Supporting Statement for Paperwork Reduction Act Submissions

Medicare Enrollment Application – Reassignment of Medicare Benefits
(CMS-855R/OMB control number: 0938-1179)

A. BACKGROUND

The primary function of the CMS-855R enrollment application is to allow providers and suppliers to reassign their Medicare benefits to a group or individual practice and collects information necessary to establish correct claims payment. The goal of periodically evaluating and revising the CMS-855R enrollment application is to simplify and clarify the information collection without jeopardizing our need to collect specific reassignment information.

Goals of the Provider/Supplier Enrollment Application Revisions

At this time CMS is also using this opportunity to make minor editorial and clerical corrections to the CMS-855R to simplify and clarify the current data collection and to remove obsolete questions. CMS is adding a data collection to identify a secondary group location where the provider/supplier will render services. Like the primary practice location, this secondary location data collection is optional. If completed, the information will go to the Physician Compare website. Through data analytics CMS will be able to monitor and track claims submitted by groups on behalf of the providers/suppliers who have reassigned their benefits to the group to ensure the billing patterns and volume of claims submitted on behalf of any given provider/supplier are valid and possible. For example, a provider who has reassigned its benefits to the group works for the group submitting claims that equal to approximately 40 hours a week. The provider also has a private practice where claims are submitted equaling approximately 40 hours a week. In addition, the provider practices at a hospital where the claims submitted add up to approximately 40 hours a week. CMS would be able to see the provider cannot possibly submit claims for 120 hours per week and CMS would investigate the provider.

With the exception of adding a new submission reason (change of reassignment information) and the option to identify a secondary practice location address, there are only minor revisions to this revision package, such as re-wording the instructions for better provider/supplier flow and understanding.

JUSTIFICATION

1. *Need and Legal Basis*

Various sections of the Social Security Act (Act), the United States Code (U.S.C.), Code of Federal Regulations (CFR) and the Internal Revenue Code (Code) require providers and suppliers to furnish information concerning the identification of individuals or entities that furnish medical supplies and services to beneficiaries before payment can be made.

- C.F.R. section 424.500 state the requirements for enrollment, periodic resubmission and

certification of enrollment information for revalidation, and timely reporting of updates and changes to enrollment information. These requirements apply to all providers and suppliers except for physicians and practitioners who have entered into a private contract with a beneficiary as described in part 405, subpart D of this chapter. Providers and suppliers must meet and maintain these enrollment requirements to bill either the Medicare program or its beneficiaries for Medicare covered services or supplies.

- Sections 1833(e) of the Act require the submission of information necessary to determine the amounts due to a provider, supplier or other person.
- Section 31001(I) of the Debt Collection Improvement Act of 1996 (DCIA) (Public Law 104-134) amended 31 U.S.C. 7701 by adding paragraph (c) to require that any person or entity doing business with the Federal Government provide their Tax Identification Number (TIN).
- The Balanced Budget Act of 1997 (BBA) (Public Law 105-33) section 4313, amended sections 1124(a)(1) and 1124A of the Act to require disclosure of both the Employer Identification Number (EIN) and Social Security Number (SSN) of each provider or supplier, each person with ownership or control interest in the provider or supplier, as well as any managing employees. The Secretary of Health and Human Services (the Secretary) signed and sent to the Congress a "Report to Congress on Steps Taken to Assure Confidentiality of Social Security Account Numbers as Required by the Balanced Budget Act" on January 26, 1999, with mandatory collection of SSNs and EINs effective on or about April 26, 1999.
- Sections 1814(a), 1815(a), and 1833(e) of the Act require the submission of information necessary to determine the amounts due to a provider or other person.
- Section 1866(j)(1)(C) of the Act requires us to consult with providers and suppliers of services before making changes in provider enrollment forms.
- Section 508 of the Rehabilitation Act of 1973, as incorporated with the Americans with Disabilities Act of 2005 requires all Federal electronic and information technology to be accessible to people with disabilities, including employees and members of the public.
- 42 C.F.R. section 424.502, defines enrollment and enrollment related terms.
- Federal law 5 U.S.C. 522(b)(4) requires privileged or confidential commercial or financial information protection from public disclosure.
- Executive Order 12600 requires the pre-disclosure of notification procedures for confidential commercial information.

The revised CMS-855R application collects this information, including the information necessary to uniquely identify the provider/supplier.

2. *Purpose and users of the information*

Providers/suppliers who wish to reassign their benefits in the Medicare program must complete the CMS-855R reassignment application. It is submitted at the time the provider/supplier first reassigns of his/her Medicare benefits to a group practice, as well as any subsequent reassignments, changes to current reassignment information or terminations of established reassignments as requested by the provider/supplier or group. The application is used by the Medicare Administrative Contractor (MAC) to collect data to assure the applicant has the necessary information that allows the MAC to correctly establish, change, or terminate the reassignment.

Groups typically complete the CMS-855R on behalf of the provider/supplier who is reassigning benefits, changing reassignment information, or terminating a reassignment. For example, if a physician joins a group practice, the group will complete the CMS-855R to reassign the newly hired physician's benefits (claims payment), to the group as part of the hiring process. Conversely, if a provider/supplier leaves a group, the group will typically complete the CMS-855R to terminate that provider/supplier's reassignment of benefits to the group. In addition, if the provider/supplier choses to complete the practice location section of the CMS-855R, the provider/supplier will then be listed on the Physician Compare website for beneficiaries to find and/or research.

The Provider Enrollment Chain and Ownership System (PECOS) keeps track of all reassignments. If the provider or supplier or group becomes out of compliance, CMS can link the provider/supplier or group to all other affiliations. For example, a non-physician practitioner is found to be billing fraudulently in his/her private practice. CMS can go to PECOS and find what other locations (e.g., hospital) or groups the non-physician practitioner has reassigned his/her benefits. CMS then notifies the other entities (e.g., groups) that the non-physician practitioner has been barred from seeing and submitting claims for Medicare beneficiaries. So everywhere the non-physician practitioner practices would submit a CMS-855R for termination of his/her reassignment(s).

This revision adds a new submission reason for completing and submitting the CMS-855R. There is now a change of reassignment submission reason. This is a new box to check but there have always been changes of information submitted to CMS regarding reassignments. Typically, changes of information were submitted as a termination of one reassignment and then a CMS-855R was submitted as a new reassignment. The change of information option allows the group to submit one CMS-855R for changes of information, lessening the burden on the provider/supplier, group, and MAC.

The collection and verification of reassignment information defends and protects our beneficiaries from illegitimate providers/suppliers. These procedures also protect the Medicare Trust Fund against fraud. It gathers information that allow Medicare contractors to ensure that the provider/supplier is not sanctioned from the Medicare and/or Medicaid program(s), or debarred, or excluded from any other Federal agency or program. The data (e.g., Social Security Numbers, Employer Identification Numbers) collected also ensures that the applicant has the necessary credentials to provide the health care services for which they intend to bill Medicare through the reassignment. This is sole instrument implemented for this purpose.

3. *Improved Information Techniques*

This collection lends itself to electronic collection methods and is currently available through the CMS website. The Provider Enrollment, Chain and Ownership System (PECOS) is a secure, intelligent and interactive national data storage system maintained and housed within the CMS Data Center with limited user access through strict CMS systems access protocols. Access to the data maintained in PECOS is limited to CMS and Medicare contractor employees responsible for provider/supplier enrollment activities. The provider/supplier has access to its own records.

PECOS is an electronic Medicare enrollment system through which providers and suppliers can: submit Medicare enrollment applications, view and print enrollment information, update enrollment information, and track the status of a submitted Medicare enrollment application. The data stored in PECOS mirrors the data collected on the paper CMS-855R (Medicare Enrollment Application for Reassignment of Benefits) and is maintained indefinitely as both historical and current information. CMS also supports an Internet-based provider/supplier CMS-855 enrollment platform which allows the provider/supplier to complete an online CMS-855R application and transmit it to the Medicare contractor database for processing. Then the data is transferred from the Medicare contractor processing database into PECOS by the Medicare contractor. CMS also has the ability to allow suppliers to upload supporting documentation (required for enrollment) electronically. CMS has also adopted an electronic signature standard; however, providers/suppliers will have the choice to e-sign via the CMS website or to submit a hard copy of the CMS-855R certification page with an original signature. Periodically, CMS will require adjustment to the format of the CMS-855R form (either paper, electronic or both) for clarity or to improve form design. These adjustments do not alter the OMB data collection approval. Currently, approximately 36% of individual provider/suppliers use the electronic method of reassigning their benefits in the Medicare program via the PECOS system.

4. *Duplication and Similar Information*

There is no duplicative information collection instrument or process.

5. *Small Business*

This form will affect small businesses; however, these businesses have always been required to provide CMS with substantially the same information in order to reassign benefits in the Medicare program and for CMS successfully process their Medicare claims.

6. *Less Frequent Collections*

This information is collected on an as needed basis. The information provided on the CMS-855R is necessary for individuals reassigning benefits to groups in the Medicare program. After the initial reassignment and approval, the information collected is less frequent and initialized for a change reassignment information, and for individuals and groups to terminate reassignments.

In addition, to ensure uniform data submissions, CMS requires that all changes to previously submitted enrollment data be reported via this CMS-855R application.

7. *Special Circumstances*

There are no special circumstances associated with this collection.

8. *Federal Register Notice/Outside Consultation*

A 60-day notice published in the Federal Register on February 22, 2019 (84 FR 5690). A single comment was received and CMS submitted a response.

A 30-day FR Notice will publish on. No outside consultation was sought.

9. *Payment/Gift to Respondents*

The primary function of the CMS-855R enrollment application is to allow providers and suppliers to reassign their Medicare benefits to a group or individual practice. The form collects information necessary to establish correct claims payment. Once the CMS-855R is completed, submitted, and accepted, the person or organization (e.g., group practice) collects the provider/supplier's claims payment for services rendered to Medicare beneficiaries.

Providers and suppliers typically reassign their Medicare benefits to another practice, either individual or group, in which the practice where the benefits were reassigned provides payment to the provider/supplier in the form of a salary or hourly wage.

10. *Confidentiality*

CMS will comply with all Privacy Act, Freedom of Information laws and regulations 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.

The SORN title is Provider Enrollment, Chain and Ownership System (PECOS), number 09-70-0532.

11. *Sensitive Questions*

There are no sensitive questions associated with this collection.

12. *Burden Estimate (hours and costs)*

A. Burden Estimates (hours)

For this proposed revision of the CMS-855R, CMS has recalculated the prior revision's estimated burden hours. CMS believes this recalculation is necessary for this data collection tool because the number of affected users, reasons to collect the data, and the collection methods have changed. CMS believes these new burden hours accurately reflect the current burden for the purposes of this application when completing this proposed revision of the CMS-855R. CMS is basing the new burden amounts on data compiled from PECOS and the Medicare Administrative Contractors (MACs). The new estimates for completing the CMS-855R (Reassignment of Medicare Benefits) for initial reassignments, reporting updates in reassignment

information, and terminating reassignments are taken directly from the actual applications processed for calendar year 2017. The new figures are exact and therefore more accurate than prior estimates.
The hour burden to the respondents is calculated based on the following assumptions:

- There were 23,460 applications for initial reassignments.
- There were 284,270 applications for changing reassignment information.
- There were 49,898 applications for terminating a reassignment.
- All submission reasons must complete the same actions as initial reassignments on the CMS-855R application and therefore all submission reasons are being counted in the initial reassignment figure for the purpose of this burden estimate.
- Completion of the CMS-855R takes 0.25 hours (15 minutes) for initial applications, updates of application information, and termination of reassignments.

CMS is requesting approval of the revised number of burden hours as follows:
HOURS ASSOCIATED WITH COMPLETING THE CMS-855R APPLICATION:
357,628 respondents completing the initial application form to receive their initial reassignment via PECOS and CMS-855R paper application.

TOTAL FOR INITIAL APPLICATIONS = 357,628 respondents x 0.25 hours = 89,407 hours for initial applications using the CMS-855R.

B. Burden Estimate (costs)

CMS contacted the MACs to determine how the CMS-855R was typically completed (by administrative staff and office workers, reviewed and signed by the health diagnosing and treating practitioners). In addition, the MACs indicated that the burden for initial reassignments, updates to reassignment information, and termination of reassignments were identical, as the same data fields on the instrument must be completed for any form submission reason. CMS used the hourly wage calculations which were taken from the most recent wage data provided by the Bureau of Labor Statistics (BLS) for May 2017. (see http://www.bls.gov/oes/current/oes_nat.htm#43-0000) and http://www.bls.gov/oes/current/oes_nat.htm#29-1000, indicating the mean hourly wage for the general categories of "Office and Administrative Support Occupations" and "Health Diagnosing and Treating Practitioners." All wage rates have been inflated by 100% to account for fringe benefits.
The cost burden to the respondents is calculated based on the following assumptions:

- There were 357,628 applications for initial reassignments in 2017 using the CMS-855R.
- All submission reasons must complete the same actions as initial reassignments on the CMS-855R application and therefore all submission reasons are being counted in the initial reassignment figure for the purpose of this burden estimate.
- Completion of the CMS-855R takes 0.25 hours (15 minutes) for initial applications.
- Cost to the respondents is calculated as follows based on the following assumptions:
    - The CMS-855R can be completed by administrative staff and reviewed and signed by professional staff, and

    - The record keeping burden is included in the time determined for completion by administrative staff.
- The cost per respondent per application was determined using as follows:
    - The most recent wage data provided by the Bureau of Labor Statistics (BLS) for May 2017, the mean hourly wage for the general category of "Office and Administrative Support Occupations" is $18.24 per hour (see http://www.bls.gov/oes/current/oes_nat.htm#43-0000). With fringe benefits and overhead, the total hourly rate is $36.48.
    - The most recent wage data provided by the BLS for May 2017 (see http://www.bls.gov/oes/current/oes_nat.htm#29-1000), the mean hourly wage for the general category of "Health Diagnosing and Treating Practitioners" is $48.45. With fringe benefits and overhead, the total hourly rate is $96.90.
- Based on the information above, CMS has split the cost burden as follows:
    - Office and administrative support workers complete the application in approximately 10 minutes, or 0.17 hours, and
    - Health diagnosing and treating practitioners review and sign the application in approximately 5 minutes, or 0.08 hours.

CMS is requesting approval of the revised number of burden costs as follows:
COSTS ASSOCIATED WITH COMPLETING THE CMS-855R APPLICATION:
357,628 respondents completing the initial application form for reassignment of benefits via PECOS and the CMS-855R paper application.

0.17 hours (10 minutes) x $36.48 = $6.20 per application completed by office and administrative support workers.
0.08 hours (5 minutes) x $96.90 = $7.75 per application reviewed and signed by Health Diagnosing and Treating Practitioners.
Subtotal = $6.20 + 7.75 = $13.95 per application
Total – 357,628 respondents x $13.95 per application = $4,988,910.60 annually for completion of initial applications using the CMS-855R.

Table 1 – Summary of Burden Hours and Costs

Regulation Section(s)	OMB Control No.	Number of Respondents	Number of Responses	Burden per Response (hours)	Total Annual Burden (hours)	Hourly Labor Cost of Reporting ($) includes 100% fringe benefits	Total Cost ($)

Reassignment Application Form (CMS-855R)	0938-1179	357,628	357,628 per year	0.08 hours by Health Diagnosing and Treating Practitioners 0.17 hours by office and administrative support workers	89,407 hours	Health Diagnosing and Treating Practitioners at $96.90 per hour office and administrative support workers at $36.48 per hour	$4,988,911
3-year total	**0938-1179**	**1,072,884 for initial enrollments**	**1,072,884 for initial enrollments**	**0.25 hours**	**268,221 hours for initial enrollments**	**Health Diagnosing and Treating Practitioners at $96.90 per hour** **Office and Administrative Support Workers at $36.48 per hour**	**$14,966,733 for initial enrollments**

13. *Cost to Respondents (Capital)*

There are no capital costs associated with this collection.

14. *Cost to Federal Government*

The CMS-855R application form revisions will not result in any additional cost to the federal government because the CMS-855R application revisions are designed for better flow and to reduce the burden on the provider/supplier and the contractor. Medicare contractors currently finalize approximately 1.3 million various provider/supplier enrollment applications a year, including the CMS-855R. The CMS-855R form changes will not result in any additional cost to the federal government because Medicare contractors are already processing applications from providers/suppliers who are reassigning their benefits or terminating a reassignment of benefits. Applications will continue to be processed in the normal course of Federal duties.

15. *Changes in Burden/Program Changes*

The total burden is 89,408 hours. Due to better reporting methods and more accurate data collection via PECOS, CMS is seeking approval of new burden estimates based on current data collection information. As a result of the decrease in the number of respondents, the burden hours decreased by 5,497 hours (from 94,905 to 89,408 hours). Based numbers derived from PECOS, the total number of respondents decreased by 21,991 (from 379,619 to 367,628).

16. *Publication/Tabulation*

There are no plans to publish the outcome of the data collection.

17. *Expiration Date*

The expiration date will be displayed on the top, right-hand corner of page 1 of the CMS-855R application.