cdc.gov/ebola/situation-summary/index.html* (last visited September 10, 2026).

Airport (ATL), Chicago O'Hare International Airport (ORD), and Los Angeles International Airport (LAX). These international transportation corridors support continuous movement of travelers between Central and East Africa and major U.S. metropolitan centers, increasing the likelihood that aliens exposed to Ebola disease could enter the United States before symptoms become apparent. Complex multi-leg itineraries and the rapid pace of international travel create substantial challenges for identifying potentially infected travelers before arrival.

A traveler infected in outbreak regions of DRC may transit through multiple countries and major international airports before developing fever or other clinical signs of disease. The risk of Bundibugyo virus disease introduction into the United States is heightened by the virus's incubation period, which can extend up to 21 days, allowing infected persons to travel internationally while asymptomatic and therefore unlikely to be detected through routine symptom-based screening measures. The current outbreak has already demonstrated this risk: a physician infected while providing patient care in DRC traveled internationally before becoming ill and was diagnosed only after arriving in France.[12] That case required extensive public health coordination, including federal, state, and local government efforts to identify, notify, and monitor potentially exposed U.S. citizens, demonstrating that a single infected traveler can impose significant cross-border public health response demands even without onward transmission occurring within the United States. Accordingly, the interconnected nature of global air travel presents a credible pathway for Bundibugyo virus disease importation into the United States, underscoring the importance of aggressive surveillance, traveler monitoring, airport public health screening, healthcare preparedness, and rapid containment capabilities.

Travelers utilizing air transit pathways originating in or passing through DRC, Uganda, and South Sudan include non-U.S. citizens, including regional migrants, foreign contract workers, humanitarian personnel, business travelers, students, refugees, and third-country nationals moving through international aviation hubs in Africa, the Middle East, and Europe. Many travelers entering U.S.-bound itineraries from these pathways may do so under temporary visas, refugee or asylum processing mechanisms, international organizational travel, or multi-country itineraries that obscure their original point of departure. As a result, public health screening and border security systems face heightened operational complexity in identifying travelers with recent exposure histories linked to Ebola-affected regions, particularly when travelers originate from or transit through multiple jurisdictions prior to arrival at major U.S. metropolitan airports.

CDC has issued a series of Travel Health Notices (THNs) for the region; the THNs for the affected provinces have escalated over time. On August 4, 2026, CDC escalated the THN issued for Ituri and North Kivu Provinces of DRC to a Level 4 (avoid all travel).[13] A Level 3 THN (reconsider nonessential travel) is currently in place for South Kivu, Haut-Uélé, and Tshopo Provinces of DRC.[14] The rest of DRC and all of Uganda remain under a Level 2 THN (practice enhanced precautions).[15] Modifications to the THNs reflect the geographic distribution of reported cases and do not indicate a reduced level of concern regarding the outbreak, which continues to expand in affected areas and poses a risk of further transmission and geographic spread.

CDC modeling indicates that, absent rapid and sustained public health interventions, the outbreak could become one of the largest Ebola epidemics ever recorded.[16] The analysis further demonstrates that early identification of cases, contact tracing, isolation and treatment of symptomatic persons, community engagement, and safe burial practices are critical to reducing transmission and mitigating outbreak growth.[17] CDC has concluded that the current outbreak is already the largest known outbreak of Bundibugyo virus disease and that large-scale, sustained public health measures are necessary to prevent further international spread of the disease and to reduce the risk of introduction of infected persons into the United States.[18]

Restricting entry of covered aliens into the United States reduces the volume of higher-risk international arrivals requiring public health monitoring and follow-up. By limiting the number of potentially exposed travelers entering through major U.S. ports of entry, federal, state, and local public health authorities have concentrated finite surveillance, screening, contact tracing, quarantine management, and medical monitoring resources on returning U.S. citizens and U.S. nationals, including those who have worked in the outbreak areas.

Paired with the DHS arrival restrictions redirecting travelers to specific U.S. airports,[19] this approach has reduced operational strain on airport screening systems, CDC port health stations, public health laboratories, and healthcare facilities responsible for evaluating suspected Bundibugyo virus disease cases. It also has improved the ability of authorities to conduct detailed exposure assessments, ensure compliance with monitoring requirements during the 21-day incubation period, rapidly identify symptomatic travelers, and allocate specialized isolation and treatment capacity more effectively. In the context of a rapidly evolving Bundibugyo virus disease outbreak with significant cross-border mobility, prioritizing surveillance efforts toward a smaller and more traceable traveler population has strengthened the overall effectiveness of U.S. disease containment and border health security operations.

