amount of $200,000.00 to HRI. HRI will establish a Project Advisory Committee, convene its meetings, document the proceedings, and evaluate and rank potential projects based on their success potential. HRI will develop a site restoration plan incorporating the work from professional engineers. Each plan will include an adaptive monitoring plan to document the effectiveness of the techniques and actions used to restore habitat for colonial nesting waterbirds.

Keala J. Hughes,

Director of External Affairs & Tribal Relations, Gulf Coast Ecosystem Restoration Council.

[FR Doc. 2026–19029 Filed 9–16–26; 8:45 am]

BILLING CODE 6560–58–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3483–FN]

Medicare and Medicaid Programs; Application From DNV Healthcare USA Inc. (DNV) for Continued CMS-Approval of its Hospital Accreditation Program

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

ACTION: Notice.

SUMMARY: This notice acknowledges the approval of an application from DNV Healthcare USA Inc. (DNV) for continued CMS recognition as a national accrediting organization for hospitals that wish to participate in the Medicare or Medicaid programs.

DATES: The decision announced in this notice is effective September 26, 2026, through September 26, 2032.

FOR FURTHER INFORMATION CONTACT: Lillian Williams, *Lillian.Williams@cms.hhs.gov,* and (410) 786–8636 CMS AO Application Team *AO_Applications@cms.hhs.gov.*

SUPPLEMENTARY INFORMATION:

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services from a hospital, provided certain requirements are met. Section 1861(e) of the Social Security Act (the Act) establishes distinct criteria for facilities seeking designation as a hospital. Regulations concerning provider agreements are at 42 CFR part 489 and those pertaining to activities relating to the survey and certification of facilities are at 42 CFR part 488. The regulations at 42 CFR part 482 specify the minimum conditions that a hospital must meet to participate in the Medicare program.

Generally, to enter into an agreement with Medicare, a hospital must first be certified by a state survey agency (SA) as complying with the conditions or requirements set forth in part 482 of our regulations. Thereafter, the hospital is subject to regular surveys by an SA to determine whether it continues to meet these requirements. However, there is an alternative to surveys by SAs.

Section 1865(a)(1)(A) of the Act provides that, if a provider entity demonstrates through accreditation by a Centers for Medicare & Medicaid Services (CMS) approved national accrediting organization (AO) that all applicable Medicare requirements are met or exceeded, we will deem that provider entity to have met such requirements. Accreditation by an AO is voluntary and is not required for Medicare participation.

If an AO is recognized by the Secretary of the Department of Health and Human Services as having standards for accreditation that meet or exceed Medicare requirements, any provider entity accredited by the national accrediting body's approved program would be deemed to meet the Medicare conditions. A national AO applying for approval of its accreditation program under part 488, subpart A, must provide CMS with reasonable assurance that the AO requires the accredited provider entities to meet requirements that meet or exceed the Medicare conditions. ''Deemed status'' is defined at § 488.1, and it means that CMS has certified that a provider or supplier for Medicare participation based on the fact it has been accredited by a CMS-approved AO and met other participation requirements to become a ''deemed'' provider or supplier.

CMS reviews the standards and processes utilized by such AOs periodically, and if CMS determines that the AO's standards and processes meet or exceed those used by CMS surveyors, CMS grants or renews ''deeming authority'' to the AO for certain types of providers and suppliers, as outlined within this notice. Any provider or supplier thereafter surveyed by such approved AO and found to have met Medicare's regulatory standards is recognized by CMS as a ''deemed'' provider or supplier. Our regulations concerning the approval of AOs are set forth at §§ 488.4 and 488.5. The regulation at § 488.5(e)(2)(i) permits CMS to approve or re-approve an AO application for a period not to exceed 6 years.

DNV's current term of approval for their hospital accreditation program expires September 26, 2026.

II. Application Review Process

Section 1865(a)(3)(A) of the Act provides a statutory timetable to ensure that our review of applications for CMS-approval of an accreditation program is conducted in a timely manner. The Act provides us 210 days after the date of receipt of a complete application, with any documentation necessary to make the determination, to complete the application review process. Within 60 days after receiving a complete application, we must publish a notice in the **Federal Register** that identifies the national accrediting body making the request, describes the request, and provides no less than a 30-day public comment period. At the end of the 210-day period, we must publish a notice in the **Federal Register** approving or denying the application.

III. Provisions of the Proposed Notice

On April 9, 2026, we published a proposed notice in the **Federal Register** (91 FR 17970), announcing DNV Healthcare USA Inc.'s (DNV's) request for continued approval of its Medicare hospital accreditation program. CMS approves or denies an AO's application based on an assessment of the factors stated, which may include, but is not limited to, a review of the information required to be submitted by the AO, interviews with AO staff, an evaluation of the AO's survey process and findings, or other activities necessary to determine that the AO meets the requirements set forth at §§ 488.4 and 488.5. Under Section 1865(a)(2) of the Act and in our regulations at § 488.5 and § 488.8(h), we reviewed DNV's Medicare hospital application in accordance with the criteria specified by our regulations, which included an assessment of the following:

- DNV's (1) corporate policies; (2) financial viability; (3) ability to investigate and respond appropriately to allegations of violations of the Medicare program requirements; and (4) survey review and decision-making process.
- Survey processes to confirm that they are comparable to SAs' survey processes, and DNV can adequately assess whether a provider or supplier meets or exceeds the Medicare program requirements.
- The composition of the survey team.
- Procedures for monitoring deemed hospitals it has found to be out of

compliance with DNV's program requirements.

