Supporting Statement for Paperwork Reduction Act Submissions

CMS-855B Medicare Enrollment Application for Clinics/Group Practices and Other Suppliers Revision CMS-855B/OMB Control Number: 0938-NEW)

A. BACKGROUND

The primary function of the CMS-855B Medicare enrollment application for suppliers, also known as Health Diagnosing and Treating Practitioners, is to gather information from the supplier that tells us who the supplier is, whether the supplier meets certain qualifications to be a Medicare health care provider or supplier, where the supplier practices or renders services, and other information necessary to establish correct claims payments.

There are two principal facets of this submission:

1. **Request for Individual OMB Control Number for the CMS-855B –** The currently approved CMS-855B form is currently approved under OMB control number 0938-0685 (Expiration date: December 31, 2021). The CMS-855B application under OMB control number 0938-0685 will be removed from the Medicare application bundle collection during its next resubmission cycle. The reason CMS is pulling out this form is that the agency has found that the regulations governing the enrollment requirements for groups, clinics, and suppliers can change at intervals separate from the other provider and supplier types reimbursed by Medicare. The ability to revise the CMS-855B separately from the other CMS-855 enrollment applications will lessen the burden on both CMS and OMB as well as the public during the Federal Register notice period, as only one subset of providers/suppliers will be effected by CMS-855B revisions. CMS intends to maintain the continuity of the CMS-855 enrollment applications by using the same formats and lay-out of the current CMS-855 enrollment applications, regardless of the separation of the CMS-855B from the collective enrollment application package.

2. **Corrections to the content of the CMS-855B -** The goal of evaluating and revising the CMS-855B enrollment application is to simplify and clarify the information collection In addition, periodically new congressional legislation or regulations require CMS to update the Medicare Provider Enrollment Applications (CMS-855s). The majority of these changes are minor in nature for the purposes of provider/supplier enrollment, such as instruction clarification for the supplier, adding new specialty codes for the supplier to choose from, questions with "Yes/No" check boxes rather than requiring text answers, spelling and formatting corrections, removal of duplicate fields, and indicating which addresses the suppliers wish to use for different types of correspondence. This revision also includes a re-sequencing and re-numbering of the sections and sub-sections of the application to create a more logical flow of the data to make it easier for the supplier to complete (for example, by putting most address collection information in one section). This re-sequencing also makes this application sync with the other CMS-855 enrollment applications. For example, all section 5s collect organizational ownership information, section 6s collect individual ownership information, section 8s collect billing agency/agent information, etc. Other minor editorial and clerical corrections were made to better clarify the current data collection. Some of the instructions were simplified for the suppliers completing this application in response to comments received by MACs and suppliers during focus groups discussing suggested revisions of the current version of this application.

   This ICR submission includes the addition of an attachment for Opioid Treatment Programs (OTPs). This attachment is only used to capture the OTP personnel and consists of limited data fields (name, Social Security Number, National Provider Identifier, and license number) in response to the "SUPPORT for Patients and Communities Act" that was signed into law on October 24, 2018. This legislation was designed to alleviate the nationwide opioid crisis by: (1) reducing the abuse and supply of opioids; (2) helping individuals recover from opioid addiction and supporting the families of these persons; and (3) establishing innovative and long-term solutions to the crisis. Section 2005 of the SUPPORT Act establishes a new Medicare Part B benefit for opioid use disorder (OUD) treatment services furnished by opioid treatment programs (OTPs) beginning on or after January 1, 2020. Also, NPI information and a list of commonly used acronyms was added to the instruction pages.

   All information previously collected for Advanced Diagnostic Imaging number reporting was removed to lessen supplier burden. CMS can derive this information from other sources. Electronic storage information was added as some suppliers no longer store paper records. The contact person section was made optional to reduce the reporting burden for suppliers. Additionally, some obsolete questions were removed.