IV. Legal Basis for This Order Under Sections 362 and 365 of the Public Health Service Act and 42 CFR 71.40

CDC is issuing this Order pursuant to sections 362 and 365 of the Public Health Service Act (42 U.S.C. 265, 268) and the implementing regulation at 42 CFR 71.40. In accordance with these authorities, the CDC Director is permitted to prohibit, in whole or in

[12] World Health Organization, *WHO Director-General's opening remarks at the media briefing—24 June 2026,* available at *https://www.who.int/news-room/speeches/item/who-director-general-s-opening-remarks-at-the-media-briefing—24-june-2026* (last accessed September 10, 2026).

[13] CDC issued a Level 2 THN (practice enhanced precautions) for Ituri and North Kivu Provinces of DRC on May 15, 2026; this was escalated to a Level 3 THN (reconsider nonessential travel) on May 18, 2026. The current Level 4 THN is available at *https://wwwnc.cdc.gov/travel/notices/level4/ebola-drc-provinces* (last accessed September 10, 2026).

[14] South Kivu was added to the Level 3 THN on May 22, 2026; Haut-Uélé and Tshopo Provinces were added on August 4, 2026. The current THN is available at *https://wwwnc.cdc.gov/travel/notices/level3/ebola-democratic-republic-of-the-congo* (last accessed September 10, 20262026).

[15] CDC issued a Level 1 THN (practice usual precautions) for Uganda on May 15, 2026. On May 27, 2026, the THN for Uganda was elevated to a Level 2. On June 15, 2026, CDC issued a Level 2 THN for the remainder of DRC and Uganda. The current THN is available at *https://wwwnc.cdc.gov/travel/notices/level2/ebola-drc-uganda* (last accessed September 10, 2026).

[16] Mooring EQ, Koval WT, Routledge I, et al. *Modeled Scenario Projections for the Ebola Disease Outbreak Caused by Bundibugyo Virus, 2026.* MMWR Morb Mortal Wkly Rep 2026;75:285–289. DOI: *http://dx.doi.org/10.15585/mmwr.mm7522e1.*

[17] *Id.*

[18] *Id.*

[19] DHS, Arrival Restrictions Applicable to Flights Carrying Persons Who Have Recently Traveled From or Were Otherwise Present Within the Democratic Republic of the Congo, Uganda, or South Sudan, 91 FR 29896 (May 21, 2026).

part, the introduction into the United States of persons from designated foreign countries (or one or more political subdivisions or regions thereof) or places, only for such period of time that the Director deems necessary to avert the serious danger of the introduction of a quarantinable communicable disease,[20] by issuing an Order in which the Director determines that:

(1) By reason of the existence of any quarantinable communicable disease in a foreign country (or one or more political subdivisions or regions thereof) or place there is serious danger of the introduction of such quarantinable communicable disease into the United States; and

(2) This danger is so increased by the introduction of persons from such country (or one or more political subdivisions or regions thereof) or place that a suspension of the right to introduce such persons into the United States is required in the interest of public health.[21]

Section 362 and the implementing regulation provide the Director with a public health tool to suspend introduction of persons not only to prevent the introduction of a quarantinable communicable disease, but also to aid in continued efforts to mitigate spread of that disease.[22]

The term ''introduction into the United States'' is defined in 42 CFR 71.40 as ''the movement of a person from a foreign country (or one or more political subdivisions or regions thereof) or place, or series of foreign countries or places, into the United States so as to bring the person into contact with persons or property in the United States, in a manner that the Director determines to present a risk of transmission of a quarantinable communicable disease to persons, or a risk of contamination of property with a quarantinable communicable disease.'' 42 CFR 71.40(b)(1). Similarly, the term ''serious danger of the introduction of such quarantinable communicable disease into the United States'' is defined as, ''the probable introduction of one or more persons capable of transmitting the quarantinable communicable disease into the United States, even if persons or property in the United States are already infected or contaminated with the quarantinable communicable disease.'' 42 CFR 71.40(b)(3).

Section 71.40(b)(2) defines ''[p]rohibit, in whole or in part, the introduction into the United States of persons'' in Section 362 to mean ''to prevent the introduction of persons into the United States by suspending any right to introduce into the United States, physically stopping or restricting movement into the United States.'' *See also* 42 U.S.C. 265 (authorizing the prohibition when the danger posed by the communicable disease ''is so increased by the introduction of persons . . . from such country . . . that a suspension of the right to introduce such persons . . . is required in the interest of public health'').

