• The firm is currently able to meet its obligations but there may be uncertainty regarding the firm's ability to do so prospectively.

• The holding company's liquidity contingency plan may be insufficient to support its obligation to act as a source of financial strength for its depository institution(s).

• Supervisory issues may exist that undermine the credibility of the firm's liquidity metrics and stress testing results.

Deficient-2. Financial or operational deficiencies in a supervised insurance organization's liquidity management present a threat to its safety and soundness, a threat to the holding company's ability to serve as a source of financial strength for its depository institution(s), or have already put the firm in an unsafe and unsound condition.

Examples of issues that may result in a Deficient-2 rating include, but are not limited to:

• Liquidity shortfalls may exist within the firm that have prevented the firm, or are expected to prevent the firm, from fulfilling its obligations, including the holding company's obligation to act as a source of financial strength for its depository institution(s).

• Liquidity adequacy may currently fail to meet regulatory minimums or there is significant concern that the firm will not meet liquidity adequacy minimums prospectively for at least one of its regulated subsidiaries.

• Supervisory issues may exist that significantly undermine the firm's liquidity metrics either currently or prospectively.

• Significant fungibility constraints may exist that would prevent the holding company from supporting its depository institution(s) and fulfilling its obligation to serve as a source of financial strength.

• The holding company may have failed to act as source of financial strength for its depository institution when needed.

C. Incorporating the Work of Other Supervisors

Similar to the approach taken by the Federal Reserve in its consolidated supervision of other firms, the oversight of supervised insurance organizations relies to the fullest extent possible, on work performed by other relevant supervisors. Federal Reserve supervisory activities are not intended to duplicate or replace supervision by the firm's other regulators and Federal Reserve examiners typically do not specifically assess firms' compliance with laws outside of its jurisdiction, including state insurance laws. The Federal Reserve collaboratively coordinates with, communicates with, and leverages the work of the Office of the Comptroller of the Currency (OCC), Federal Deposit Insurance Corporation (FDIC), Securities and Exchange Commission (SEC), Financial Crimes Enforcement Network (FinCEN), Internal Revenue Service (IRS), applicable state insurance regulators, and other relevant supervisors to achieve its supervisory objectives and eliminate unnecessary burden.

Existing statutes specifically require the Board to coordinate with, and to rely to the fullest extent possible on work performed by the state insurance regulators. The Board and all state insurance regulators have entered into Memorandums of Understanding (MOU) allowing supervisors to freely exchange information relevant for the effective supervision of supervised insurance organizations. Federal Reserve examiners take the actions below with respect to state insurance regulators to support accomplishing the objective of minimizing supervisory duplication and burden, without sacrificing effective oversight:

• Routine discussions (at least annually) with state insurance regulatory staff with greater frequency during times of stress;

• Discussions around the annual supervisory plan, including how best to leverage work performed by the state and potential participation by state insurance regulatory staff on relevant supervisory activities;

• Consideration of the opinions and work done by the state when scoping relevant examination activities;

• Documenting any input received from the state and considering the assessments of and work performed by the state for relevant supervisory activities;

• Sharing and discussing with the state the annual ratings and relevant conclusion documents from supervisory activities;

• Collaboratively working with the states and the NAIC on the development of policies that affect insurance depository institution holding companies; and

• Participating in supervisory colleges.

The Federal Reserve relies on the state insurance regulators to participate in the activities above and to share proactively their supervisory opinions and relevant documents. These documents include the annual ORSA,[10] the state insurance regulator's written assessment of the ORSA, results from its examination activities, the Corporate Governance Annual Disclosure, financial analysis memos, risk assessments, material risk determinations, material transaction filings (Form D), the insurance holding company system annual registration statement (Form B), submissions for the NAIC liquidity stress test framework, and other state supervisory material. If the Federal Reserve determines that it is necessary to perform supervisory activities related to aspects of the supervised insurance organization that also fall under the jurisdiction of the state insurance regulator, it will communicate the rationale and result of these activities to the state insurance regulator.

By order of the Board of Governors of the Federal Reserve System.

Ann E. Misback,

Secretary of the Board.

[FR Doc. 2022–21414 Filed 10–3–22; 8:45 am]

BILLING CODE 6210–01–P

[10] *See* NAIC Own Risk and Solvency Assessment (ORSA) Guidance Manual (December 2017) at *https://content.naic.org/sites/default/files/publication-orsa-guidance-manual.pdf.*

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Healthcare Research and Quality

Meeting of the National Advisory Council for Healthcare Research and Quality

AGENCY: Agency for Healthcare Research and Quality (AHRQ), HHS.

ACTION: Notice of public meeting.

SUMMARY: This notice announces a meeting of the National Advisory Council for Healthcare Research and Quality.

