to CMS requesting modifications to the HCPCS Level II codeset. Applications have been received prior to HIPAA implementation and must continue to be collected to ensure quality decision-making. The HIPAA of 1996 required CMS to adopt standards for coding systems that are used for reporting health care transactions. The regulation that CMS published on August 17, 2000 (45 CFR 162.10002) to implement the HIPAA requirement for standardized coding systems established the HCPCS Level II codes as the standardized coding system for describing and identifying health care equipment and supplies in health care transactions. HCPCS Level II was selected as the standardized coding system because of its wide acceptance among both public and private insurers. Public and private insurers were required to be in compliance with the August 2000 regulation by October 1, 2002. Modifications to the HCPCS are initiated via application form submitted by any interested stakeholder. These applications have been received on an on-going basis with an annual deadline for each cycle. The purpose of the data provided is to educate the decision-making body about products and services for which a modification is requested so that an informed decision can be reached in response to the recommended coding.

Subsequent to the publication of the 60-day notice (84 FR 48145), we made minor clarifying edits to the information collection request. The edits are highlighted in a crosswalk document that is available for review along with the rest of the information collection request on the CMS PRA website. *Form Number:* CMS–10224 (OMB control number: 0938–1042); *Frequency:* Annually; *Affected Public:* Private Sector (Business or other for-profit and Not-for-profit institutions); *Number of Respondents:* 100; *Total Annual Responses:* 100; *Total Annual Hours:* 1,100. (For policy questions regarding this collection contact Kimberlee Combs Miller at 410–786–6707.)

Dated: November 20, 2019.

William N. Parham, III,

Director, Paperwork Reduction Staff, Office of Strategic Operations and Regulatory Affairs.

[FR Doc. 2019–25559 Filed 11–22–19; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Statement of Organization, Functions, and Delegations of Authority

Part F of the Statement of Organization, Functions, and Delegations of Authority for the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) (last amended at **Federal Register**, Vol. 75, No. 56, pp. 14176–14178, dated March 24, 2010; Vol. 76, No. 203, pp. 65197–65199, dated October 20, 2011; Vol. 78, No. 86, p. 26051, dated May 3, 2013; Vol. 79, No. 2, pp. 397–398, dated January 3, 2014; and Vol. 84, No. 32, p. 4470, dated February 15, 2019) is amended reflect the establishment of the Office of Program Operations and Local Engagement (OPOLE), and the abolishment of the Consortium for Medicare Health Plan Operations (CMHPO), the Consortium for Financial Management and Fee for Service Operations (CFMFFSO), and the Consortium for Quality Improvement and Survey and Certification Operations (CQISCO) to improve business alignment of the regional locations with the program components and improve local engagement with external stakeholders. The Center for Clinical Standards and Quality (CCSQ), Center for Medicaid and CHIP Services (CMCS), Chief Operating Officer (COO), Office of Communications (OC), Office of Financial Management (OFM), and the Office of Human Capital (OHC) were restructured to align audit management activities; change the reporting relationship of the Emergency Preparedness and Response Operations, and modernize CMS's approach to public and internal communications.

In the current structure, CMHPO and CFMFFSO serve as the local focal points for Medicare (both original Medicare and the Medicare Advantage and Part D Health Plans) and for the federally-facilitated exchanges, have been well-aligned with several program areas. The combination of the CMHPO and CFMFFSO functions under the new OPOLE structure will improve coordination across Medicare program lines and integrates communication and local engagement activities into a single structure that reports directly to the CMS Administrator, in alignment with the CMS program centers themselves.

CCSQ administers all quality, clinical, and medical science issues and survey and certification policies for CMS's programs. The regional employees who conduct the quality and safety surveys of facilities and oversee the enforcement of the quality and safety standards, as well as those who manage the quality improvement organizations will be fully integrated into CCSQ. The changes will improve business processes, leadership alignment, and customer focus, enabling CMS to unify its quality improvement, survey and enforcement activities while preserving its ability to consider local and state requirements. With this integration, CCSQ will be the agency's single point of contact for this work.