JUSTIFICATION

1. *Need and Legal Basis*

Various sections of the Social Security Act (Act), the United States Code (U.S.C.), Internal Revenue Service Code (Code) and the Code of Federal Regulations (CFR) require providers and suppliers to furnish information concerning the amounts due and the identification of individuals or entities that furnish medical

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. 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 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 1842(r) of the Act requires us to establish a system for furnishing a unique identifier for each provider/supplier who furnishes services for which payment may be made. In order to do so, we need to collect information unique to that provider or supplier.
- Section 1866(j)(1)(C) of the Act requires us to consult with providers and suppliers of services before making changes in provider/supplier enrollment forms.
- 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.
- 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).
- Section 1866(b)(2)(D) and 1842(h)(8) of the Act require denial of enrollment (directly or indirectly) of persons convicted of a felony for a period not less than 10 years from the date of conviction.
- 42 C.F.R. section 424.502, defines enrollment and enrollment related terms.
- Sections 1102 and 1871 of the Act, provide general authority for the Secretary to prescribe regulations for the efficient administration of the Medicare program
- The Internal Revenue (IRS) Code, section 3402(t) requires us to collect additional information about the proprietary/non-profit structure of a Medicare provider/supplier to allow exclusion of non-profit organization from the mandatory 3% tax withholding.
- The IRS section 501(c) requires each Medicare provider/supplier to report information about its proprietary/non-profit structure to the IRS for tax withholding determination.
- The Patient Protection and Affordable Care Act, section 3109(a) allows certain Medicare supplier types to be exempt from the accreditation requirement.
- Section 1866(j)(2)(A) of the Act requires the Secretary, in consultation with the Department of Health and Human Services' Office of the Inspector General, to establish procedures under which screening is conducted with respect to providers/suppliers of medical or other items or services and suppliers under Medicare, Medicaid, and CHIP.
- Section 1866(j)(2)(B) of the Act requires the Secretary to determine the level of screening to be conducted according to the risk of fraud, waste, and abuse with respect to the category of provider or supplier.
- Section 1848(k)(3)(B) defines covered professional services and eligible professionals.
- Section 3004(b)(1) of the Public Health Service Act (PHSA) requires the Secretary to adopt an initial set of standards, implementation guidance, and certification criteria and associated standards and

implementation specifications will be used to test and certify complete EHRs and EHR modules in order to make it possible for eligible professionals and eligible hospitals to adopt and implement Certified EHR Technology.

- The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), section 135(a) amended section 1834(e) of the Social Security Act and required the Secretary to designate organizations to accredit suppliers, including but not limited to suppliers, physicians, non-physician practitioners and Independent Diagnostic Testing Facilities, that furnish the technical component of advanced diagnostic imaging services.
- Section 2205 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act or the SUPPORT for Patients and Communities Act requires a new Medicare Part B benefit for opioid use disorder (OUD) treatment services furnished by opioid treatment programs (OTPs) beginning on or after January 1, 2020.
- Section 6401(a) of the Affordable Care Act (ACA) requires the Secretary to impose a fee on each "institutional provider of medical or other items or services and suppliers." The fee is to be used by the Secretary to cover the cost of program integrity efforts including the cost of screening associated with provider/supplier enrollment processes, including those under section 1866(j) and section 1128J of the Social Security Act.
- Section 6201(c), of the Affordable Care Act (ACA) Subtitle C, requires DHHS to obtain state and national background checks on prospective employees, including national fingerprint-based criminal history record checks.
- 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.

The CMS-855 applications collect this information, including the information necessary to uniquely identify and enumerate the provider/supplier. Additional information necessary to ensure that providers and suppliers meet all applicable Medicare requirements and to process claims accurately and timely are also collected on the CMS-855 applications. This information also ensures that the data collected allows CMS to make correct payments to providers and suppliers under the Medicare program as established by Title XVIII of the Act.

2. *Purpose and users of the information*

The 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 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.

The CMS-855B is submitted by an applicant to the Medicare Administrative Contractors (MACs) to initially apply for a Medicare billing number, and thereafter to revalidate Medicare enrollment, reactivate Medicare enrollment, enroll with another MAC in a different geographic location, to report a change to current Medicare enrollment information, and to voluntary terminate the

supplier's Medicare enrollment, as applicable. It is used by new applicants as well as suppliers already enrolled in Medicare but need to submit the form for a reason other than initial enrollment into the Medicare program. A medical practice, group/clinic or other supplier that will bill for Medicare Part B services (e.g., group practices, clinics, independent laboratories, opioid treatment programs, portable x-ray suppliers) complete this form for the submittal reasons above.

