

SUPPLEMENTARY INFORMATION:**Change in Standard Procedure**

GSA posts the POV mileage reimbursement rates, formerly published in 41 CFR Chapter 301, solely on the internet at www.gsa.gov/mileage. Also, posted on this site is the standard mileage rate for moving purposes. This process, implemented in FTR Amendments 2010–07, 75 FR 72965, November 29, 2010, 2007–03, 72 FR 35187, June 27, 2007, and 2007–06, 72 FR 70234, December 11, 2007, in the **Federal Register** ensures more timely updates in mileage reimbursement rates by GSA for Federal employees who are on official travel or relocating. Notices published periodically in the **Federal Register**, such as this one, and the changes posted on the GSA Web site, now constitute the only notification to Federal agencies of revisions to the POV mileage reimbursement rates and the standard mileage reimbursement rate for moving purposes.

Dated: December 16, 2014.

Alexander J. Kurien,

Deputy Associate Administrator, Office of Asset and Transportation Management, Office of Government-Wide Policy.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10421]

Agency Information Collection Activities: Submission for OMB Review; Comment Request

ACTION: Notice.

SUMMARY: The Centers for Medicare & Medicaid Services (CMS) is announcing an opportunity for the public to comment on CMS' intention to collect information from the public. Under the Paperwork Reduction Act of 1995 (PRA), federal agencies are required to publish notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension or reinstatement of an existing collection of information, and to allow a second opportunity for public comment on the notice. Interested persons are invited to send comments regarding the burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information

collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

DATES: Comments on the collection(s) of information must be received by the OMB desk officer by January 29, 2015.

ADDRESSES: When commenting on the proposed information collections, please reference the document identifier or OMB control number. To be assured consideration, comments and recommendations must be received by the OMB desk officer via one of the following transmissions:

OMB, Office of Information and Regulatory Affairs, Attention: CMS Desk Officer, Fax Number: (202) 395–5806 or Email: OIRA_submission@omb.eop.gov.

To obtain copies of a supporting statement and any related forms for the proposed collection(s) summarized in this notice, you may make your request using one of following:

1. Access CMS' Web site address at <http://www.cms.hhs.gov/PaperworkReductionActof1995>.

2. Email your request, including your address, phone number, OMB number, and CMS document identifier, to Paperwork@cms.hhs.gov.

3. Call the Reports Clearance Office at (410) 786–1326.

FOR FURTHER INFORMATION CONTACT:

Reports Clearance Office at (410) 786–1326.

SUPPLEMENTARY INFORMATION: Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501–3520), federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. The term “collection of information” is defined in 44 U.S.C. 3502(3) and 5 CFR 1320.3(c) and includes agency requests or requirements that members of the public submit reports, keep records, or provide information to a third party. Section 3506(c)(2)(A) of the PRA (44 U.S.C. 3506(c)(2)(A)) requires federal agencies to publish a 30-day notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension or reinstatement of an existing collection of information, before submitting the collection to OMB for approval. To comply with this requirement, CMS is publishing this notice that summarizes the following proposed collection(s) of information for public comment:

1. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Fee-for-Service Recovery Audit Prepayment Review Demonstration and Prior Authorization Demonstration; *Use:* On July 23, 2012, the Office of Management and Budget approved the collections required for two demonstrations of prepayment review and prior authorization. The first demonstration allows Medicare Recovery Auditors to review claims on a pre-payment basis in certain States. The second demonstration established a prior authorization program for Power Mobility Device claims in certain States.

For the Recovery Audit Prepayment Review Demonstration, CMS and its agents request additional documentation, including medical records, to support submitted claims. As discussed in more detail in Chapter 3 of the Program Integrity Manual, additional documentation includes any medical documentation, beyond what is included on the face of the claim that supports the item or service that is billed. For Medicare to consider coverage and payment for any item or service, the information submitted by the provider or supplier (e.g., claims) must be supported by the documentation in the patient's medical records. When conducting complex medical review, the contractor specifies documentation they require in accordance with Medicare's rules and policies. In addition, providers and suppliers may supply additional documentation not explicitly listed by the contractor. This supporting information may be requested by CMS and its agents on a routine basis in instances where diagnoses on a claim do not clearly indicate medical necessity, or if there is a suspicion of fraud.

For the Prior Authorization of Power Mobility Devices (PMDs) Demonstration, we are piloting prior authorization for PMDs. Prior authorization will allow the applicable documentation that supports a claim to be submitted before the item is delivered. For prior authorization, relevant documentation for review is submitted before the item is delivered or the service is rendered. CMS will conduct this demonstration in California, Florida, Illinois, Michigan, New York, North Carolina, Texas, Pennsylvania, Ohio, Louisiana, Missouri, Maryland, New Jersey, Indiana, Kentucky, Georgia, Tennessee, Washington, and Arizona based on beneficiary address as reported to the Social Security Administration and recorded in the Common Working File (CWF). For the demonstration, a prior

authorization request can be completed by the (ordering) physician or treating practitioner and submitted to the appropriate DME MAC for an initial decision. The supplier may also submit the request on behalf of the physician or treating practitioner. The physician, treating practitioner or supplier who submits the request on behalf of the physician or treating practitioner, is referred to as the "submitter." Under this demonstration, the submitter will submit to the DME MAC a request for prior authorization and all relevant documentation to support Medicare coverage of the PMD item. *Form Number*: CMS-10421 (OMB control number: 0938-1169); *Frequency*: Occasionally; *Affected Public*: State, Local or Tribal Governments; *Number of Respondents*: 333,750; *Total Annual Responses*: 333,750; *Total Annual Hours*: 170,060. (For policy questions regarding this collection contact Daniel Schwartz at 410-786-4197.)

