Comments will become a matter of public record.

Sharon B. Arnold,
Deputy Director.

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DEPARTMENT OF HEALTH AND
HUMAN SERVICES

Centers for Medicare & Medicaid
Services

[CMS–6069–N]

Medicare Program; Pre-Claim Review
Demonstration for Home Health
Services

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

ACTION: Notice.

SUMMARY: This notice announces a
3-year Medicare pre-claim review
demonstration for home health services
in the states of Illinois, Florida, Texas,
Michigan, and Massachusetts where
there have been high incidences of fraud
and improper payments for these
services.

DATES: This demonstration will begin in
Illinois no earlier than August 1, 2016,
in Florida no earlier than October 1,
2016, and in Texas no earlier than
December 1, 2016. The demonstration
will begin in Michigan and
Massachusetts no earlier than January 1,
2017.

FOR FURTHER INFORMATION CONTACT:
Jennifer McMullen, (410) 786–7635.
Questions regarding the Medicare Pre-
Claim Review Demonstration for Home
Health Services should be sent to
HHPreClaimDemo@cms.hhs.gov.

SUPPLEMENTARY INFORMATION:

I. Background and Legislative
Authority

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 develop demonstration
projects that “develop or demonstrate
improved methods for the investigation
and prosecution of fraud in the
provision of care or services under the
health programs established by the
Social Security Act” (the Act).

According to this authority, we will
implement a Medicare demonstration
that establishes a pre-claim review
process for home health agencies
(HHAs) to assist in developing
improved procedures for the
identification, investigation, and
prosecution of Medicare fraud occurring
among HHAs providing services to
Medicare beneficiaries. The proposed
demonstration will begin in Illinois not
earlier than August 1, 2016, will begin
in Florida not earlier than October 1,
2016, and will begin in Texas not earlier
than December 1, 2016. The
demonstration will begin in Michigan
and Massachusetts not earlier than
January 1, 2017. Providers in each state
will be notified by the appropriate
Medicare Administrative Contractor
prior to the start of the demonstration in
the state. Additionally, CMS will utilize
other educational efforts to announce
the program to stakeholders.

This demonstration will evaluate an
additional method that may assist with
the investigation and prosecution of
fraud in order to protect the Medicare
Trust Funds from fraudulent actions
and improper payments. We believe this
demonstration will bolster the efforts
that CMS and its partners have taken in
implementing a series of anti-fraud
initiatives in these states and will
provide valuable data that CMS working
with its law enforcement partners, can
use to combat the submission of
fraudulent claims to the Medicare
program. One such anti-fraud initiative
is the use of temporary moratoria on the
enrollment of new home health
providers that were put in place in the
Miami and Chicago that and were
subsequently expanded to the Fort
Lauderdale, Detroit, Dallas, and
Houston metropolitan areas. These
temporary moratoria prohibit the new
enrollment of home health providers to
help CMS prevent and combat fraud,
wear, and abuse in these locations.

We also believe the data collected
from this demonstration will assist with
a second initiative, the Health Care
Fraud Prevention and Enforcement
Action Team (HEAT) Task Force,
created by the Department of Health and
Human Services and the Department of
Justice (DOJ), and the Heat Task Force’s
ongoing fight against Medicare fraud.
The Heat Task Force uses resources
across the government to help prevent
and stop fraud, waste, and abuse in the
Medicare and Medicaid programs. Since
2007, the Heat Task Force of the DOJ
has charged more than 2,300 defendants
with defrauding Medicare of more than
$7 billion and convicted approximately
1,800 defendants of felony health care
fraud offenses. In addition, the data
resulting from this demonstration could
provide investigators and law
enforcement with important information
to determine how to focus their
investigation activities to identify and
combat home health fraud, and in so
doing, protect the Medicare Trust Funds
from fraudulent actions and improper
payments.

This demonstration may also help
prevent improper payments in
geographic areas where HHA providers
are known to have a high incidence of
fraud. The improper payment rate for
HHA claims has been increasing over
the past several years, and fraud is one
factor contributing to the increase. It is
important to note that while all
payments made as a result of fraud are
considered “improper payments,” not
all improper payments constitute fraud.

CMS’ Comprehensive Error Rate Testing
(CERT) program, which measures
Medicare’s improper payment rate,
estimates the payments that did not
meet Medicare coverage, coding, and
billing rules. The fiscal year (FY) 2015
Department of Health and Human
Services Agency Financial Report
reported that the CERT program’s
calculated 2015 improper payment rate
for HHA claims increased to 59.0
percent from the 2014 rate of 51.4
percent and the 2013 rate of 17.3
percent. The increase in the 2015
improper payment rate was primarily
due to “insufficient documentation”
errors, specifically, insufficient
documentation to support the medical
necessity of the services. Similar
documentation errors have also
occurred in previous years. For
example, the 2014 CERT report found
that the majority of home health
payment errors occurred when the
narrative portion of the face-to-face
counter documentation did not
sufficiently describe how the clinical
findings from the encounter supported
the beneficiary’s homebound status and
need for skilled services.

Due to the substantial increase in
improper payments and concerns raised
by the home health industry, relating to
implementation of the face-to-face
encounter documentation requirement,
we made Medicare HHA payment
policy changes in an effort to simplify
the face-to-face encounter regulations.
Specifically, as of January 1, 2015, a
separate narrative is no longer required
as part of the face-to-face
documentation. Rather, the certifying
physician’s or the acute/post-acute care
facility’s medical record(s) for the
patient must contain sufficient
documentation to substantiate eligibility
for home health services.

Despite these recent changes, we
continue to see cases in which the
medical record does not support
eligibility for the home health benefit,
which constitute “insufficient
documentation” errors. Moreover, we
note that the recent regulatory changes
do not address HHA errors in home
health billing other than those related to
the face-to-face narrative requirement.
Therefore, we also plan to use this demonstration to help make sure that all coverage and clinical documentation requirements are met before claims are submitted for final payment.

We also believe that this demonstration will enable us to—(1) test the level of resources needed to implement a permanent pre-claim review program for home health services; (2) determine the feasibility of performing pre-claim reviews to prevent payment for services that have historically had a high incidence of fraud; and (3) determine the return on investment of pre-claim review for home health claims. This demonstration will support our program integrity strategy of moving beyond a reactive “pay and chase” method toward a more effective, proactive strategy that identifies potential improper payments before payments are made. We will analyze data from the home health services pre-claim review demonstration to evaluate the impact on fraud in the demonstration states, which we believe will be a step in developing improved procedures for the identification, investigation, and prosecution of Medicare fraud occurring among HHAs providing services to Medicare beneficiaries and may consider if a more focused, risk based approach to pre-claim review is warranted in the future.

The pre-claim review demonstration does not create new documentation requirements, but simply requires currently mandated documentation earlier in the claims payment process. In addition, there are no changes to the home health service benefit for Medicare fee-for-service beneficiaries.

II. Provisions of the Notice
This demonstration will implement a 3-year pre-claim review process for home health services in Illinois, Florida, Texas, Michigan, and Massachusetts. Prior to and during the demonstration, we will conduct outreach and education of home health providers and Medicare beneficiaries using media such as webinars, open door forums, frequently asked questions pages on our Web site, other Web site postings, and educational materials issued by the Medicare Administrative Contractors (MACs) to provide guidance on the pre-claim review process. Additional information about the implementation of the pre-claim review demonstration will be available on the CMS Web site at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Program/Questions-regarding-the-Medicare-Pre-Claim-Review-Demonstration-for-Home-Health

Services should be sent to HHPreClaimDemo@cms.hhs.gov. Under this demonstration, a HHA provider, the entity billing on behalf of the HHA, or the beneficiary (known as the “submitter”) will be encouraged to submit to the relevant MAC a request for pre-claim review, along with all relevant documentation to support Medicare coverage of the applicable home health level of service. After receipt of all relevant documentation, the MAC will review the pre-claim review request to determine whether the service level complies with applicable Medicare coverage and clinical documentation requirements. The HHA provider should submit the Request for Anticipated Payment (RAP) before submitting the pre-claim review request and begin providing services while waiting for the decision from the MAC.

The MAC will communicate the HHA and beneficiary a decision provisionally approving (or disapproving) payment after a submission of a request for pre-claim review. For the initial submission of a pre-claim review request, the MAC will make all reasonable efforts to make a determination and issue a notice of the decision within 10 business days.

If the MAC declines payment after review, the submitter may amend and resubmit it. A pre-claim review request may be resubmitted an unlimited number of times. For subsequent pre-claim review requests, CMS or its agents will conduct a complex medical review and make all reasonable efforts to postmark and notify the HHA and the beneficiary of its decision within 20 business days. These timeframes are consistent with the Prior Authorization of Power Mobility Devices (PMDs) Demonstration. Meeting these timeframes will be part of the contract performance metrics for the MACs that are involved in this demonstration at the time their contracts are modified to incorporate the demonstration’s work requirements (as well as the necessary funding).

If an applicable claim is submitted for payment without a pre-claim review decision, it will be stopped for prepayment review and documentation will be requested. After the first 3 months of the demonstration in a particular state, we will apply a payment reduction for claims that, after such prepayment review, are deemed payable, but did not first receive a pre-claim review decision. As evidence of compliance, the HHA must submit the pre-claim review number on the claim in order to avoid a 25-percent payment reduction. The 25-percent payment reduction cannot be recouped from or otherwise charged to the beneficiary, and is not subject to appeal. The beneficiary would not be liable for more than he or she would otherwise be if the demonstration were not in place.

The following explains the various pre-claim review scenarios:
In each of the following scenarios, the HHA would conduct all required assessments, submit the RAP, and begin services for the beneficiaries.

• **Scenario 1:** When a submitter submits a pre-claim review request to the MAC with appropriate documentation, and all relevant Medicare coverage and documentation requirements are met for the home health service, the MAC will send a provisional affirmative pre-claim review decision to the HHA and the Medicare beneficiary. When the HHA submits the claim for payment to the MAC after delivering the home health level of service(s), the claim will include a unique tracking number that indicates it has been affirmed for pre-claim review and, as long as all Medicare coverage and documentation requirements continue to be met, the claim is paid.

• **Scenario 2:** When a submitter submits a pre-claim review request with documentation that does not meet all relevant Medicare coverage and clinical documentation requirements for the home health level of service, notification of a non-affirmative decision will be sent to the HHA and the beneficiary advising them that Medicare will not pay for the service. The submitter may then resubmit the request with additional documentation to support that the Medicare requirements have been met. Alternatively, the HHA could submit the claim to the MAC, at which point the MAC would deny the claim for lack of a provisional affirmative pre-claim review decision and recoup the payment made on the RAP following their standard procedures. Upon receiving the claim denial by the MAC, the HHA or the beneficiary would have the opportunity to appeal the claim denial if they believe Medicare coverage was denied inappropriately. Beneficiaries will continue to have the option of signing an Advance Beneficiary Notice of Noncoverage (ABN) in order to receive the services and be liable for payment.

• **Scenario 3:** When a submitter submits a pre-claim review request with incomplete documentation, the request, along with a detailed decision letter explaining what information is missing, is sent back to the submitter for resubmission. Both the HHA and the beneficiary are notified and the
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Administration for Children and Families

[CFDA Number: 93.092]

Announcing the Intent To Award Single-Source Expansion Supplement Grants to Two Personal Responsibility Education Program Innovative Strategies (PREIS) Grantees

AGENCY: Family and Youth Services Bureau, ACYF, ACF.

ACTION: This notice announces the intent to award single-source expansion supplement grants under the Personal Responsibility Education Program Innovative Strategies (PREIS) program to Children’s Hospital of Los Angeles in Los Angeles, CA and Education Development Center, Inc. in Newton, MA.

SUMMARY: The Administration for Children and Families (ACF), Administration on Children, Youth and Families (ACYF), Family and Youth Services Bureau (FYSB), Adolescent Pregnancy Prevention Program, announces its intent to award a single-source expansion supplement grant of up to $151,265 to Children’s Hospital of Los Angeles and up to $55,917.20 to Education Development Center, Inc. The supplemental award will be used to increase the campaign’s reach.

DATES: The period of support for the single-source expansion supplements is September 30, 2015, through September 29, 2016.

FOR FURTHER INFORMATION CONTACT: LeBretia White, Program Manager, Adolescent Pregnancy Prevention Program, Division of Adolescent Development and Support, Family and Youth Services Bureau, 330 C Street SW., Washington, DC 20201, Telephone: 202–205–9605; Email: LeBretia.White@acf.hhs.gov.

SUPPLEMENTARY INFORMATION: Children’s Hospital of Los Angeles is funded under the Personal Responsibility Education Program Innovative Strategies (PREIS) program to adapt an existing evidence-based pregnancy prevention program for pregnant and parenting teens and rigorously evaluate the program for its impact on reducing repeat pregnancy. The supplemental award will be used to review, code, and analyze digital recordings, employ intensive tracking and follow up efforts with participants to administer the 36-month follow-up survey, conduct additional advanced analyses, develop manuscripts and briefs based on additional analyses, and disseminate study findings. Education Development Center, Inc. is funded under the Personal Responsibility Education Program Innovative Strategies (PREIS) program to implement a parent education program for Latino youth (Salud y Exito/Health and Success) and to rigorously evaluate the intervention to determine impact on reducing sexual risk-taking behavior. The supplement award will be used to augment dissemination efforts for the intervention by developing a social media campaign to promote the intervention Web site and to analyze social media data to determine the campaign’s reach.


Christopher Beach, Senior Grants Policy Specialist, Division of Grants Policy, Office of Administration, Administration for Children and Families.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Administration for Children and Families

Submission for OMB Review; Comment Request


Description: The Administration for Children and Families (ACF) within the U.S. Department of Health and Human Services (HHS) intends to collect data on a third cohort of children and families for the National Survey of Child and Adolescent Well-Being (NSCAW). NSCAW is the only source of nationally representative, longitudinal, firsthand information about the functioning and well-being, service needs, and service utilization of children and families who come to the attention of the child welfare system. The first two cohorts of NSCAW were collected beginning in 1999 and 2008 and studied children who had been the subject of investigation by Child Protective Services. Children were sampled from child welfare agencies nationwide.

The proposed data collection plan for the third cohort of NSCAW includes two phases: Phase 1 includes child...