The MAC establishes Medicare Identification Numbers. The MACs store these numbers and information in CMS' Provider Enrollment, Chain and Ownership System (PECOS). The application is used by the CMS' contractors to collect data ensures that the applicant has the necessary information for unique identification. The license numbers that come through paper applications are validated against state licensing websites. All the license numbers are captured and stored in the MAC database. Social Security Numbers (SSNs) are validated against the Social Security Administration database (SSA) and only the valid entries are allowed to proceed in the process of getting a Medicare billing number. International Tax Identification Numbers (ITINs) are not validated. However, if a user enters ITIN, additional forms of identification (e.g., driver's license, passport or birth certificate) are required. Both ITINs and SSNs are captured in the MAC database and disseminated only to approved CMS stakeholders. Mailing address, practice location address and contact information is captured to contact the supplier. Specialty type is captured to identify the specialty of the supplier. The information obtained is to help prevent fraud by allowing vetting of the suppliers as well as to ensure a supplier is not illegitimately attempting to get a Medicare billing number. In addition, the information collected allows CMS and the MACs to determine relationships among those with Medicare billing numbers. For example, a supplier who enrolls as a group practice may also have an individual Medicare billing number for private practice as well as part ownership in a hospital. This information is determined during the enrollment process. If any relationship is prohibited by CMS regulation, the supplier would be denied a Medicare billing number and other measures may be taken, such as revocation of the supplier's individual Medicare billing number or an enrollment bar so the supplier will not get a Medicare billing number for a set number of years, depending on the enrollment bar issued to the supplier.

The collection and verification of this information defends and protects our beneficiaries from illegitimate suppliers. These procedures also protect the Medicare Trust Fund against fraud. It gathers information that allow Medicare contractors to ensure that the 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 collected also ensures that the applicant has the necessary credentials to provide the health care services for which they intend to bill Medicare, including information that allows the Medicare contractor to correctly price, process and pay the applicant's claims. 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 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, complete the enrollment revalidation process, voluntarily

withdraw from the Medicare program, and track the status of a submitted Medicare enrollment application. The data stored in PECOS mirrors the data collected on the CMS-855s (Medicare Enrollment Applications) 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-855 enrollment 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, suppliers will have the choice to e-sign via the CMS website or to submit a hard copy of the CMS-855B certification page with an original signature. Periodically, CMS will require adjustment to the format of the CMS-855 form (either paper, electronic or both) for clarity or to improve form design. These adjustments do not alter the current OMB data collection approval. Currently, approximately 36% of individual provider/suppliers use the electronic method of enrolling in the Medicare program via the PECOS system.

4. *Duplication and Similar Information*

There is no duplicative information collection instrument or process.
CMS revised this form to ensure there was no duplication for the supplier completing the form.

For example, CMS:

- Added a checkbox above the Remittance Notice/Special Payments address, "Check here if your Remittance Notice/Special Payments should be mailed to your Correspondence Address in section 2A4 and skip this section." The checkbox will be used to reduce possible duplication of reporting the same correspondence address twice.
- Deleted subsection "New Enrollees and Those with a New Tax ID Number." This information is included in the subsection "Who Should Complete This Application."
- Deleted subsection "Enrolled Medicare Suppliers" because the definitions were redundant. There is a definition section at the beginning of the form. Duplicating the definitions in this subsection would require the supplier to read the definitions twice.
- Removed middle column of the table for Final Adverse Legal Actions. The middle column was, "Billing Number Information." CMS can derive the billing number information from the next section in the application and therefore the collection would be redundant.
- Deleted the question, "Is this technician employed by a hospital?" with yes/no checkboxes and "If yes, provide the name of the hospital here:" with a line space for the answer. CMS can derive and add this information to enrollment records independent of a self-reporting requirement.

5. *Small Business*

A Medicare billing number is required of all health care suppliers/providers who wish to submit claims for payment to the Medicare Trust Fund so it will affect small businesses who wish to have a Medicare billing number. However, these businesses have always been required to provide CMS with the same information in order to enroll in the Medicare program to submit information for CMS to ensure the suppliers are legitimate and to collect information to successfully process their Medicare claims.