CMCS serves as CMS's focal point for assistance with formulation, coordination, integration, and implementation of all national program policies and operations relating to Medicaid, CHIP, and the Basic Health Program. The regional employees who work on Medicaid and CHIP were integrated into CMCS as a single operating unit. It has become clear that additional integration is needed to be successful. The new structure will improve efficiency, alignment, and coordination of Medicaid and CHIP policy and operational activities throughout the regional locations, and create a leaner, more integrated structure that aligns key areas requiring a higher degree of specialization, significantly improving stakeholder experiences. It will also allow for a tighter coordination between financial policy and operations and bolster a national approach to prioritizing efforts across the portfolio of Medicaid and CHIP activities.

The COO facilitates the coordination, integration and execution of CMS policies and activities across CMS components, including new program initiatives. The Emergency Preparedness and Response Operations function that currently reports into the regional organizational component, will report to the COO.

OC serves as CMS's focal point for internal and external strategic and tactical communications providing leadership for CMS in the areas of customer service; website operations; traditional and new media including web initiatives such as social media supported by innovative, increasingly mobile technologies; media relations; call center operations, consumer materials; public information campaigns; and, public engagement. The regional public affairs officers will report to OC to improve consistency of media engagement. Other parts of this component were restructured to successfully leverage technology and to strengthen the Agency commitment to advocates and professional partners.

The internal communications' work is moving from OHC to OC.

OFM serves as the Chief Financial Officer (CFO) and Comptroller for CMS. It manages the preparation and audit of CMS financial statements, and issues the annual Agency Financial Report, in accordance with the requirements of the CFO Act. The external audit management function is being realigned from the regional component that currently serves as the local focal point for original Medicare operations to OFM. This change will integrate agency-wide responsibility and management of both external and internal audits under the responsibility of the CMS CFO.

OHC administers CMS's special hiring authorities, diversity hiring initiatives, Delegated Examining authority and internal Merit Promotion program, and recruitment and retention programs, including negotiating base salary and any appropriate special hiring incentives.

Part F, Section FC. 10 (Organization) is revised as follows:

Office of the Administrator (FC)
Office of Program Operations and Local Engagement (FCY)
Office of Enterprise Data and Analytics (FCW)
Office of Human Capital (FCX)
Office of Equal Opportunity and Civil Rights (FCA)
Office of Communications (FCT)
Office of Legislation (FCC)
Federal Coordinated Health Care Office (FCQ)
Office of Minority Health (FCN)
Office of the Actuary (FCE)
Office of Strategic Operations and Regulatory Affairs (FCF)
Office of Financial Management (FCV)
Chief Operating Officer (FCM)
Center for Clinical Standards and Quality (FCG)
Center for Medicare and Medicaid Innovation (FCP)
Center for Medicare (FCH)
Center for Medicaid and CHIP Services (FCJ)
Center for Program Integrity (FCL)
Center for Consumer Information and Insurance Oversight (FCR)

Part F, Section FC. 20 (Functions) for each organization is as follows:

Office of Program Operations and Local Engagement

• Serves as the senior level point of contact within each Region for counterparts in CMS, Department leadership (including the HHS Regional Director), as well as external stakeholders. Creates and maintains regional location cohesion and leads regional efforts to improve employee engagement.

• Responsible for consistently and effectively implementing the Agency's local outreach strategy and messaging.

• Serves as the regional lead for environmental scanning and issue identification, systematically providing a regional perspective in advising the Office of the Administrator on national initiatives and their impact on program beneficiaries, consumers, key partners, and major constituents.

• Responsible for providing the regional voice in the Agency rural health strategy, advising on effective goals, tactics, and success metrics, and implementing the strategy at a local level.

• Serves as the regional focal point for emergency response management for employees in regional locations as well as coordinating the local response to emergencies in accordance with Agency Continuity of Operations, Disaster Recovery, and Emergency Response and Preparedness Operations protocols.

• Implements national policies and procedures to support and assure appropriate State implementation of the rules and processes governing group and individual health insurance markets and the sale of health insurance policies that supplement Medicare coverage.

• Provides Medicare health and drug plans with technical assistance to comply with program requirements, monitoring plan compliance with applicable statutes, regulations, and sub-regulatory guidance.

• Serves as the regional partner in the monitoring and oversight of Qualified Health Plans and Stand Alone Dental Plans operating in the federally-facilitated exchanges.

