



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-3483-PN]

Medicare and Medicaid Programs: Application from DNV Healthcare USA Inc. for Continued CMS-Approval of its Hospital Accreditation Program

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice with request for comment.

SUMMARY: This notice acknowledges the receipt of an application from DNV Healthcare USA Inc. (DNV) for continued recognition as a national accrediting organization for its hospital accreditation program to participate in the Medicare or Medicaid programs.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than [INSERT DATE 30 DAYS AFTER DATE OF PUBLICATION IN THE FEDERAL REGISTER].

ADDRESSES: In commenting, please refer to file code CMS-3483-PN.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to <https://www.regulations.gov/docket/CMS-2026-1288>. Follow the “submit a comment” instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-3483-PN,

P.O. Box 8010,

Baltimore, MD 21244-8010.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-3483-PN,
Mail Stop C4-26-05,
7500 Security Boulevard,
Baltimore, MD 21244-1850.

For information on viewing public comments, see the beginning of the “SUPPLEMENTARY INFORMATION” section.

FOR FURTHER INFORMATION CONTACT:

Joann Fitzell, (410) 786-4280.

Lillian Williams, (410) 786-8636.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: <https://www.regulations.gov>. Follow the search instructions on that website to view public comments. CMS will not post on Regulations.gov public comments that make threats to individuals or institutions or suggest that the commenter will take actions to harm an individual. CMS continues to encourage individuals not to submit duplicative comments. We will post acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments.

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services from a Medicare-participating 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 conditions are met or exceeded, we will deem those provider entities to have met the 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 (the Secretary) 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 (CMS generally refers to its recognition of an AO's equivalency to CMS standards as "deeming authority"). 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 accredited provider entities to meet requirements that are at least as stringent as the Medicare conditions. 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 reapprove an AO application for a period not to exceed 6 years.

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

II. CMS Approval of Accreditation Organizations

Section 1865(a)(2) of the Act and our regulations at § 488.5 require CMS' review of a national AO's application consider, among other factors, the applying AO's requirements for Medicare-equivalent accreditation; survey procedures; resources for conducting required surveys; capacity to furnish information for use in enforcement activities; monitoring procedures for provider entities found not in compliance with the conditions or requirements; and ability to provide CMS with the necessary data for validation. CMS approves or denies an AO's application based on an assessment of the factors stated previously, which may include, but are 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.

Section 1865(a)(3)(A) of the Act further requires that we publish, within 60 days of receipt of an organization's complete application, a notice identifying the national accrediting body making the request, describing the nature of the request, and providing at least a 30-day public comment period. We have 210 days from the receipt of a complete application to publish notice of approval or denial of the application.

The purpose of this proposed notice is to inform the public of DNV's request for continued approval of its hospital Medicare-equivalent accreditation program. This notice also solicits public comment on whether DNV's requirements meet or exceed the Medicare conditions of participation (CoPs) for hospitals.

III. Evaluation of Request

DNV submitted all the necessary materials to enable us to make a determination concerning its request for continued approval of its hospital Medicare-equivalent accreditation program. This application was determined to be complete on February 28, 2026. Under section 1865(a)(2) of the Act and our regulations at § 488.5 (Application and re-application procedures for national accrediting organizations), our review and evaluation of DNV will be conducted in accordance with, but not necessarily limited to, the following factors:

- An assessment of the equivalency of DNV's standards for hospitals as compared with CMS' hospital CoPs.
- An assessment of DNV's survey process.
- The comparability of DNV's processes to those of state agencies, including survey frequency, and the ability to investigate and respond appropriately to complaints against accredited facilities.
- DNV's processes and procedures for monitoring a hospital found out of compliance with DNV's program requirements.
- DNV's capacity to report deficiencies to the surveyed facilities and respond to the facility's plan of correction in a timely manner.
- DNV's capacity to provide CMS with information extracted from each accreditation survey for a specified provider or supplier as part of its data submissions.
- An assessment of DNV's financial viability.
- 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. 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.*).

V. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the "DATES" section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

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,

Centers for Medicare & Medicaid Services.