6. *Less Frequent Collections*

This information is collected on an as needed basis. The information provided on these forms is necessary for initial enrollment in the Medicare program. It is essential to collect this information the first time a provider/supplier enrolls with a Medicare contractor so that CMS' contractors can uniquely identify the provider/supplier, ensure the provider's/supplier's eligibility and legitimacy, to determine if the provider/supplier meets all statutory and regulatory requirements, are properly credentialed in their specialty (if applicable), and to collect relevant information to process the provider's/supplier's claims in a timely and accurate manner.

After the initial enrollment and approval, the information collected is less frequent and often initialized by the supplier for reasons such as a change of information, enrollment within another MACs jurisdiction, and to voluntarily withdraw from the Medicare program. It will be collected to complete the enrollment revalidation process every five years. In addition, to ensure uniform data submissions, CMS requires that all changes to previously submitted enrollment data be reported via this enrollment 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 September 26, 2019 (84 FR 50846). No comments were received. Also, no public comments were submitted in response to the 30-day Notice published in the Federal Register on January 14, 2020 (85 FR 2136).

No outside consultation was sought.

9. *Payment/Gift to Respondents*

The function of the CMS-855B form is to collect and verify data that proves the legitimacy of the enrolling supplier and to collect information for correct claims payment. Once completed, submitted, processed, and accepted, the respondent will be able to receive payment for medical procedures and/or services rendered to Medicare beneficiaries in accordance with the Medicare claims payment system.

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 cost)*

A. Burden Estimate (hours)

HOURS ASSOCIATED WITH COMPLETING THE CMS-855B ENROLLMENT APPLICATION

For this proposed revision of the CMS-855B, CMS has recalculated the estimated burden hours. CMS believes this recalculation is necessary because this data collection tool has not been properly revised since 2011. In addition, the number of affected users, actual data collected and the collection methods have changed significantly. CMS believes these new burden hours accurately reflects the current burden for the purposes of this application when completing this proposed revision of the CMS-855B. 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-855B Medicare enrollment application form for the six submission reasons shown in the burden tables (initial enrollment, enrolling with another MAC, revalidation, reactivation, reporting a change of Medicare enrollment information, and voluntary termination of Medicare enrollment) are taken directly from the actual applications processed for calendar year 2018. The new figures of processed applications are exact and therefore more accurate than the prior estimates. CMS added 1,900 suppliers to the initial enrollment count to accommodate the SUPPORT for Patients and Communities Act. Section 2005 of the SUPPORT Act establishes a new Medicare Part B benefit for opioid use disorder (OUD) treatment services furnished by opioid treatment programs (OTPs) beginning on or after January 1, 2020. CMS contacted Medicare Administrative Contractors (MACs), both through conference calls and through focus groups to determine how the application was typically completed (by medical secretaries and reviewed and signed by the health diagnosing and treating practitioners).

The hour burden to the respondents is calculated based on the following assumptions:

- MACs currently process approximately 107,332 CMS-855B applications per year + 1,900 from the Support Act = 109,232 (as seen in Tables1 and 3).
- Completion of the CMS-855B hour burden depends on the reason for submittal.
- Hour burden of the respondents is calculated as follows based on the following assumption:
    - The CMS-855B will likely be completed by administrative staff (BLS category = medical secretaries),
    - The record keeping burden is included in the time determined for completion by medical secretaries,
    - The CMS-855B applications are reviewed and signed by the enrolling or enrolled supplier (BLS category = health diagnosing and treating practitioners).

- The hours are calculated based on the respondent's submission reason, which also determines the time it takes for completion and submission as well as the cost per individual submission completion (as seen in Table 2).

Table 1 – Total Number of CMS-855Bs Processed per Year by Reason for Submittal (2018)

Reason for Submittal	**Total Number of CMS-855Bs Processed per year (2018)**
Initial Enrollment	15,187 + 1,900 = 17,087
Enrolling with Another MAC	37
Revalidation	31,211
Reactivation	1,316
Reporting a Change of Medicare Enrollment Information	55,650
Voluntary Termination of Medicare Enrollment	3,931
GRAND TOTAL (Total Processed CMS-855Bs for All Reasons for Submission)	**109,232**

Reason for Submittal	**Hours for Completion by Medical Secretaries per CMS-855B**	**Hours for a Health Diagnosing and Treating Practitioner to Review and Sign CMS-855B**	**Total Hours for Completion per CMS-855B**	**Cost for Completion by Medical Secretaries per CMS-855B**	**Cost for Review and Signature by a Health Diagnosing and Treating Practitioner per CMS-855B**	**Total Cost of Completion per CMS-855B**
Initial Enrollment	2.5	0.5	3	$109.86	$295.56	$405.42
Enrolling with Another MAC	1.5	0.5	2	$73.24	$197.04	$270.28
Revalidation	1.5	0.5	2	$73.24	$197.04	$270.28
Reactivation	1.5	0.5	2	$73.24	$197.04	$270.28
Reporting a Change of Medicare Enrollment Information	0.75	0.25	1	$36.62	$98.52	$135.14
Voluntary Termination of Medicare Enrollment	0.42	0.08	0.5	$18.31	$49.26	$67.57

Table 2 – Individual Burden Hours and Costs for Completion of the CMS-855B per Reason for Submittal

B. Burden Estimate (costs)

For this proposed revision of the CMS-855B, CMS has recalculated the estimated burden cost. CMS believes this recalculation is necessary because this data collection tool has not been revised since 2011, as noted in the hour burden estimates for the revised CMS-855B above. In addition, the number of affected users, actual data collected and the collection methods have changed significantly. CMS believes this new burden cost accurately reflects the current burden for the purposes of this application when completing this proposed revision of the CMS-855B. CMS is basing the new burden amounts on data compiled from PECOS and the Medicare Administrative Contractors (MACs). The new cost estimates for completing an individual CMS-855B Medicare enrollment application form for the six submission reasons shown above in table 2 (initial enrollment, revalidation, reactivation, enrolling with another MAC, reporting a change of Medicare enrollment information, and voluntary termination of Medicare enrollment) are taken directly from the actual applications processed for calendar year 2018. The new figures are exact and therefore more accurate than the prior estimates.

To derive average costs, CMS used data from the U.S. Bureau of Labor Statistics' (BLS) May 2019 National Occupational Employment and Wage Estimates for all salary estimates (http://www.bls.gov/oes/current/oes_nat.htm). For the purposes of this application, CMS used the wages under the general categories of "Medical Secretaries," and "Health Diagnosing and Treating Practitioners." In this regard, CMS adjusted the employee hourly wage estimates by a factor of 100 percent. This is necessarily an estimated adjustment, both because fringe benefits and overhead costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Nonetheless, there is no practical alternative and CMS believes that doubling the hourly wage to estimate total cost is an accurate estimation method that has been used successfully in previous burden calculations.

The cost burden to the respondents is calculated based on the following assumptions:

- MACs currently process approximately 109,232 supplier CMS-855B applications per year.
- 1,900 supplier applications have been added to the total initial applications processed to accommodate the Support Act of 2018, as described above.
- Completion of the CMS-855B costs burden depends on the reason for submittal and respondent.
    - The reason for submittal of the CMS-855B determines the hour burden.
    - The hour burden and the respondents determine the cost burden, as seen in Table 2 (above).
- Cost to the respondents is calculated as follows based on the following assumptions:
    - The CMS-855B will likely be completed by administrative staff (BLS category = medical secretaries),
    - The record keeping burden is included in the time determined for completion by the medical secretary,
    - The most recent wage data provided by the Bureau of Labor Statistics (BLS) for May 2019, the mean hourly wage for the general category of "Medical Secretary" is $18.31

per hour (see http://www.bls.gov/oes/current/oes_nat.htm). With fringe benefits and overhead, the total per hour rate is $36.62.

- The most recent wage data provided by the BLS for May 2019 (see http://www.bls.gov/oes/current/oes_nat.htm), the mean hourly wage for the general category of "Health Diagnosing and Treating Practitioners" is $49.26. With fringe benefits and overhead, the total hourly rate is $98.52.

