amendments only based on a determination that the amendments comply the requirements of relevant federal statutes and regulations and can serve as a basis for FFP.

• Whether Louisiana SPAs 13–23, 13–25 and 13–28 comply with the requirements of 1902(a)(2) and 1902(a)(4) of the Act which requires that the state plan provide for the non-federal share of expenditures under the state plan, from either state or local funding. Because the SPAs at issue propose to claim for FFP without adjustment to reflect unallowable expenditures resulting from the provider related donation and hold harmless arrangement discussed above, they would result in a non-federal share that would be insufficient to meet the requirements of section 1902(a)(2). Moreover, section 1902(a)(4) of the Act requires that the state plan comply with methods of administration as are found necessary by the Secretary for the proper and efficient operation of the plan. Among the implementing regulations for section 1902(a)(4) of the Act is the requirement at 42 CFR 430.10 that a state plan contain all information necessary for CMS to determine that the plan can be approved to serve as a basis for FFP in the state program. Because the state has not established that the supplemental payments are not part of a hold harmless arrangement that would result in a reduction in FFP, t the state has not established that the SPAs are consistent with section 1902(a)(4) and the implementing regulations at 42 CFR 430.10.

• Whether the state has established that the supplemental payments set forth in Louisiana SPAs 13–23, 13–25, and 13–28 are consistent with the statutory requirement at section 1902(a)(30)(A) of the Act that payments must be ''consistent with efficiency, economy, and quality of care''.

• Whether Louisiana SPAs 13–23, 13–25 and 13–28 comport with the broad principles of the federal-state partnership embodied in section 1903(a) of the Act, because they indicate circumstances in which the federal government would pay more than its share of the net expenditures, after accounting for claimed expenditures that are effectively repaid by the provider-related donations.

If the hearing date is not acceptable, I would be glad to set another date that is mutually agreeable to the parties. The hearing will be governed by the procedures prescribed by federal regulations at 42 CFR Part 430.

I am designating Mr. Benjamin R. Cohen as the presiding officer. If these arrangements present any problems, please contact Mr. Cohen at (410) 786 3169. In order to facilitate any communication that may be necessary between the parties prior to the hearing, please notify the presiding officer to indicate acceptability of the hearing date that has been scheduled and provide names of the individuals who will represent the state at the hearing.

Sincerely,

Marilyn Tavenner

cc: Benjamin R. Cohen

Section 1116 of the Social Security Act (42 U.S.C. section 1316; 42 CFR section 430.18)

(Catalog of Federal Domestic Assistance program No. 13.714, Medicaid Assistance Program.)

Dated: July 23, 2014.

Marilyn Tavenner,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2014–17871 Filed 7–28–14; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–6057–N]

Medicare Program; Expanded Medicare Prior Authorization for Power Mobility Devices (PMDs) Demonstration

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

ACTION: Notice.

SUMMARY: This notice announces the expansion of the Medicare Prior Authorization for Power Mobility Devices (PMDs) Demonstration to 12 additional states.

DATES: This expanded demonstration begins on October 1, 2014.

FOR FURTHER INFORMATION CONTACT: Doris M. Jackson, (410) 786–4459.

Questions regarding the Medicare Prior Authorization for Power Mobility Device Demonstration should be sent to *pademo@cms.hhs.gov*.

SUPPLEMENTARY INFORMATION:

