Supporting Statement

CMS-10357 -- Letter Requesting Waiver of Medicare/Medicaid Enrollment Application Fee; Submission of Fingerprints; Submission of Medicaid Identifying Information; Medicaid Site Visit and Rescreening

A. Background

On March 23, 2010, the President signed into law H.R. 3590, the Patient Protection and Affordable Care Act (Affordable Care Act), Public Law 111-148. Section 6401 of the law establishes a number of important payment safeguard provisions, several of which were incorporated into CMS-6028-FC. CMS-6028-FC, entitled "Medicare, Medicaid, and Children's Health Insurance Programs (CHIP); Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers," was published in the *Federal Register* on February 2, 2011. The provisions therein were designed to improve the integrity of the Medicare, Medicaid, and CHIP programs so as to reduce fraud, waste and abuse.

Of the elements of CMS-6028-FC, six were listed in the ICR section:

- **Medicare Enrollment Application Fee Waiver Request (42 CFR § 424.514)**: Certain providers and suppliers enrolling in Medicare are required to submit a fee with their application. Under 42 CFR § 424.514, if the applicant believes it has a hardship that justifies a waiver of the application fee, it may submit a letter describing said hardship. The burden associated with this requirement is the time and effort necessary to draft and submit the letter.

- **Fingerprints (42 CFR § 424.518 and § 455.434):** Certain providers and suppliers enrolling in Medicare, Medicaid, and CHIP will be required to submit fingerprints – either digitally or via the FD-258 standard fingerprint card - of their owners. The burden associated with this requirement will be the time and effort necessary for the provider or supplier to obtain and submit the fingerprint cards.

- **Suspension of Medicaid Payments (42 CFR § 455.23):** A State Medicaid agency must suspend all Medicaid payments to a provider when there is a pending investigation of a credible allegation of Medicaid fraud against an individual or entity, unless it has good cause not to suspend payments or to suspend payment only in part. The State Medicaid agency may suspend payments without first notifying the provider of its intention to suspend such payments. A provider may request, and must be granted, administrative review where state law so requires. The burden associated with this requirement is the time and effort necessary for a provider to request administrative review. While this requirement is subject to the PRA, we believe the associated burden is exempt in

accordance with 5 CFR 1320.4; information collected subsequent to an administrative action is not subject to the PRA.

- **Collection of SSNs and DOBs for Medicaid and CHIP providers (42 CFR § 455.104(b)(1)):** The state Medicaid agency or CHIP agency must require that all persons with an ownership or control interest in a Medicaid or CHIP provider submit their SSNs and DOBs. The burden associated with this requirement is the provider's acquisition and submission of this data.

- **Site Visits for Medicaid-only or CHIP-only providers (42 CFR § 455.450(b)):** A state Medicaid agency or CHIP agency must conduct on-site visits for providers it determines to be "moderate" or "high" categorical risk. The burden associated with this requirement is the time and effort the state Medicaid agency or CHIP agency needs to perform the site visit.

- **Rescreening of Medicaid and CHIP Providers Every 5 Years (42 CFR § 455.414):** A state Medicaid agency or CHIP agency must screen all providers at least every 5 years. This is consistent with the Medicare requirement in current 42 CFR § 424.515 that providers and suppliers revalidate their enrollment information at least every 5 years. The burden associated with this requirement is the time and effort necessary for Medicaid-only or CHIP-only providers to re-enroll in Medicaid or CHIP, and the time and effort necessary for the state Medicaid agency or CHIP agency to conduct the provider screening.

B. Justification

1. Need and Legal Basis

The provisions of CMS-6028-F, and the information collection elements described above, were necessary to carry out Section 6401 of the Affordable Care Act.

2. Information Users

CMS and/or its Medicare contractors use the letters referred to in § 424.514, and the Medicare fingerprint collection in 42 CFR § 424.518.

States and/or their agents use the information collections related to: (1) fingerprinting for Medicaid and CHIP providers, (2) SSNs and DOBs for Medicaid and CHIP providers, (3) site visits for Medicaid-only or CHIP-only providers, and (4) rescreening of Medicaid and CHIP providers every 5 years.