The three year summary of all burden hours and costs are reflected in Table 3 (below).

Table 3 – Summary of Burden Hours and Costs for Three Years

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 ($) includes 100% fringe benefits	Total Cost ($)
Initial Enrollments - Medicare Enrollment Application for Clinics, Groups and Other Suppliers (CMS-855B)	0938-NEW	17,087	17,087 per year	0.5 hours by Health Diagnosing and Treating Practitioners 2.5 hours by Medical Secretaries 3 hours total	51,261 Hours	Health Diagnosing and Treating Practitioners at $295.56 per hour Medical Secretaries at $109.86 per hour $405.42 total	$20,782,234.62
Enrolling with another Medicare Administrative Contractor - (MAC) – Medicare Enrollment Application for Clinics, Groups and Other Suppliers (CMS-855B)	0938-NEW	37	37 per year	0.5 hours by Health Diagnosing and Treating Practitioners 1.5 hours by Medical Secretaries 2 hours total	74 hours	Health Diagnosing and Treating Practitioners at $197.04 per hour Medical Secretaries at $73.24 per hour $270.28 total	$20,000.72
Revalidation - Medicare Enrollment Application for Clinics, Groups and Other Suppliers (CMS-855B)	0938-NEW	31,211	31,211 per year	0.5 hours by Health Diagnosing and Treating Practitioners 1.5 hours by Medical Secretaries 2 hours total	62,422 hours	Health Diagnosing and Treating Practitioners at $197.04 per hour Medical Secretaries at $73.24 per hour $270.28 total	$16,871,418.16
Reactivation - Medicare Enrollment Application for Clinics, Groups and Other Suppliers (CMS-855B)	0938-NEW	1,316	1,316 per year	0.5 hours by Health Diagnosing and Treating Practitioners 1.5 hours by Medical Secretaries 2 hours total	2,632 hours	Health Diagnosing and Treating Practitioners at $197.04 per hour Medical Secretaries at $73.24 per hour $270.28 total	$711,376.96

13. *Cost to Respondents (Capital)*

There are no capital costs associated with this collection.

14. *Cost to Federal Government*

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

15. *Changes in Burden/Program Changes*

The existing ICR was written to include additional suppliers enrolling due to rulemaking (FY 2017 Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (CMS-1645-7/RIN: 0938-AS75)). This rule required providers and suppliers to enroll in the Medicare program as a prerequisite to enrolling with a Medicare Advantage plan. The burden calculations for that statement depended on old data, namely the burden statement from the 2011 revision statement. However, in 2011, there was no way to accurately count the number of hours it took per response and there were less submittal reasons, so the figure was determined by totaling MAC estimates. With the use of the PECOS system, updated information technology allows CMS to accurately count the hours per submittal reason and consequently, total hours annually. The 2011 the burden hour estimates were based on outdated data. The enrollment requirements in the (RIN: 0938-AS75) were replaced with the preclusion list requirements finalized in the Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs for Contract Year 2019 final rule (CMS-4182-F/RIN: 0938-AT08)). The requirements related to the policy and technical amendments rule do not include enrollment requirements pertaining to the CMS-855B application; therefore, burden has been adjusted accordingly.

With the use of the PECOS system, updated information technology allows CMS to accurately count the hours per submittal reason and consequently, total annual hours. There are six submission reasons for completion of the CMS-855B enrollment application (initial enrollment, revalidation, reactivation, enrolling with another MAC, reporting a change of Medicare enrollment information, and voluntary termination of Medicare enrollment). Currently, the burden hours for the entirety of all submission reasons and respondents is 176,004 ½ hours annually (over a three-year period 528,013 ½ hours) with approximately 327,696 respondents. Both the burden hour per submission reason as well as the respondents are valued and calculated in this burden estimate.

16. *Publication/Tabulation*

A list of participating providers/suppliers can be accessed at https://www.medicare.gov/physiciancompare/. However, this list is not based on this information collection. It is based on 0938-0373 (Medicare Participating Physician or Supplier Agreement - CMS-460).

17. *Expiration Date*

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