I. Background

Section 402(a)(1)(J) of the Social Security Amendments of 1967 (42 U.S.C. 1395b–1(a)(1)(J)), authorizes the Secretary to conduct demonstrations designed to develop or demonstrate improved methods for the investigation and prosecution of fraud in the provision of care or services provided under the Medicare program. On September 1, 2012, we implemented the Medicare Prior Authorization for Power Mobility Devices (PMDs) Demonstration that would operate for a period of 3 years (September 1, 2012 through August 31, 2015). The demonstration was initially implemented in California, Florida, Illinois, Michigan, New York, North Carolina, and Texas. These states were selected for the demonstrations based upon their history of having high levels of improper payments and incidents of fraud related to PMDs. The objective of the demonstration is to develop improved methods for the investigation and prosecution of fraud in order to protect the Medicare Trust Fund from fraudulent actions and any resulting improper payments. This demonstration is providing the agency with valuable data through which the agency, working with its partners, can develop new avenues for combating the submission of fraudulent claims to the Medicare program for PMDs and improving methods for the investigation and prosecution of PMD fraud. We will share demonstration data within the agency, with our contractors, and with law enforcement partners for further analysis and investigation. We believe that data evidencing changes in physician ordering and supplier billing practices that coincide with this demonstration could provide investigators and law enforcement with important information for determining how and where to focus their investigations concerning fraud in the provision of PMDs. For instance, results from this demonstration could potentially indicate collaboration between ordering physicians and suppliers in submitting fraudulent claims for PMDs. This data could assist investigators and law enforcement in targeting their investigations in this area. Additionally, changes in billing practices that result from this demonstration could provide specific leads for investigators and law enforcement personnel. For instance, where a supplier that frequently submitted claims prior to the demonstration stops submitting claims during the demonstration, law enforcement may determine it prudent to investigate that supplier.

Data we will analyze will include the following:

• Suppliers who no longer bill or have a significant decrease in billing.

• Physicians/treating practitioners with a high volume of submissions.

• Codes that show a dramatic increase in use.

Based on preliminary data collected, spending per month on PMDs in the

seven demonstration states decreased after September 2012, indicating that physicians ordering and supplier billing practices have changed as a result of the demonstration. In addition, spending per month on PMDs decreased in the non-demonstration states. National suppliers have adjusted their billing practices nationwide and appear to have increased compliance with our policies in all locations, not just their offices in the demonstration states.

II. Provisions of the Notice

Because of the initial success of the demonstration in reducing spending on PMDs, we are expanding the demonstration to 12 additional states (Pennsylvania, Ohio, Louisiana, Missouri, Washington, New Jersey, Maryland, Indiana, Kentucky, Georgia, Tennessee, and Arizona) which have high expenditures and improper payments for PMDs based on 2012 billing data. The 19 states selected for the demonstration, which include the 7 current and 12 additional states account for 71 percent of expenditures for PMDs in 2012. The remaining states and territories would be the control group for the demonstration.

Prior to the start of the expanded demonstration, contractors and the public will be notified about the expansion. This notice will serve as notification in addition to Web site postings and tweets.

CMS or its agents will continue to conduct outreach and education including webinars, in-state meetings, and other educational sessions in the additional states as appropriate. Updated information will be posted to the CMS Web site (*http://go.cms.gov/PADemo*). We will also work to limit the impact on Medicare beneficiaries by educating the Medicare beneficiaries about their protections. In addition, physicians, treating practitioners, and suppliers who have recently ordered a PMD for a beneficiary residing in a demonstration state will be notified via letter about the expanded demonstration prior to the start date of the demonstration.

Under the expanded demonstration, we will continue to follow the policies and procedures that are currently in place for the demonstration. In accordance with current demonstration policy, a request for prior authorization and all relevant documentation to support the medical necessity along with the written order for the covered item must be submitted when one of the following Healthcare Common Procedures Coding System (HCPCS) codes for a PMD is ordered:

- Group 1 Power Operated Vehicles (K0800 through K0802 and K0812).
- All standard power wheelchairs (K0813 through K0829).
- All Group 2 complex rehabilitative power wheelchairs (K0835 through K0843).
- All Group 3 complex rehabilitative power wheelchairs without power options (K0848 through K0855).
- Pediatric power wheelchairs (K0890 and K0891).
- Miscellaneous power wheelchairs (K0898).

Under this demonstration, a physician, treating practitioner or supplier may submit the prior authorization request and all relevant documentation to support Medicare coverage of the PMD item along with the written order for the covered item to their Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC). The physician, treating practitioner or supplier who submits the request is referred to as the ''submitter.''

In order to be affirmed, the request for prior authorization must meet all applicable rules, policies, and National Coverage Determination (NCD)/Local Coverage Determination (LCD) requirements for PMD claims. The LCD documentation requirement mandates that the physician or treating practitioner shall complete the seven element order, face-to-face encounter, and whatever other clinical documentation that is necessary to determine medical necessity regardless of which entity is functioning as the submitter. The supplier completes the detailed product description (DPD) regardless of which entity is functioning as the submitter.

After receipt of all relevant documentation, CMS or its agents will make every effort to conduct a complex medical review and postmark the notification of their decision with the prior authorization number within 10 business days. Notification is provided to the physician/treating practitioner, supplier, and the Medicare beneficiary for the initial submission. If a subsequent prior authorization request is submitted after a non-affirmative decision on a prior authorization request, CMS or its agents will make every effort to conduct a review and postmark the notification of decision with the prior authorization number within 20 business days.

If the prior authorization request is not affirmed, and the claim is submitted by the supplier, the claim will be denied. Medicare beneficiaries may use existing appeal rights to contest claim denials. Suppliers must issue an Advance Beneficiary Notice to the beneficiary per CMS policy, prior to delivery of the item for the beneficiary to be held financially liable when a Medicare payment denial is expected for a PMD.

Submitters may also request expedited reviews in emergency situations where a practitioner indicates clearly, with supporting rationale, that the standard (routine) timeframe for a prior authorization decision (10 days) could seriously jeopardize the beneficiary's life or health. The expedited request must be accompanied by the required supporting documentation for this request to be considered complete thus commencing the 48-hour review. Inappropriate expedited requests may be downgraded to standard requests. After conducting an expedited review, CMS or its agents will communicate a decision for the prior authorization request to the submitter within 48 hours of the complete submission.

The following explains the various prior authorization scenarios:

- *Scenario 1:* A submitter sends a prior authorization request to the DME MAC with appropriate documentation and all relevant Medicare coverage and documentation requirements are met for the PMD. The DME MAC then sends an affirmative prior authorization decision to the physician or treating practitioner, supplier, and Medicare beneficiary. The supplier submits the claim to the DME MAC and the claim is linked to the prior authorization via the claims processing system. Provided all requirements in the applicable NCD/LCD are met, the claim is paid.
- *Scenario 2:* A submitter sends a prior authorization request, but all relevant Medicare coverage and documentation requirements are not met for the PMD. The DME MAC sends a non-affirmative prior authorization decision to the physician or treating practitioner, supplier, and Medicare beneficiary advising them that Medicare will not pay for the item. If the supplier delivers the PMD and submits a claim with a non-affirmative prior authorization decision, the DME MAC would deny the claim. The supplier and/or the Medicare beneficiary would then have the Medicare denial for secondary insurance purposes and would have full appeal rights. Existing liability provisions with respect to delivery of a valid Advance Beneficiary Notice of Noncoverage (ABN) apply.

If an applicable PMD claim is submitted without a prior authorization decision it will be stopped and documentation will be requested to conduct medical review. As with the

initial states in the demonstration, after the first 3 months of the expanded demonstration, we will assess a payment reduction in the new states for claims that, after review, are deemed payable, but did not first receive a prior authorization decision. As evidence of compliance, the supplier must submit the prior authorization number on the claim in order to not be subject to the 25-percent payment reduction. The 25-percent payment reduction is non-transferrable to the Medicare beneficiary and not subject to appeal. In the case of capped rental items, the payment reduction will be applied to all claims in the series.

The 25-percent reduction in the Medicare payment is for each payable base claim not preceded by a prior authorization request except in competitive bidding areas. If a competitive bid contract supplier submits a payable claim for a Medicare beneficiary with a permanent residence in a competitive bidding area that is included in the supplier's contract, without first receiving a prior authorization decision, that competitive bid contract supplier would receive the applicable single payment amount under the competitive bid program, and would not be subject to the 25 percent reduction. These suppliers must still adhere to all other requirements of the demonstration.

• *Scenario 3:* A submitter sends a prior authorization request where documentation is incomplete. The DME MAC sends back the prior authorization request to the submitter with an explanation about what information is missing and notifies the physician or treating practitioner, supplier, and Medicare beneficiary. The submitter may resubmit the prior authorization request.

• *Scenario 4:* The DME supplier fails to submit a prior authorization request, but nonetheless delivers the item to the Medicare beneficiary and submits the claim to the DME MAC for payment. The PMD claim is reviewed under normal medical review processing timeframes and if approved the 25-percent payment reduction would apply.

++ If the claim is determined to be not medically necessary, or insufficiently documented the claim will be denied. The supplier or Medicare beneficiary can appeal the claim denial. If the claim, after review, is deemed not payable, then all current Medicare beneficiary/supplier liability policies and procedures and appeal rights remain in effect.

++ If the claim is determined to be payable, it will be paid. However, the 25-percent reduction in the Medicare payment will be applied for failure to receive a prior authorization decision before the submission of a claim. This payment reduction will not be applied to competitive bidding program contract suppliers submitting claims for Medicare beneficiaries who maintain a permanent residence in a Competitive Bidding Area (CBA) according to the Common Working File (CWF). These contract suppliers will continue to receive the applicable single payment amount as determined in their contract. The 25-percent payment reduction is non-transferrable to the Medicare beneficiary for claims that are deemed payable. This payment reduction amount will begin 3 months after the start of the expanded demonstration and is not subject to appeal. In the case of capped rental items the payment reduction will be applied to all claims in the series. After a claim is submitted and processed, appeal rights are available if necessary.

If the prior authorization request is not affirmed, and the claim is submitted by the supplier, the claim will be denied. Medicare beneficiaries may use existing appeal rights to contest claim denials. Suppliers must issue an ABN to the beneficiary per CMS policy, prior to delivery of the item in order for the beneficiary to be held financially liable when a Medicare payment denial is expected for a PMD.

Additional information is available on the CMS Web site (*http://go.cms.gov/PADemo*).

III. Collection of Information Requirements

In the February 7, 2012 **Federal Register** (77 FR 6124) and the May 29, 2012 **Federal Register** (77 FR 31616), we published a 60-day and a 30-day notice, respectively, announcing and soliciting comments concerning the information collection requirements associated with the Medicare Prior Authorization for PMDs Demonstration implemented on September 1, 2012. The information collection request for the demonstration was approved under OMB control number 0938–1169. Subsequent to the initial approval, we published an additional **Federal Register** notice (79 FR 18913) announcing that we were seeking emergency review and approval from OMB regarding the expansion of the demonstration; specifically, we revised the information collection request to account for the addition of 12 new states to the program. The emergency revised information collection request was approved on June 13, 2014, and is still approved under OMB control number 0938–1169 with an expiration date of December 31, 2014.

Dated: June 27, 2014.

Marilyn Tavenner,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2014–17805 Filed 7–28–14; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Proposed Information Collection Activity; Comment Request

Proposed Projects: Evaluation of the Transitional Living Program (TLP)

Title: Evaluation of the Transitional Living Program (TLP)

OMB No.: 0970–0383

Description: The Runaway and Homeless Youth Act (RHYA), as amended by Public Law 106–71 (42 U.S.C. 5701 et seq.), provides for the Transitional Living Program (TLP), a residential program lasting up to 18 months designed to prepare older homeless youth ages 16–21 for a healthy and self-sufficient adulthood. Section 119 of RHYA requires a study on the long-term housing outcomes of youth after exiting the program.

The proposed collection is being carried out in two steps:

1. Interviews with TLP grantee administrators and front line staff about program structure, implementation, and approaches to service delivery.

2. A set of surveys to be administered to run away and homeless youth to measure their short-term and longer-term outcomes such as demographic characteristics, receipt of TLP or ''TLP-like'' services, housing, employment, education, social connections (e.g., social relationships, civic engagement), psychosocial well-being (e.g., depressive symptoms, traumatic stress, risky behavior, history of abuse), and other measures related to self-sufficiency and well-being (exposure to violence, financial competence).

This information will be used to better understand the most effective practices that improve the long-term outcomes for runaway and homeless youth and reduce future episodes of homelessness.

Respondents: (1) Youth ages 16–21 participating in Transitional Living Programs and (2) the Executive Director and front line staff representing TLP grantees.