Instrument	Total number of respondents	Annual number of responses per respondent	Average burden hours per response	Annual burden hours
CED PPR	79	2	1.5	237
CED PPR Short Form	48	2	0.5	48
Estimated Total Annual Burden Hours			285	

Authority: Section 680(a)(2), Community Services Block Grant Act, 42 U.S.C. 9921.

Mary C. Jones,

ACF/OPRE Certifying Officer.

[FR Doc. 2025–23546 Filed 12–19–25; 8:45 am]

BILLING CODE 4184–27–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

[OMB #: 0970–0407]

Submission for Office of Management and Budget Review; Office of Refugee Resettlement Cash and Medical Assistance Program Quarterly Report on Expenditures and Obligations (ORR–2)

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 Office of Refugee Resettlement (ORR) is requesting a 3-year extension of the ORR–2: Cash and Medical Assistance (CMA) Program Quarterly Report on Expenditures and Obligations (Office of Management and Budget (OMB) #0970–0407, expiration February 28, 2026). Minor changes are proposed to the form and instructions.

DATES: *Comments due* January 21, 2026.

ADDRESSES: The public may view and comment on this information collection request at: *https://www.reginfo.gov/public/do/PRAViewICR?ref_nbr=202512-0970-007*. You can also obtain copies of the proposed collection of information by emailing *infocollection@acf.hhs.gov*. Identify all emailed requests by the title of the information collection.

SUPPLEMENTARY INFORMATION:

Description: ORR reimburses, to the extent of available appropriations, certain non-federal costs for the provision of CMA to refugees, along with allowable expenses for the administration of the refugee resettlement program at the state level. States and Replacement Designees currently submit the ORR–2 Quarterly Report on Expenditures and Obligations, which provides aggregate expenditure and obligation data. The ORR–2 collects expenditures and obligations data separately for each of the following four CMA program components: refugee cash assistance, refugee medical assistance, CMA administration, and services for unaccompanied refugee minors. This breakdown of financial status data allows ORR to track program expenditures in greater detail to anticipate any funding issues and to meet the requirements of ORR regulations at 45 CFR 400.211 to collect these data for use in estimating future costs of the refugee resettlement program. ORR must implement the methodology at 45 CFR 400.211 each year after receipt of its annual appropriation to ensure that appropriated funds will be adequate for reimbursement to states for the costs of assistance to eligible refugees. The estimating methodology prescribed in the regulations requires the use of actual past costs by program component. If the methodology indicates that appropriated funds are inadequate, ORR must take steps to reduce federal expenses, such as by limiting the number of months of eligibility for Refugee Cash Assistance and Refugee Medical Assistance. The ORR–2 is a single-page financial report that allows ORR to collect the necessary data to ensure that funds are adequate for the projected need and thereby meet the requirements of both the Refugee Act and ORR regulations.

Minor changes to the names of certain lines on the ORR–2 are proposed to align with changes proposed to the ORR–1 form in a **Federal Register** notice published on June 24, 2025, at 90 FR 26819 (*https://www.federalregister.gov/d/2025-11546*), and approved by OMB in August 2025 (*https://www.reginfo.gov/public/do/PRAViewIC?ref_nbr=202506-0970-018&icID=9799*). ORR also proposes minor changes to the instructions to align with the Uniform Administrative Requirements, Cost Principles, and Audit Requirement for Federal Awards at 2 CFR part 200.

Respondents: State governments and Replacement Designees.

Instrument	Total number of respondents	Annual number of responses per respondent	Average burden hours per response	Annual burden hours
Cash and Medical Assistance Program, Quarterly Report on Expenditures and Obligations	57	4	1.5	342

Authority: 8 U.S.C. 1521–1524

Mary C. Jones,

ACF/OPRE Certifying Officer.

[FR Doc. 2025–23592 Filed 12–19–25; 8:45 am]

BILLING CODE 4184–45–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Addition of Duchenne Muscular Dystrophy to the Recommended Uniform Screening Panel

AGENCY: Health Resources and Services Administration, Department of Health and Human Services (HHS).

ACTION: Notice.

SUMMARY: HRSA published a **Federal Register** notice on August 14, 2025 (90 FR 39197), requesting comments from the public on the potential recommendation of adding Duchenne Muscular Dystrophy (DMD) to the Recommended Uniform Screening Panel (RUSP). After consideration of public comments and evidence-based reports, HRSA recommended to the HHS Secretary that DMD be added to the RUSP. The Secretary has accepted the recommendation as detailed in this notice. Conditions listed on the RUSP are part of the evidence-informed preventive health guidelines supported by HRSA for infants, children, and adolescents. Non-grandfathered group health plans and health insurance issuers are required to cover screenings included in these HRSA-supported comprehensive guidelines without cost-sharing (*e.g.,* copayment, co-insurance, etc.). Please see the RUSP (*https://newbornscreening.hrsa.gov/about-newborn-screening/recommended-uniform-screening-panel*) for additional information.