3. Use of Information Technology

For Medicare, the standard electronic system used by Medicare contractors is the Provider

Enrollment, Chain and Ownership System (PECOS). The waiver letter is typically submitted via hard copy, as this requirement generally does not lend itself to electronic submission at this time. The provider or supplier will be able to submit fingerprints either digitally or via the FD-258 standard fingerprint card.

For Medicaid and CHIP, the use of information technology varies by state. Each state is responsible for administering its own Medicaid and CHIP programs.

4. Duplication of Efforts

This information collection does not duplicate any other effort and the information cannot be obtained from any other source.

5. Small Businesses

Each of the data collections described above impact small businesses. However, because of the relative infrequency with which the information is submitted and the minimal time involved in each data collection, the overall impact on small businesses remains extremely negligible.

6. Less Frequent Collection

- **Waiver of Application Fee –** In general, providers and suppliers submit this letter only once.
- **Fingerprints** – In general, fingerprints will be collected from the affected providers and suppliers only once.
- **Collection of SSNs and DOBs** – This information is collected upon initial enrollment, revalidation every 5 years, and if/when the provider adds a new individual with an ownership or control interest. In general, the provider must to furnish the SSN or DOB of at least one individual no more than twice in a 5-year period.
- **Site Visits –** In general, site visits of the affected providers is performed only once – specifically, upon initial enrollment.
- **Rescreening –** Rescreening of Medicaid providers occurs once every five years.

7. Special Circumstances

There are no special circumstances associated with this information collection request.

8. Federal Register/Outside Consultation

The 60-day *Federal Register* notice published on August 1, 2014.

9. Payments/Gifts to Respondents

Not applicable.

10. Confidentiality

CMS, its Medicare contractors, state Medicaid agencies and its agents, will comply with all Federal and State laws – including, but not limited to, the Federal Privacy Act and Freedom of Information Act – that apply to this collection. Privileged or confidential commercial or financial information is protected from public disclosure by Federal law 5 U.S.C. 522(b)(4) and Executive Order 12600.

11. Sensitive Questions

There are no sensitive questions associated with this collection.

12. Burden Estimates (Hours & Wages)

The wage estimates below, unless otherwise noted, are taken from the most recent wage data provided by the Bureau of Labor Statistics (BLS) for May 2013 (see http://www.bls.gov/oes/current/oes231011.htm). The applicable BLS employment categories for each estimate are noted in each section below.

a. Medicare Enrollment Application Fee Waiver Request

Based on CMS statistics, roughly 100 providers per year have submitted a waiver request letter to CMS. We continue to estimate that it takes the provider approximately 1 hour to prepare and submit the letter. Generally speaking, such letters are prepared and submitted by managers of the provider. According to the most recent BLS data for May 2013, the mean hourly wage for the category of "Medical Health and Service Managers" is $48.72; with fringe benefits and overhead (and accordingly applying a factor of 1.5), the rate is $73.08 ($48.72 x 1.5). This results in a 100-hour burden and a total annual cost of $7,308.

100 providers X 1 hour X $73.08 = $7,308.

b. Fingerprints

1. Medicare

We continue to estimate that 7,000 home health agencies (HHAs) and suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) will be required to submit the fingerprints of an average of 5 individuals within its organization per year, or 35,000 individuals per year. We believe it will take the individual 2 hours to complete the fingerprinting process. We believe that the aforementioned category of "Medical Health and

Service Managers" is the most appropriate labor category. This results in a 70,000-hour burden and a total annual cost of $5,115,600.

7,000 providers X 5 individuals X 2 hours X $73.08 = $5,115,600

We also continue to estimate that an additional 2,000 "high-risk" Medicare providers will be required each year to submit the fingerprints of an average of 5 individuals within its organization. Again, we believe it will take the individual 2 hours to complete the fingerprinting process at a per hour labor cost of $73.08. This results in a 20,000-hour burden and a total annual cost of $1,461,600.

2,000 providers X 5 individuals X 2 hours X $73.08 = $1,461,600

We further continue to estimate that 500 physicians will be required each year to submit fingerprints. We believe it will take the individual 2 hours to complete the fingerprinting process. According to BLS data for May 2013, the mean per hour wage for the category of "Physicians and Surgeons, All Other" is $90.00; with fringe benefits and overhead (and accordingly applying a factor of 1.5), the rate is $135.00. This results in a 1,000-hour burden and a total annual cost of $135,000.