As stated in the Final Rule for 42 CFR 71.40, CDC ''may, in its discretion, consider a wide array of facts and circumstances when determining what is required in the interest of public health in a particular situation . . . includ[ing] . . . [t]he overall number of cases of disease; any large increase in the number of cases over a short period of time; the geographic distribution of cases; any sustained (generational) transmission; the method of disease transmission; morbidity and mortality associated with the disease; the effectiveness of contact tracing; the adequacy of state and local health care systems; and the effectiveness of state and local public health systems and control measures.'' [23]

As stated in 42 CFR 71.40, this Order does not apply to U.S. citizens, U.S. nationals, members of the armed forces of the United States and associated personnel if the Secretary of War provides assurance to the Director that the Secretary of War has taken or will take measures such as quarantine or isolation, or other measures maintaining control over such individuals, to prevent the risk of transmission of the quarantinable communicable disease into the United States, or United States government employees or contractors on orders abroad, or their accompanying family members who are on their orders or are members of their household, if the Director receives assurances from the relevant head of agency and determines that the head of the agency or department has taken or will take measures such as quarantine or isolation, to prevent the risk of transmission of a quarantinable communicable disease into the United States.[24]

In addition, this Order does not apply to additional classes of persons excepted by the CDC Director. Creating exceptions in the Order is consistent with Section 362 and 42 CFR 71.40. Section 362 explicitly states that the prohibition of introduction into the United States may be ''in whole or in part.'' This phrase is also included in section 71.40(a) and, as explained in the Final Rule, is intended to allow the Director to narrowly tailor the use of the authority to what is required in the interest of public health.[25] As noted in the Final Rule for 42 CFR 71.40, the CDC Director may also take into account international obligations and humanitarian concerns.[26] Pursuant to this capability, CDC is therefore excepting certain categories of persons, as described herein.

This Order will be in effect for 30 days to avert the serious danger of the introduction, transmission, and spread of Ebola disease into the United States. Finally, as directed by 42 CFR 71.40(c), this Order sets out the following:

(1) The foreign countries (or one or more political subdivisions or regions thereof) or places from which the introduction of persons is being prohibited;

(2) The period of time or circumstances under which the introduction of any persons or class of persons into the United States is being prohibited;

(3) The conditions under which that prohibition on introduction will be effective, in whole or in part, including any relevant exceptions that the Director determines are appropriate;

(4) The means by which the prohibition will be implemented; and

(5) The serious danger posed by the introduction of the quarantinable communicable disease in the foreign country or countries (or one or more political subdivisions or regions thereof) or places from which the introduction of persons is being prohibited.

V. Determination and Implementation

Based on the foregoing, I hereby determine that Ebola disease, a highly transmissible quarantinable communicable disease, is confirmed currently present in DRC and recently present in Uganda. There is a material risk that the outbreak will spread to South Sudan and again to Uganda. I also determine that the prevalence of Ebola disease in these foreign countries constitutes a serious danger of the introduction of this disease into the United States due to the limited screening and testing and mitigation measures currently available. Finally, I determine that a temporary 30-day suspension of the right to introduce

[20] *See* Exec. Order No. 13,295, Revised List of Quarantinable Communicable Diseases (April 2, 2003) (adding viral hemorrhagic fevers, including Ebola, to the U.S. federal list of quarantinable communicable diseases).

[21] 42 U.S.C. 265; 42 CFR 71.40.

[22] 85 FR 56424 at 56425–26.

[23] *Id.* at 56444.

[24] 42 CFR 71.40(e) and (f).

[25] 85 FR 56424 at 56444.

[26] *Id.* at 56447.

covered aliens is necessary to protect the public health from the serious danger of the introduction of Ebola disease into the United States, pending an ongoing public health assessment of the Ebola disease outbreak.

I consulted with the Department of State, DHS, and other federal departments as needed before I issued this Order and requested that DHS aid in the enforcement of this Order because CDC does not have the capability, resources, or personnel needed to do so.[27] As part of the consultation, DHS developed operational plans for implementing this Order. These plans are consistent with the language of this Order.

Although this Order is not a rule subject to notice and comment under the Administrative Procedure Act (APA) and is issued with immediate effect, in order to ensure that the forthcoming public health risk assessment is informed by public input, the Order is being issued with a simultaneous 15-day comment period.

This Order takes effect at 5:00 p.m. Eastern Daylight Time on Friday, September 11, 2026. For individuals intending to travel to the United States by air, the Order will apply to flights departing after 4:59 p.m. Eastern Daylight Time on Friday, September 11, 2026.