- Ability to report deficiencies to the surveyed hospital and respond to the hospital's plan of correction in a timely manner.
- Verification of DNV's agreement to provide CMS with a copy of the most current accreditation survey, together with any other information related to the survey as we may require, including corrective action plans.

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

In accordance with Section 1865(a)(3)(A) of the Act, on April 9, 2026, the proposed notice solicited public comments regarding whether DNV's requirements met or exceeded the Medicare conditions for hospitals. CMS received several comments, all of which supported the continued approval of DNV's hospital accreditation program. Commenters described DNV as fair, thorough, and knowledgeable of applicable standards and noted that its accreditation program supports hospital quality, patient safety, and effective hospital management. We thank the commenters for their input and have considered it when making our decision.

V. Provisions of the Final Notice

A. Differences Between DNV's Standards and Requirements for Accreditation and Medicare Conditions and Survey Requirements

We assessed DNV's hospital accreditation requirements and survey process in comparison with the Medicare CoPs of part 482 and the survey and certification process requirements of parts 488 and 489. Our review and evaluation of DNV's hospital application, which were conducted as described in section III. of this final notice, yielded the following areas where, as of the date of this final notice, DNV has completed revising its documentation in order to meet our requirements by:

- Revising the Survey Report and Corrective Action Plan Submittal Form to include an allowance for the Fire Safety Evaluation System (FSES) and revising the survey guidance to address the FSES process, required documentation, survey resubmittal requirements, and approval process.
- Revising the inspection, testing, and maintenance frequency guidance to define quarterly, semiannual, annual, 3-year, and 5-year frequencies consistent with CMS requirements and clarifying that the specified frequency is required unless otherwise permitted by the manufacturer or applicable National Fire Protection Association (NFPA) codes and standards.

B. Term of Approval

Based on our review and observations described in sections III. and V. of this final notice, we find that DNV provides reasonable assurance that accredited entities would meet or exceed the applicable Medicare conditions and we approve DNV as a national AO for hospitals that request participation in the Medicare program. The decision announced in this final notice is effective September 26, 2026, through September 26, 2032 (6 years). In accordance with § 488.5(e)(2)(i), the term of the approval will not exceed 6 years.

VI. 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 Vanessa Garcia, who is the Federal Register Liaison, to electronically sign this document for purposes of publication in the **Federal Register**.

Vanessa Garcia,

Federal Register Liaison, Center for Medicare & Medicaid Services.

[FR Doc. 2026–19061 Filed 9–16–26; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

[Office of Management and Budget #: 0970–0642]

Proposed Information Collection Activity; Diaper Distribution Demonstration and Research Pilot Beneficiary and Organizational Survey and Beneficiary Report

AGENCY: Office of Community Services, Administration for Children and Families, Department of Health and Human Services.

ACTION: Request for public comments.

SUMMARY: The Office of Community Services (OCS), Administration for Children and Families (ACF), Department of Health and Human Services, is proposing to continue to collect data to understand diaper need and outcomes for beneficiaries of the Diaper Distribution Demonstration and Research Pilot (DDDRP). This collection (Office of Management and Budget (OMB) #: 0970–0642) currently includes the Beneficiary Report and Beneficiary Survey. No changes are proposed to the Beneficiary Report. OCS is proposing revisions to the Beneficiary Survey and proposes adding a new Organizational Survey.

DATES: Comments due November 16, 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: This notice is to invite public comments on OCS's proposal to revise the Beneficiary Survey, introduce a survey of grant recipients and their partners, and to continue to use the Beneficiary Report with no changes. This revision request would extend approval of information collection activities for an additional 3 years.

The DDDRP beneficiary survey was developed to examine diaper need and outcomes for beneficiaries served by DDDRP. It was piloted under the Formative Data Collections for ACF Program Support umbrella generic (OMB #: 0970–0531) with the first three cohorts of DDDRP grant recipients. To continue to learn about the people who receive grant services and the extent to which they achieve expected short-term outcomes, the updated proposed survey includes two versions: An enrollment version and a follow-up version.

- The Enrollment Version of the Beneficiary Survey is a revised version of the current Beneficiary Survey. This version will continue to collect demographic data on the children served and caregivers enrolling in the program; information about the employment, education, and income of caregivers; and indicators of diaper need. The survey has been revised to also include contact information for the caregiver, early learning environment participation of children, and diaper-related health. The survey has also been revised to remove several items that proved to be not informative enough to