500 physicians X 2 hours X $135,000 = $135,000

We therefore project that the aforementioned Medicare fingerprinting requirements will result in a combined hourly burden of 91,000 (70,000 + 20,000 + 1,000), at a total cost of $6,712,200 ($5,115,600 + $1,461,600 + $135,000).

ii. Medicaid

We continue to anticipate that Medicaid and CHIP will request 26,000 individuals to submit fingerprints prior to enrollment, and that it will take the individual 2 hours to complete the fingerprinting process. Using the aforementioned wage category for Medical Health and Service Managers, this results in a 52,000-hour burden and a total annual cost of $3,800,160.

26,000 physicians X 2 hours X $73.08 = $3,800,160

c. Collection of SSNs and DOBs

According to existing data, there are currently roughly 2 million Medicaid enrolled providers. As we estimated in the PRA Supporting Statement for CMS-6028-P, approximately one-fifth

(or 400,000 (2 million x 20 percent) of existing Medicaid providers are required to re-enroll each year. We also continue to estimate (as we did in the CMS-6028-P PRA Supporting Statement) that there will be 56,250 newly enrolling Medicaid providers each year, for a total of 456,250 Medicaid providers that are subject to the SSN and DOB reporting requirements each year.

We further project that it takes each provider an average of 2 minutes to report the SSN and DOB for all persons with an ownership or control interest. The specific individual within the provider organization who obtains and submits this data will vary by provider type and size. For purposes of consistency, however, we will continue to use the "Medical Health and Service Managers" category's hourly rate of $73.08. Thus, the estimated annual burden associated with this requirement for Medicaid providers is 14,242 hours at a cost of $1,040,805.

427,264 providers X 2 minutes, divided by 60 minutes = 14,242 hours

14,242 hours X $73.08 = $1,040,805

d. Site Visits

We continue to estimate that State Medicaid agencies conduct approximately 5,000 site visits for Medicaid-only providers nationally per year. We further continue to estimate that it takes one individual 8 hours to perform each on-site visit (including travel time). Thus, the total estimated hour burden associated with this requirement for Medicaid is 40,000 hours per year (5,000 site visits X 8 hours).

The hourly wages of the state officials or other individuals who perform these site visits vary widely. For purposes of consistency, though, we will use the projected hourly wage of those persons who conduct Medicare site visits, which, with overhead and fringe benefits, is $45.35 (as shown in the table in section 14 below). This results in an annual cost burden of $1,814,000 (40,000 hours X $45.35 per hour).

e. Rescreening Medicaid Providers

i. Providers Reenrolling

As stated previously, according to data taken from SPIA for FFYs 2007 and 2008, there has been an average of 1,855,070 existing Medicaid providers nationally over that 2-year period. We continue to estimate that one-fifth, or 371,014 (1,855,070 x 20 percent) of existing Medicaid providers are required to re-enroll each year. Although provider enrollment requirements vary by State, we believe it takes each provider an average of 2 hours to complete the Medicaid re-enrollment requirements. Consequently, the estimated annual burden associated with this requirement for Medicaid providers continues to be 742,028 hours

(371,014 x 2 hours). Using the above-referenced hourly rate of $73.08 results in a cost of $54,227,406 (742,028 hours X $73.08 per hour).

ii. State Agency Processing of Reenrollment Applications

We continue to estimate that roughly 80 percent of Medicaid providers also participate in Medicare, and thus have provider screening activities performed by Medicare contractors. We hence continue to believe that states are required to conduct provider screening activities for 74,203 (371,014 x 20 percent) re-enrolling, Medicaid-only providers each year. We further estimate that it takes states, on average, 4 hours to perform the required provider screening activities – noting that currently enrolled providers are generally categorized as lower risk than newly-enrolling providers. The estimated hour burden associated with this requirement for state Medicaid agencies is 296,812 hours (74,203 x 4 hours).