* * * * *

In testimony whereof, the Assistant Secretary for Health, U.S. Department of Health and Human Services, has hereunto set his hand at _____ this 11th day of September, 2026.

Dated:

Admiral Brian Christine, MD, Assistant Secretary for Health (ASH) and Head of the United States Public Health Service (USPHS) Commissioned Corps Department of Health and Human Services.

Public Participation

Interested persons or organizations are invited to participate by submitting written views, recommendations, and data so that the public can provide input that may inform the forthcoming public health risk assessment and whether any subsequent exercise of this authority is necessary.

Please note that comments received, including attachments and other supporting materials, are part of the public record and are subject to public disclosure. Comments will be posted on *https://www.regulations.gov.* Therefore, do not include any information in your comment or supporting materials that you consider confidential or inappropriate for public disclosure. If you include your name, contact information, or other information that identifies you in the body of your comments, that information will be on public display. CDC will review all submissions and may choose to redact, or withhold, submissions containing private or proprietary information such as Social Security numbers, medical information, inappropriate language, or duplicate/near duplicate examples of a mass-mail campaign. Do not submit comments by email. CDC does not accept comment by email.

Authority

The authority for this order is Sections 362 and 365 of the Public Health Service Act (42 U.S.C. 265, 268), as amended.

Brian Christine,

Admiral, Assistant Secretary for Health (ASH) and Head of the United States Public Health Service (USPHS) Commissioned Corps Department of Health and Human Services.

[FR Doc. 2026–18948 Filed 9–15–26; 8:45 am]

BILLING CODE 4163–18–P

[27] 42 U.S.C. 268; 42 CFR 71.40(d).

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1864–N]

Medicare Program; Public Meeting for New Revisions to the Healthcare Common Procedure Coding System (HCPCS) Level II Coding

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

ACTION: Notice.

SUMMARY: This notice announces the second biannual Healthcare Common Procedure Coding System (HCPCS) Level II public meeting of 2026 to discuss the CMS preliminary coding, Medicare benefit category, and Medicare payment determinations, if applicable, for new revisions to the HCPCS Level II code set for non-drug and non-biological items and services, as well as how to register for the meeting.

DATES:

Primary meeting date: Monday, November 2, 2026, 9 a.m. to 5 p.m. Eastern Standard Time (EST).

Overflow meeting date: Tuesday, November 3, 2026, 9 a.m. to 5 p.m. EST (virtual only).

Deadline for Registration of Speakers, In-person Attendees, and Requests for Special Accommodations: The deadline to register as a speaker, register for in-person attendee, or request special accommodations is 5 p.m. Eastern Daylight Time (EDT) on Monday, October 19, 2026.

Deadline for Submission of Written Comments: 5:00 p.m. EST on Wednesday, November 4, 2026.

ADDRESSES:

Meeting Location: The HCPCS Level II public meeting will be a hybrid event held as follows:

- *In-person:* The Centers for Medicare & Medicaid Services (CMS), 7500 Security Boulevard, Baltimore, MD 21244.
- *Virtual:* Live stream via Teams (link will be posted on the HCPCS Level II website).

Registration of Speakers, In-person Attendees, and Requests for Special Accommodations: Individuals wishing to speak at the meeting must follow the instructions in sections IV. and V. of this notice by the deadline specified in the **DATES** section of this notice via email to *HCPCS@cms.hhs.gov.* Individuals who need special accommodations should follow the instructions specified in section III.C. of this notice or send an email by the deadline specified in the **DATES** section of this notice to *HCPCS@cms.hhs.gov.*

Submission of Written Comments: Written comments must be submitted via email by the deadline specified in the **DATES** section of this notice to *HCPCS@cms.hhs.gov.*

FOR FURTHER INFORMATION CONTACT: Sundus Ashar, (410) 786–0750, *Sundus.ashar1@cms.hhs.gov,* or *HCPCS@cms.hhs.gov.*

SUPPLEMENTARY INFORMATION:

I. Background

On December 21, 2000, Congress enacted the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106–554). Section 531(b) of BIPA mandated that the Secretary establish procedures that permit public consultation for coding and payment determinations for new durable medical equipment (DME) under Medicare Part B of title XVIII of the Social Security Act. In the November 23, 2001 **Federal Register** (66 FR 58743), we published a notice providing information regarding the establishment of the annual public meeting process for DME.

In 2020, we implemented changes to our Healthcare Common Procedure Coding System (HCPCS) Level II coding procedures, including the establishment of quarterly coding cycles for drugs and biological products and biannual coding