• Responds, handles and oversees resolution of inquiries and casework concerning Medicare beneficiary and federally-facilitated exchange consumer rights and protections, enrollment, eligibility, coverage and costs.

• Serves as the regional focal point for CMS interactions with Medicare Shared Savings Program Accountable Care Organizations (ACO) and innovation models.

• Serves as the regional focal point for CMS oversight of the Medicare Administrative Contractors' program and fiscal integrity function.

• Implements national policy for Medicare Parts A and B beneficiaries and health care providers.

Center for Clinical Standards and Quality

• Serves as the focal point for all quality, clinical, medical science issues, survey and certification, and policies for CMS's programs. Provides leadership and coordination for the development and implementation of a cohesive, CMS-wide approach to measuring and promoting quality and leads CMS's priority-setting process for clinical quality improvement. Coordinates quality-related activities with outside organizations. Monitors quality of Medicare, Medicaid, and the Clinical Laboratory and Improvement Amendments (CLIA). Evaluates the success of interventions.

• Identifies and develops best practices and techniques in quality improvement; implementation of these techniques will be overseen by appropriate components. Collaborates on demonstration projects to test and promote quality measurement and improvement.

• Develops, tests, evaluates, adopts and supports performance measurement systems (*i.e.,* quality measures) to evaluate care provided to CMS beneficiaries except for demonstration projects residing in other components.

• Assures that CMS's quality-related activities (survey and certification, technical assistance, beneficiary information, payment policies and provider/plan incentives) are fully and effectively integrated. Carries out the Health Care Quality Improvement Program for the Medicare, Medicaid, and CLIA programs.

• Oversees the planning, policy, coordination and implementation of the survey, certification and enforcement programs for all Medicare and Medicaid providers and suppliers, and for laboratories under the auspices of CLIA.

• Serves as CMS's lead for management, oversight, budget, and performance issues relating to the survey and certification program and the related interactions with the States.

• Leads in the specification and operational refinement of an integrated CMS quality information system, which includes tools for measuring the coordination of care between health care settings; analyzes data supplied by that system to identify opportunities to improve care and assess success of improvement interventions.

• Develops requirements of participation for providers and plans in the Medicare, Medicaid, and CLIA programs. Revises requirements based on statutory change and input from other components.

• Operates the Quality Improvement Organization and End-Stage Renal Disease Network program in conjunction with Regional Offices, providing policies and procedures, contract design, program coordination, and leadership in selected projects.

• Identifies, prioritizes and develops content for clinical and health related

aspects of CMS's Consumer Information Strategy; collaborates with other components to develop comparative provider and plan performance information for consumer choices.

• Prepares the scientific, clinical, and procedural basis for coverage of new and established technologies and services and provides coverage recommendations to the CMS Administrator. Coordinates activities of CMS's Technology Advisory Committee and maintains liaison with other departmental components regarding the safety and effectiveness of technologies and services; prepares the scientific and clinical basis for, and recommends approaches to, quality-related medical review activities of carriers and payment policies.

• Identifies new and innovative approaches and tests for improving quality programs and lowering costs.

Center for Medicaid and CHIP Services

• Serves as CMS's focal point for assistance with formulation, coordination, integration, and implementation of all national program policies and operations relating to Medicaid, CHIP, and the Basic Health Program (BHP).

• In partnership with States, assists State agencies in successfully carrying out their responsibilities for effective program administration and beneficiary protection, and, as necessary, supports States in correcting problems and improving the quality of their operations.

• Identifies and proposes modifications to Medicaid, CHIP, and BHP program measures, regulations, laws, and policies to reflect changes or trends in the health care industry, program objectives, and the needs of Medicaid, CHIP, and BHP beneficiaries. Collaborates with the Office of Legislation on the development and advancement of new legislative initiatives and improvements.

• Serves as CMS's lead for management, oversight, budget, and performance issues relating to Medicaid, CHIP, BHP and the related interactions with States and the stakeholder community.

• Coordinates with the Center for Program Integrity on the identification of program vulnerabilities and implementation of strategies to eliminate fraud, waste, and abuse.