The hourly wages of the state officials or other individuals who process Medicaid applications vary widely. For purposes of consistency, we will use the projected hourly wage of those persons who process Medicare applications, which, with fringe benefits and overhead, is $30.65 (as shown in the table in section 14 below). This results in an annual cost burden of $9,097,288 (296,812 hours X $30.65 per hour). However, we believe that this burden on states is offset in large part by (1) the application fees collected and (2) the Federal share for the amounts not covered by the application fee.

f. Total

Provision	OMB Control No.	Respondents	Responses	Burden per Response (hours)	Total Annual Burden (hours)	Hourly Labor Cost of Reporting ($)	Total Labor Cost of Reporting ($)	Total Cost ($)
Application Fee Waiver (424.514)	0938-1137	100	100	1	100	73.08	7,308	7,308
Medicare F-printing (HHA/DMEPOS) (424.518)	0938-1137	35,000	35,000	2	70,000	73.08	5,115,600	5,115,600
Medicare F-printing (High-risk) (424.518)	0938-1137	10,000	10,000	2	20,000	73.08	1,461,600	1,461,600
Medicare F-printing (Physicians) (424.518)	0938-1137	500	500	2	1,000	135.00	135,000	135,000
Medicaid F-printing (455.434)	0938-1137	26,000	26,000	2	52,000	73.08	3,800,160	3,800,160
SSN/DOB Collection (455.104)	0938-1137	427,264	427,264	.033	14,242	73.08	1,040,805	1,040,805
Site Visits (455.450)	0938-1137	5,000	5,000	8	40,000	45.35	1,814,000	1,814,000

Provider Rescreening (455.414)	0938-1137	371,014	371,014	2	742,028	73.08	54,227,406	54,227,406
State Medicaid Agency Processing of Rescreening Application (455.414)	0938-1137	74,203	74,203	4	296,812	30.65	9,097,288	9,097,288
TOTAL		**949,081**	**949,081**		**1,236,182**		**76,699,167**	**76,699,167**

As indicated in the following chart, we estimate that the total hourly burden of the aforementioned elements of CMS-6028-F will be 1,236,182 hours, at a total cost of $76,699,167.

13. Estimates of other Total Annual Cost Burden to Respondents or Record Keepers (Capital Costs)

There are no additional record keeping/capital costs.

14. Annualized Cost to the Federal Government

The following chart identifies the annual cost to the Federal Government – through CMS, its Medicare contractors, Medicaid State agencies and/or its agents - to execute the activities outlined in this Supporting Statement.

Provision	Documents to be Collected/Tasks to be Performed	Time Needed to Process Document/ Complete Task (hours)	Total Annual Processing/ Task Burden (hours)	Per Hour Cost of Processing/Task	Per Hour Cost with Fringe Benefits & Overhead ($)	Total Cost of Processing/ Task Burden ($)
Application Fee Waiver (424.514)	100	2	200	20.43 *	30.65 ***	6,130
Medicare F-printing (HHA/ DMEPOS)	35,000	.5	17,500	20.43 *	30.65 ***	536,375
Medicare F-printing (High-risk) (424.518)	10,000	.5	5,000	20.43 *	30.65 ***	153,250
Medicare F-printing (Physicians) (424.518)	500	.5	250	20.43 *	30.65 ***	7,663
Medicaid F-printing (455.434)	26,000	.5	13,000	20.43 *	30.65 ***	398,450
SSN/DOB Collection (455.104)	427,264	.5	213,632	20.43 *	30.65 ***	6,547,821
Site Visits (455.450)	5,000	8	40,000	30.23 **	45.35 ***	1,814,000
Provider Rescreening (455.414) ****	N/A	N/A	N/A	N/A	N/A	N/A

State Medicaid Agency Processing of Rescreening Application (455.414)	74,203	4	296,092	20.43 *	30.65 ***	9,075,220
TOTAL			**585,674**			**18,538,909**

* Per hour cost based on Grade 7/Step 1 salary in Washington, DC area.
** Per hour cost based on Grade 11/Step 1 salary in Washington, DC area.
*** Per hour cost with fringe benefits and overhead, using a factor 1.5 (e.g., 20.43 x 1.5 = 30.65) (See http://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2014/DCB_h.pdf)
**** The burden associated with the processing of reenrollment applications is covered under the "State Medicaid Agency Processing of Rescreening Application" category.

15. Changes to Burden

No changes to burden hours.

16. Publication/Tabulation Dates

N/A

17. Expiration Date

This collection does not lend itself to displaying an expiration date.

18. Certification Statement

There are no exceptions to item 19 of OMB Form 83-I.