Dated: December 23, 2014.

Martique Jones,

Director, Regulations Development Group,
Office of Strategic Operations and Regulatory Affairs.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-3296-FN]

RIN 0938-ZB14

Medicare Program; Evaluation Criteria and Standards for Beneficiary and Family Centered Care Quality Improvement Organization Contract

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

ACTION: Final notice.

SUMMARY: This final notice announces the general criteria we will use to evaluate the effectiveness and efficiency of Beneficiary and Family Centered Care (BFCC) Quality Improvement Organizations (QIOs) that entered into contracts with CMS under the 11th Statement of Work (SOW) in May 2014. The activities for the BFCC-QIO SOW began August 1, 2014. (This contract allows for a transition period from the incumbent QIOs to the successor QIOs.) In addition, this notice addresses the public comments received on the July 28, 2014 notice with comment period entitled, "Evaluation Criteria and Standards for Beneficiary and Family

Centered Care Quality Improvement Organization Contracts."

DATES: *Effective Dates*: August 1, 2014 to July 31, 2019.

FOR FURTHER INFORMATION CONTACT: Alfreda Staton, (410) 786-4194.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1153(h)(2) of the Social Security Act (the Act) requires the Secretary of the Department of Health and Human Services (the Secretary) to publish in the **Federal Register** the general criteria and standards that will be used to evaluate the effective and efficient performance of contract obligations by the Quality Improvement Organizations (QIOs) and to provide the opportunity for public comment with respect to these criteria and standards.

II. Provisions of the Notice With Comment Period

On July 28, 2014, we published a notice with comment period in the **Federal Register** (79 FR 43747 through 43749) entitled, "Evaluation Criteria and Standards for Beneficiary and Family Centered Care Quality Improvement Organization Contracts," announcing the general criteria we would use to evaluate the effectiveness and efficiency of Beneficiary and Family Centered Care (BFCC) Quality Improvement Organizations (QIOs) that entered into contracts with CMS under the 11th Statement of Work (SOW) in May 2014 (HHSM-500-2014-RFP-BFCC-QIO). That notice generally summarized the tasks of the BFCC-QIOs and the criteria to be used for annual performance evaluations during the 5-year term of the contract. BFCC-QIO performance under the 11th SOW contract began on August 1, 2014, after a transition period.

The tasks of the BFCC-QIOs under the BFCC-QIO 11th SOW contract are as follows:

- Quality of care reviews, including beneficiary complaint and general quality of care reviews.
- Beneficiary appeals of denials of hospital admissions discharge and terminations of services decisions commonly referred to as Grijalva, BIPA, and Weichardt appeals.
- Medical necessity reviews.
- Appropriateness of setting reviews.
- Diagnosis Related Group (DRG) reviews.
- Readmission reviews.
- Reviews under Emergency Medical Treatment and Active Labor Act (EMTALA).
- Sanctions.
- Monitoring of Physician Acknowledgement Statements under

section 1156(a) of the Act and our regulations at 42 CFR 412.46.

Evaluation of the Tasks Measures

The measures of BFCC-QIO performance for the 11th SOW are as follows:

- Quality of Review: Inter-Rater Reliability.
- 4-day Data Entry Compliance.
- Timeliness of Beneficiary Complaints and Other Quality of Care Reviews.
- Timeliness of Discharge/Service Termination Reviews.
- Timeliness of EMTALA and Higher Weighted Diagnosis-Related Group Reviews.
- Complainant Agreement to Complete Survey.
- Beneficiary Experience with Quality of Care Complaints.
- Beneficiary Experience with Appeal Reviews.

Evaluation Criteria

The Annual and 54th Month Evaluation Criteria for each of these measures are specifically defined in Attachment J-10, "Annual and 54th Month Evaluation Criteria Measures Table," of the BFCC-QIO SOW; the criteria for evaluating each deliverable are identified in Schedule F of the 11th SOW. Additional detail is provided in the notice posted at: <http://www.gpo.gov/fdsys/pkg/FR-2014-07-28/pdf/2014-17625.pdf>.

III. Analysis of and Responses to Public Comments on the Notice With Comment Period

Two commenters submitted several comments concerning the general criteria we would use to evaluate the effectiveness and efficiency of BFCC-QIOs that will enter into contracts with CMS under the 11th SOW. One commenter was affiliated with a private healthcare quality improvement entity and the other commenter was with a healthcare quality improvement association. A summary of the comments and our responses are as follows:

Comment: Both commenters expressed concern with potential public perception of bias arising from the evaluation criterion that considers of beneficiary experience with the quality of care complaints and appeal reviews as part of the evaluation of the BFCC-QIO's performance of quality-of-care and other statutory and regulatory reviews and appeals. The commenters indicated that consideration of beneficiary experience with the quality of care complaints and appeal reviews as part of the evaluation of the BFCC-