4120-01-U-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifiers: CMS-P-0015A and CMS-10599]

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Centers for Medicare & Medicaid Services, Health and Human Services (HHS).

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 60 days for public comment on the proposed action. Interested persons are invited to send comments regarding our burden estimates or any other aspect of this collection of information, including the necessity and utility of the proposed information collection for the proper performance of the agency's functions, the accuracy of the estimated burden, ways to enhance the quality, utility, and clarity of the information to be collected, and the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

DATES: Comments must be received by **[INSERT DATE 60 DAYS AFTER DATE OF PUBLICATION IN THE *FEDERAL REGISTER*]**.

ADDRESSES: When commenting, please reference the document identifier or OMB control number. To be assured consideration, comments and recommendations must be submitted in any one of the following ways:

1. Electronically. You may send your comments electronically to http://www.regulations.gov. Follow the instructions for "Comment or Submission" or "More Search Options" to find the information collection document(s) that are accepting comments.

2. By *regular mail.* You may mail written comments to the following address:

CMS, Office of Strategic Operations and Regulatory Affairs

Division of Regulations Development

Attention: Document Identifier/OMB Control Number: _____

Room C4-26-05

7500 Security Boulevard

Baltimore, Maryland 21244-1850.

To obtain copies of a supporting statement and any related forms for the proposed collection(s) summarized in this notice, please access the CMS PRA web site by copying and pasting the following web address into your web browser: https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing

FOR FURTHER INFORMATION CONTACT: William N. Parham at (410) 786-4669.

SUPPLEMENTARY INFORMATION:

Contents

This notice sets out a summary of the use and burden associated with the following information collections. More detailed information can be found in each collection's supporting statement and associated materials (see **ADDRESSES**).

CMS-P-0015A Medicare Current Beneficiary Survey

CMS-10599 Pre-Claim Review Demonstration For Home Health Services

Under the 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 requires federal agencies to publish a 60-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.

Information Collections

1. *Type of Information Collection Request*: Revision of a currently approved collection; *Title of Information Collection:* Medicare Current Beneficiary Survey; *Use:* CMS is the largest single payer of health care in the United States. The agency plays a direct or indirect role in administering health insurance coverage for more than 150 million people across the Medicare, Medicaid, CHIP, and Health Insurance Marketplace populations. A critical aim for CMS is to be an effective steward, major force, and trustworthy partner in supporting innovative approaches to improving quality, accessibility, and affordability in healthcare. CMS also aims to put patients first in the delivery of their health care needs.

The Medicare Current Beneficiary Survey (MCBS) is the most comprehensive and complete survey available on the Medicare population and is essential in capturing information not otherwise collected through operational or administrative data on the Medicare program. The MCBS is a nationally-representative, longitudinal survey of Medicare beneficiaries that is sponsored by CMS and is directed by the Office of Enterprise Data and Analytics (OEDA). MCBS data collection is primarily conducted by phone and is supplemented with limited video interviewing or in-person visits. The survey captures beneficiary information whether aged or disabled, living in the community or facility, or serviced by managed care or fee-for-service. Data produced as part of the MCBS are enhanced with administrative data (e.g., fee-for-service claims, prescription drug event data, enrollment, etc.) to provide users with more accurate and complete estimates of total health care costs and utilization. The MCBS has been continuously fielded for more than 30 years, encompassing over 1.2 million interviews and more than 140,000

survey participants. Respondents participate in up to 11 interviews over a four-year period. The MCBS provides a holistic view of Medicare beneficiaries' social and medical risk factors and rich information on the relationship between these risk factors, healthcare utilization, and health outcomes, at a point in time and over time.

The MCBS continues to provide unique insight into the Medicare program and helps CMS and its external stakeholders better understand and evaluate the impact of existing programs and significant new policy initiatives. MCBS data are used to assess potential changes to the Medicare program. For example, MCBS data were instrumental in supporting the initial implementation of the Medicare prescription drug benefit and continue providing a means to evaluate prescription drug costs and out-of-pocket burden for these drugs to Medicare beneficiaries. Beginning in Fall 2026, this proposed revision to the clearance will remove questionnaire items that are no longer relevant for administration. The revisions will result in a net decrease in respondent burden. *Form Number*: CMS-P-0015A (OMB control number 0938-0568); *Frequency*: Occasionally; *Affected Public*: Business or other for-profits and Not-for-profits Institutions; *Number of Respondents*: 13,568; *Number of Responses*: 35,015; *Total Annual Hours*: 32,132. (For questions regarding this collection, contact William Long at 410-786-7927).

2. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Review Choice Demonstration for Home Health Services; *Use:* 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 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)." Pursuant to this authority, the CMS seeks to develop and implement a Medicare demonstration project, which CMS believes will help assist in developing improved procedures for the identification, investigation, and

prosecution of Medicare fraud occurring among Home Health Agencies (HHA) providing services to Medicare beneficiaries.

This revised demonstration helps assist in developing improved procedures for the identification, investigation, and prosecution of potential Medicare fraud. The demonstration helps make sure that payments for home health services are appropriate through either pre-claim or post payment review, thereby working towards the prevention and identification of potential fraud, waste, and abuse; the protection of Medicare Trust Funds from improper payments; and the reduction of Medicare appeals. CMS has implemented the demonstration in Illinois, Ohio, North Carolina, Florida, and Texas with the option to expand to other states in the Palmetto/JM jurisdiction. Under this demonstration, CMS offers choices for providers to demonstrate their compliance with CMS' home health policies. Providers in the demonstration states may participate in either 100 percent pre-claim review or 100 percent post payment review. These providers will continue to be subject to a review method until the HHA reaches the target affirmation or claim approval rate. Once an HHA reaches the target pre-claim review affirmation or post-payment review claim approval rate, it may choose to be relieved from claim reviews, except for a spot check of their claims to ensure continued compliance. Providers who do not wish to participate in either 100 percent pre-claim or post payment reviews have the option to furnish home health services and submit the associated claim for payment without undergoing such reviews; however, they will receive a 25 percent payment reduction on all claims submitted for home health services and may be eligible for review by the Recovery Audit Contractors.

The information required under this collection is required by Medicare contractors to determine proper payment or if there is a suspicion of fraud. Under the pre-claim review option, the HHA sends the pre-claim review request along with all required documentation to the Medicare contractor for review prior to submitting the final claim for payment. If a claim is submitted without a pre-claim review decision on one file, the Medicare contractor will request the information from the HHA to determine if payment is appropriate. For the post payment

review option, the Medicare contractor will also request the information from the HHA provider who submitted the claim for payment from the Medicare program to determine if payment was appropriate. *Form Number:* CMS-10599 (OMB control number: 0938-1311); *Frequency:* Frequently, until the HHA reaches the target affirmation or claim approval threshold and then occasionally; *Affected Public:* Private Sector (Business or other for-profits and Not-for-profits); *Number of Respondents:* 4,700; *Number of Responses:* 3,173,016; *Total Annual Hours:* 1,600,608. (For questions regarding this collection contact Jennifer McMullen (410)786-7635.)

William N. Parham, III,

Director,

Division of Information Collections and Regulatory Impacts,

Office of Strategic Operations and Regulatory Affairs.

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