• Leads and supports all CMS interactions and collaboration relating to Medicaid, CHIP, and BHP with States and local governments, territories, Indian tribes and tribal healthcare providers, key stakeholders (*e.g.,* consumer and policy organizations and the health care provider community) and other Federal government entities. Facilitates communication and disseminates policy and operational guidance and materials to all stakeholders and works to understand and consider their perspectives, support their efforts, and to develop best practices for beneficiaries across the country and throughout the health care system.

• Develops and implements a comprehensive strategic plan, objectives, and measures to carry out CMS's Medicaid, CHIP, and BHP mission and goals and positions the organization to meet future challenges with Medicaid, CHIP, and BHP.

Chief Operating Officer

• Overall responsibility for facilitating the coordination, integration and execution of CMS policies and activities across CMS components, including new program initiatives.

• Promotes accountability, communication, coordination, and facilitation of cooperative corporate decision-making among CMS senior leadership on management, operational and programmatic cross-cutting issues.

• Tracks and monitors CMS performance and intervenes, as appropriate, to ensure key milestones/deliverables are successfully achieved. Keeps the Administrator and Principal Deputy Administrator advised of the status of significant national initiatives and programs that affect beneficiaries and/or the health care industry and makes recommendations regarding necessary corrective actions.

• Oversees all planning, implementation and evaluation of administrative and operational activities for CMS, including enterprise-wide information systems and services, acquisition and grants, financial management, electronic health standards, facilities, and human resources.

Office of Communications

• Serves as CMS's focal point for internal and external strategic and tactical communications providing leadership for CMS in the areas of customer service; website operations; traditional and new media including web initiatives such as social media supported by innovative, increasingly mobile technologies; media relations; call center operations, consumer materials; public information campaigns; and, public engagement.

• Serves as senior advisor to the Administrator in all activities related to the media. Provides consultation, advice, and training to CMS's senior staff with respect to relations with the news media.

• Coordinates with external partners including the Department of Health and Human Services (HHS) and the White House on key communication and public engagement initiatives, leveraging CMS resources to strategically support these activities.

• Contributes to the formulation of policies, programs, and systems as related to strategic and tactical communications.

• Coordinates with the Office of Legislation on the development and advancement of new legislative initiatives and improvements.

• Oversees communications research, design and development, evaluation and continuous improvement activities for improving internal and external communication tools, including but not limited to brochures, public information campaigns, handbooks, websites, reports, presentations/briefings.

• Identifies communication best practices for the benefit of CMS beneficiaries (*i.e.,* of the Medicare and Medicaid programs) and other CMS customers.

• Formulates and implements a customer service plan that serves as a roadmap for the effective treatment and advocacy of customers and the quality of information provided to them.

• Oversees beneficiary and consumer call centers and provides leadership for CMS in the area of call center operations.

• Oversees all CMS interactions and collaborations with key stakeholders (external advocacy groups, contractors, local and State governments, HHS, the White House, other CMS components, and other Federal entities) related to the Medicare and Medicaid and other Agency programs.

• Coordinates stakeholder relations, community outreach, and public engagement with the CMS Regional Offices.

Office of Financial Management

• Serves as the Chief Financial Officer and Comptroller for CMS. Manages the preparation and audit of CMS financial statements, and issues the annual Agency Financial Report, in accordance with the requirements of the CFO Act.

• Formulates, presents and executes all CMS budget accounts; develops outlay plans and tracks contract and grant award amounts; acts as liaison with the Congressional Budget Office on budget estimates; reviews demonstration waivers (except 1115) for revenue neutrality. Is responsible for ensuring that the budget is formulated

in accordance with CMS's strategic plan and the Government Performance and Results Act (GPRA) goals and performance measures.

• Acts as liaison to the Department of Health and Human Services (HHS), Assistant Secretary for Financial Resources, Office of Management and Budget (OMB), and the Congressional appropriations committees for all matters concerning CMS's operating budget.

• Manages the Medicare financial management system, the Medicare contractors' budgets, Quality Improvement Organizations' budgets, research budgets, managed care payments, the issuance of State Medicaid grants, and the funding of the State survey/certification and the Clinical Laboratory and Improvement Act programs. Is responsible for all CMS disbursements.

• Maintains CMS financial data and prepares external reports to other agencies such as HHS, Treasury, OMB, Internal Revenue Service, General Services Administration, related to CMS's obligations, expenditures, prompt payment activities, debt and cash management, and other administrative functions.

• Performs cash management activities and establishes and maintains systems to control the obligation of funds and ensure that the Anti-Deficiency Act is not violated.

• Manages the Medicare Secondary Payer Program and Medicare Debt Resolution activities.

• Develops CMS policies governing both Medicare Secondary Payer and Medicaid Third Party Liability.

• Oversees the Medicare fee-for-service and the Medicaid and CHIP improper payment measurement programs to measure payment accuracy.

• Develops and publishes the Medicare Fee-For-Service, Medicaid, and Children's Health Insurance Error Rate. Develops improper payment measurement methodologies to report related Marketplaces and related programs.

• Manages, develops, and enhances CMS's core financial management system, the Healthcare Integrated General Ledger Accounting System (HIGLAS), which tracks the financial activity and transactions of all of CMS's programs.

• Manages the development to maintain information technology program systems that support accounting operations, for the Medicare Benefits, Medicare Secondary Payer, Marketplace, Medicaid, CHIP Grants, and Administrative Program Accounting lines of business.

• Coordinates the development and monitoring of all audit corrective action plans and the Office of the Inspector General (OIG) clearance documents that address each OIG and the Government Accountability Office agreed upon recommendations.

• Develops an enterprise risk assessment program to better support CMS programs.

• Works collaboratively with components and contracting officials to review contract language and contract cost estimates in order to develop contract-specific performance and financial information.

• Coordinates performance management and promotes the use of Agency performance measures to foster a more results-orientated performance culture through CMS.

• Ensures compliance with a number of agency performance requirements such as GPRA and the GPRA Modernization Act, OMB program analysis and the Department strategic plan priorities.

Office of Human Capital

• Administers CMS's special hiring authorities, diversity hiring initiatives, Delegated Examining authority and internal Merit Promotion program, and recruitment and retention programs, including negotiating base salary and any appropriate special hiring incentives.

• Collects, analyzes and coordinates strategic planning data for use by CMS for recruitment purposes. Uses data to focus recruitment efforts.

• Provides leadership for the development and implementation of CMS Leadership and Management Development Programs. Coordinates management development activities with the Leadership Development and Recognition Board.

• Manages and oversees CMS learning management systems and coordinates with DHHS on department-wide courses.

• Administers plans, develops, directs, coordinates and evaluates Agency-wide management programs, performance management, delegations of authority, and position management. Ensures program operations are compliant with federal regulations and Departmental requirements and guidance, and develops and implements guidance and educational tools to support successful administration of these programs.

• Provides oversight of collective bargaining agreements and provision of advisory services to CMS managers. Conducts negotiations on behalf of management and/or advises management on the conduct of labor-management negotiations. Coordinates and develops CMS-wide policy regarding the development, implementation, and evaluation of labor relations' activities.

• Provides managers and senior Agency officials (in accordance with Federal Service Labor-Management Relations statue(s), and Master Labor Agreement) with advice and assistance on activities associated with labor management relations, including but not limited to bargaining unit status determinations, unfair labor practices, negotiability issues, workplace changes affecting bargaining unit employees, and case work associated with labor relations activities, (*e.g.,* grievances).

• Develops and coordinates the policies and procedures necessary to implement the CMS Ethics Program. Provides advice and guidance to the CMS Deputy Ethics Counselor (DEC) concerning all issues that must be considered by the DEC.

Authority: 44 U.S.C. 3101.

Dated: November 18, 2019.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2019–25426 Filed 11–20–19; 4:15 pm]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3379–FN]

Medicare and Medicaid Programs; Continued Approval of the Accreditation Commission for Health Care Accreditation Program

AGENCY: Centers for Medicare & Medicaid Services, HHS.

ACTION: Final notice.

SUMMARY: This final notice announces our decision to approve the Accreditation Commission for Health Care (ACHC) for continued recognition as a national accrediting organization for hospices that wish to participate in the Medicare or Medicaid programs. A hospice that participates in Medicaid must also meet the Medicare conditions for participation.

DATES: This final notice is effective November 27, 2019 through November 27, 2025.

FOR FURTHER INFORMATION CONTACT: Lillian Williams, (410) 786–8636, or Joann Fitzell, (410) 786–4280.

SUPPLEMENTARY INFORMATION: