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:

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services in a hospice provided certain requirements are met by the hospice. Section 1861(dd) of the Social Security Act (the Act) establishes distinct criteria for facilities seeking designation as a hospice. 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 418 specify the conditions that a hospice must meet in order to participate in the Medicare program, the scope of covered services and the conditions for Medicare payment for hospices.

Generally, to enter into an agreement, a hospice must first be certified as complying with the conditions set forth in part 418 and recommended to the Center for Medicare & Medicaid (CMS) for participation by a state survey agency. Thereafter, the hospice is subject to periodic surveys by a state survey agency to determine whether it continues to meet these conditions. However, there is an alternative to certification surveys by state agencies. Accreditation by a nationally recognized Medicare accreditation program approved by CMS may substitute for both initial and ongoing state review.

Section 1865(a)(1) of the Act provides that, if the Secretary of the Department of Health and Human Services (the Secretary) finds that accreditation of a provider entity by an approved national accrediting organization meets or exceeds all applicable Medicare conditions, CMS may treat the provider entity as having met those conditions, that is, may ''deem'' the provider entity to be in compliance. Accreditation by an accrediting organization is voluntary and is not required for Medicare participation.

If an accrediting organization is recognized by the Secretary as having standards for accreditation that meet or exceed Medicare requirements, any provider entity accredited by the national accrediting organization's approved program may be deemed to meet the Medicare conditions. A national accrediting organization applying for CMS approval of their accreditation program under 42 CFR part 488, subpart A, must provide CMS with reasonable assurance that the accrediting organization requires the accredited provider entities to meet requirements that are at least as stringent as the Medicare conditions. Our regulations concerning the approval of accrediting organizations are set forth at § 488.5. Section 488.5(e)(2)(i) requires accrediting organizations to reapply for continued approval of its Medicare accreditation program every 6 years or sooner as determined by CMS. The Accreditation Commission for Health Care (ACHC'S) term of approval as a recognized accreditation program for its hospice accreditation program expires November 27, 2019.

II. Application Approval 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 to publish notice in the **Federal Register** of approval or denial of the application. The Act also states 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.

III. Provisions of the Proposed Notice

In the June 28, 2019 **Federal Register** (84 FR 31068), we published a proposed notice announcing ACHC's request for continued approval of its Medicare hospice accreditation program. In the June 28, 2019 proposed notice, we detailed our evaluation criteria. Under section 1865(a)(2) of the Act and in our regulations at § 488.5, we conducted a review of ACHC's Medicare hospice accreditation application in accordance with the criteria specified by our regulations, which include, but are not limited to the following:

- An onsite administrative review of ACHC's: (1) Corporate policies; (2) financial and human resources available to accomplish the proposed surveys; (3) procedures for training, monitoring, and evaluation of its hospice surveyors; (4) ability to investigate and respond appropriately to complaints against accredited hospices; and (5) survey review and decision-making process for accreditation.
- The comparison of ACHC's Medicare hospice accreditation program standards to CMS's current Medicare hospice conditions of participation.
- A documentation review of ACHC's survey process to—

++ Determine the composition of the survey team, surveyor qualifications, and ACHC's ability to provide continuing surveyor training.

++ Compare ACHC's processes to those we require of state survey agencies, including periodic resurvey and the ability to investigate and respond appropriately to complaints against accredited hospices.

++ Evaluate ACHC's procedures for monitoring hospices it has found to be out of compliance with ACHC's program requirements. (This pertains only to monitoring procedures when ACHC identifies non-compliance. If noncompliance is identified by a state survey agency through a validation survey, the state survey agency monitors corrections as specified at § 488.9(c))

++ Assess ACHC's ability to report deficiencies to the surveyed hospice and respond to the hospice's plan of correction in a timely manner.

++ Establish ACHC's ability to provide CMS with electronic data and reports necessary for effective validation and assessment of the organization's survey process.

++ Determine the adequacy of ACHC's staff and other resources.

++ Confirm ACHC's ability to provide adequate funding for performing required surveys.

++ Confirm ACHC's policies with respect to surveys being unannounced.

++ ACHC's policies and procedures to avoid conflicts of interest, including the appearance of conflicts of interest, involving individuals who conduct surveys or participate in accreditation decisions.

++ Obtain ACHC'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.