FOR FURTHER INFORMATION CONTACT: CDR Leticia Manning, Newborn Screening Team Lead, Division of Services for Children with Special Health Needs, Maternal and Child Health Bureau, HRSA, 5600 Fishers Lane, Rockville, Maryland 20857 or *NBSPrograms@hrsa.gov*.

SUPPLEMENTARY INFORMATION: The RUSP is a list of conditions that the Secretary of HHS recommends for states to screen as part of their state universal newborn screening (NBS) programs. Conditions on the RUSP are chosen based on evidence that supports the potential net benefit of screening, the ability of states to screen for the disorder, and the availability of effective treatments. Although states ultimately determine what conditions their NBS program will screen for, it is recommended that every newborn be screened for all conditions on the RUSP. Conditions listed on the RUSP are part of the comprehensive preventive health guidelines supported by HRSA for infants and children under section 2713 of the Public Health Service Act. Non-grandfathered group health plans and health insurance issuers are required to cover screenings included in these HRSA-supported comprehensive guidelines without charging a co-payment, co-insurance, or deductible for plan years beginning on or after the date that is 1 year from the Secretary's adoption of the condition for screening.

The Advisory Committee on Heritable Disorders in Newborns and Children (ACHDNC), now inactive, was tasked with reviewing available scientific evidence and then making recommendations to the Secretary of HHS regarding what conditions should be on the RUSP. When a condition was nominated, ACHDNC determined whether there is sufficient evidence available for early screening and refers it to the ACHDNC's Evidence Review Group (ERG). The ERG was responsible for identifying and assessing all available evidence and summarizing for ACHDNC the strength and effectiveness of the evidence found on the net benefit of screening, the ability of states to screen for the condition, and the availability of effective treatments. The ERG completed an evidence review for DMD. Following the completion of the evidence review for DMD, but prior to issuing a recommendation to the Secretary on the inclusion of DMD to the RUSP, ACHDNC was terminated.

DMD is a rare genetic condition that causes progressive muscle weakness and degeneration. Individuals eventually require a wheelchair for mobility and have a shortened lifespan. There are Food and Drug Administration-approved treatments which allow children to walk longer before needing a wheelchair and extend heart and lung functions.

Summary of Public Comments

A **Federal Register** notice sought public comment on the potential recommendation of including or not including DMD on the RUSP. HRSA requested that the respondents consider the ERG's report summary on DMD and the suitability of state NBS programs screening for DMD within the newborn period in their response. HRSA considered all public comments as part of its deliberate process along with review of the completed DMD evidence review report prior to making a recommendation to the Secretary of HHS. A total of 379 respondents commented on the inclusion of DMD on the RUSP. Of these, 366 responses (97 percent) expressed support to add DMD to the RUSP and 11 responses (3 percent) opposed its addition. The responses in support of or against adding DMD to the RUSP are summarized below.

Comments on Adding DMD to the RUSP

Ninety-seven percent of commenters (366 comments) were in favor of adding DMD to the RUSP. A variety of stakeholders, including clinicians and families, described benefits and reasons in support of adding DMD to the RUSP. A vast majority of respondents commented that by adding DMD to the RUSP, families may receive a DMD diagnosis sooner enabling access to early intervention, support services, and more treatment options. Families expressed the invaluable benefit of receiving an earlier diagnosis for their child to reduce the diagnostic odyssey due to an unknown diagnosis through progressive symptoms and the negative impacts it causes to the family's overall well-being and mental health. Families with multiple children shared that knowledge of the first child having DMD, enabled them to better prepare for, identify, and treat subsequent children with DMD leading to improved health outcomes. Other comments emphasized that if DMD is added to the RUSP, state adoption to screen for DMD will swiftly follow allowing for researchers to conduct population-level analyses of treatment efficacy.

Three percent of commenters (11 comments) were against adding DMD to the RUSP. One commenter noted that there is a high rate of false positives of the screening test which can lead to uncertainty/worry before confirmation of a negative result and there are unclear cutoff thresholds for positive/negative results. However, the screening test can have additional steps included on the same bloodspot prior to confirmatory testing, or by implementing DNA analysis, that would reduce the false positive rate.

Additional comments highlighted the lack of data that supports treatment during the newborn period is beneficial for the infant. As noted in the evidence-based review (*https://publications.aap.org/pediatrics/article/doi/10.1542/peds.2025-073192/203177/Evidence-Regarding-Duchenne-Muscular-Dystrophy?autologincheck=redirected*), treatment may improve outcomes for DMD with additional studies needed to