DATES: The meeting will be held on Thursday, November 17, 2022, from 11:30 a.m. to 3 p.m.

ADDRESSES: The meeting will be held virtually for the public. Members of the National Advisory Council will be able to participate in-person or virtually.

FOR FURTHER INFORMATION CONTACT: Jaime Zimmerman, Designated Management Official, at the Agency for Healthcare Research and Quality, 5600 Fishers Lane, Mail Stop 06E37A, Rockville, Maryland 20857, (301) 427–1456. For press-related information, please contact Bruce Seeman at (301) 427–1998 or *Bruce.Seeman@AHRQ.hhs.gov.*

Closed captioning will be provided during the meeting. If another reasonable accommodation for a disability is needed, please contact the Food and Drug Administration (FDA) Office of Equal Employment Opportunity and Diversity Management on (301) 827–4840, no later than Thursday, November 3, 2022. The agenda, roster, and minutes will be available from Ms. Heather Phelps, Committee Management Officer, Agency for Healthcare Research and Quality, 5600 Fishers Lane, Rockville, Maryland 20857. Ms. Phelps' phone number is (301) 427–1128.

SUPPLEMENTARY INFORMATION:

I. Purpose

In accordance with section 10(a) of the Federal Advisory Committee Act, 5 U.S.C. App., this notice announces a meeting of the National Advisory Council for Healthcare Research and Quality (the Council). The Council is authorized by Section 941 of the Public Health Service Act, 42 U.S.C. 299c. In accordance with its statutory mandate, the Council is to advise the Secretary of the Department of Health and Human Services and the Director of AHRQ on matters related to AHRQ's conduct of its mission including providing guidance on (A) priorities for health care research,

(B) the field of health care research including training needs and information dissemination on health care quality and (C) the role of the Agency in light of private sector activity and opportunities for public private partnerships. The Council is composed of members of the public, appointed by the Secretary, and Federal ex-officio members specified in the authorizing legislation.

II. Agenda

On Thursday, November 17, 2022, NAC members will meet to conduct preparatory work prior to convening the Council meeting at 11:30 a.m., with the call to order by the Council Chair, an introduction of NAC members, and approval of previous Council summary notes. The NAC members will then receive an update from the AHRQ Director, including a focus on health equity. The agenda will also include (1) an update and discussion by NAC members on AHRQ's efforts to promote Safer Together: A National Patient Safety Action Plan and (2) A report out and discussion of the final report from the Subcommittee of the NAC on AHRQ's Patient-Centered Outcomes Research Trust Fund (PCORTF) investments. The meeting is open to the public and will adjourn at 3:00 p.m. For information regarding how to access the meeting as well as other meeting details, including information on how to make a public comment, please go to *https://www.ahrq.gov/news/events/nac/.* The final agenda will be available on the AHRQ website no later than Thursday, November 3, 2022.

Dated: September 29, 2022.

Marquita Cullom,

Associate Director.

[FR Doc. 2022–21525 Filed 10–3–22; 8:45 am]

BILLING CODE 4160–90–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3434–PN]

Medicare and Medicaid Programs: Application From the Accreditation Commission for Health Care (ACHC) for Continued Approval of its End-Stage Renal Disease (ESRD) Accreditation Program

AGENCY: Centers for Medicare & Medicaid Services, HHS.

ACTION: Notice with request for comment.

SUMMARY: This notice acknowledges the receipt of an application from the Accreditation Commission for Health Care (ACHC) for continued recognition as a national accrediting organization for end-stage renal disease (ESRD) facilities that wish 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 5 p.m. on November 3, 2022.

ADDRESSES: In commenting, please refer to file code CMS–3434–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 *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–3434–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–3434–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: Joy Webb, (410) 786–1667 or Jennifer Milby, (410) 786–8828.

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. CMS will not post on *Regulations.gov* public comments that make threats to individuals or institutions or suggest that the individual will take actions to harm the 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 an end-stage renal disease (ESRD) facility (also known as a ''dialysis facility'') provided certain requirements are met. Section 1881(b) of the Social Security Act (the Act), establish distinct criteria for facilities seeking designation as an ESRD facility. 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 494 specify the minimum conditions that an ESRD facility must meet to participate in the Medicare program.

Generally, to enter into an agreement, an ESRD facility must first be certified by a state survey agency (SA) as complying with the conditions or requirements set forth in part 494 of our regulations. Thereafter, the ESRD facility is subject to regular surveys by a SA to determine whether it continues to meet these requirements.

Section 1865(a)(1) 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 as having 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. 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 are at least as stringent as the Medicare conditions. Our regulations concerning the approval of AOs are set forth at §§ 488.4, 488.5 and 488.5(e)(2)(i). The regulations at § 488.5(e)(2)(i) require AOs to reapply for continued approval of its accreditation program every 6 years or sooner as determined by CMS.