In accordance with section 1865(a)(3)(A) of the Act, the June 28, 2019 proposed notice also solicited public comments regarding whether ACHC's requirements met or exceeded the Medicare CoPs for hospices. No comments were received in response to the proposed notice.

IV. Provisions of the Final Notice

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

We compared ACHC's hospice accreditation requirements and survey process with the Medicare CoPs of part 418, and the survey and certification process requirements of parts 488 and 489. Our review and evaluation of ACHC's hospice application, which were conducted as described in section III of this final notice, yielded the following areas where, as of the date of this notice, ACHC has completed revising its standards and certification processes in order to meet the requirements at:

- § 418.56(c)(2), to address the requirement the frequency of services necessary to meet the specific patient and family needs.
- § 418.110(c)(1), to require an inpatient hospice to address real or potential threats to the health and safety of the patients, others, and property.
- § 418.110)(d)(1)(i), to address the requirement that hospice must meet applicable provisions and must proceed in accordance with the Life Safety Code (National Fire Protection Association (NFPA) 101 and Tentative Interim amendments TIA 12–1, TIA 12–2, TIA 12–3 and TIA 12–4.)
- § 418.110(d)(5), to address the requirement when a sprinkler system is shut down for more than 10 hours.
- § 418.110(d)(5)(i), to address the requirement to evacuate the building or portion of the building affected by the system outage until the system is back in service.
- § 418.110(d)(5)(ii), to address the requirement to establish a fire watch until the system is back in service.
- § 418.110(d)(6), to require both existing and new buildings to have an outside window or door in every sleeping room and, for any building constructed after July 5, 2016, to require that the sill height must not exceed 36 inches above the floor.
- § 418.110(e), to address the requirement that except as otherwise provided in this section, the hospice must meet the applicable provisions and must proceed in accordance with the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12–2, TIA 12–3, TIA 12–4, TIA 12–5 and TIA 12–6).
- § 418.11(e)(1), to address the requirement that Chapters 7, 8, 12, and 13 of the adopted Health Care Facilities Code do not apply to a hospice.
- § 418.110(e)(2), to address the requirement that if application of the Health Care Facilities Code required under paragraph (e) of this section would result in unreasonable hardship for hospice, CMS may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients.
- § 418.110(q) through § 418.110(q)(1)(xi), address the requirement that the standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C 552(a) and 1 CFR part 51.

B. Term of Approval

Based on our review and observations described in section III of this final notice, we approve ACHC as a national accreditation organization for hospices that request participation in the Medicare program, effective November 27, 2019 through November 27, 2025.

V. 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. 35 *et seq.*).

Dated: November 5, 2019.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2019–25429 Filed 11–22–19; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3390–PN]

Medicare Program; Application From Accreditation Commission for Health Care for Initial CMS-Approval of Its Home Infusion Therapy Accreditation Program

AGENCY: Centers for Medicare and Medicaid Services, HHS.

ACTION: Notice with request for comment.

SUMMARY: This proposed notice acknowledges the receipt of an application from Accreditation Commission for Health Care for initial recognition as a national accrediting organization for suppliers of home infusion therapy services that wish to participate in the Medicare program. The statute requires that within 60 days of receipt of an organization's complete application, the Centers for Medicare & Medicaid Services (CMS) publish a notice that identifies the national accrediting body making the request, describes the nature of the request, and provides at least a 30-day public comment period.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on December 26, 2019.

ADDRESSES: In commenting, please refer to file code CMS–3390–PN. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

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 *http://www.regulations.gov.* 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–3390–PN, P.O. Box 8016,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–3390–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: Christina Mister-Ward, (410)786–2441 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: *http://www.regulations.gov* . Follow the search instructions on that website to view public comments.

I. Background

Home infusion therapy (HIT) is a treatment option for Medicare beneficiaries with a wide range of acute and chronic conditions. Section 5012 of the 21st Century Cures Act (Pub. L. 114–255, enacted December 13, 2016) added section 1861(iii) to the Social Security Act (the Act), establishing a new Medicare benefit for HIT services. Section 1861(iii)(1) of the Act defines ''home infusion therapy'' as professional services, including nursing services; training and education not otherwise covered under the Durable Medical Equipment (DME) benefit; remote monitoring; and other monitoring services. Home infusion therapy must be furnished by a qualified HIT supplier and furnished in the individual's home. The individual must: