Supporting Statement for Paperwork Reduction Act Submissions
Medicare Enrollment Application for Institutional Providers
CMS-855A, OMB 0938-0685

Note: This information collection request is currently entitled, "CMS-855 Medicare Enrollment Applications CMS-855A, -855B, and -855I." Based on the changes described in section 15 of this Supporting Statement, we are revising the title as indicated above.

BACKGROUND

The primary function of the CMS-855 Medicare enrollment application is to gather information from a provider or supplier that tells us who it is, whether it meets certain qualifications to be a health care provider or supplier, where it practices or renders services, the identity of the owners of the enrolling entity, and other information necessary to establish correct claims payments.

The changes in this collection of information request are associated with our December 28, 2020 (85 FR 84472) final rule (CMS-1734-F, RIN 0938-AU10).

Existing § 424.67 outlines a number of enrollment requirements for OTPs. One requirement, addressed in § 424.67(b)(1), is that OTPs must complete the Form CMS-855B application (Medicare Enrollment Application: Clinics/Group Practices and Certain Other Suppliers; OMB Control Number: 0938-1377) to enroll in Medicare. The reference to the Form CMS-855B was predicated in part on the assumption that OTPs would generally submit the CMS-1500 claim form (Health Insurance Claim Form; OMB Control Number: 0938-1197) to receive payment for their services. However, we have received requests to allow OTPs to bill for services on an institutional claim form (specifically, the 837I). To do so, these OTPs would have to enroll in Medicare via the Form CMS-855A (Medicare Enrollment Application for Institutional Providers (OMB Control Number: 0938-0685). To account for circumstances where an OTP wishes to pursue Form CMS-855A enrollment for the reason stated above, we have finalized these changes.

Additionally, we foresee three main implications associated with our changes to § 424.67. First, newly enrolling OTPs would be able to complete and submit a Form CMS-855A (Medicare Enrollment Application - Institutional Providers) instead of a Form CMS-855B. Second, we anticipate that numerous OTPs that are currently enrolled via the Form CMS-855B would terminate the latter enrollments and complete/submit a Form CMS-855A application in order to bill for OTP services via the 837I. (As stated in § 424.67(c), an OTP cannot be enrolled via both the Form CMS-855A and Form CMS-855B; it must choose one of these two enrollment mechanisms.) Third, it is possible that some OTPs that enroll using the Form CMS-855A (pursuant to revised § 424.67(b)) would later change their enrollment to a Form CMS-855B. We estimate a burden of 399 new respondents in the next 3 years. (Specifically, 100 new OTPs (or approximately 33 per year) would enroll over the next 3 years, and 300 existing OTP enrollees (an average of 100 per year) would change their CMS-855B enrollment to a CMS-855A enrollment over this same time period.) We are not making any changes to the CMS-855A application.

As noted below in section 15, we are removing the requirements, burden, and applications associated with CMS-855B (Medicare Enrollment Application for Clinics, Group Practices, and Certain Other Suppliers) and CMS-855I (Medicare Enrollment Application for Physicians and Non-Physician Practitioners). Importantly, both of those forms remain active. To avoid duplication, however, they are being removed from this 0938-0685 control number since they are now approved separately under their own separate control numbers, namely: 0938-1377 for CMS-855B and 0938-1355 for CMS-855I.

Overall, the changes amount to a reduction of 1,430,602 responses, 192,267 hours, and $17,144,125 (from $20,720,304 to $3,576,179). Please see section 15 for details.

A. 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.

- 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 physician 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 1842(u) of the Act requires us to deny billing privileges under Medicare to physicians and certain other health care professionals certified by a State Child Support Enforcement Agency as owing past-due child support.
- 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.
- 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.
- The Social Security Act, section 302 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, paragraph 1834(a)(20) requires us to collect additional

information about accreditation of Advanced Diagnostic Imaging Suppliers, namely whether a not the ADI is accredited and in some cases, the services the ADI provides. This information is specific to provider/supplier type.

- 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 physicians, non-physician practitioners and Independent Diagnostic Testing Facilities, that furnish the technical component of advanced diagnostic imaging services.
- The Tax Increase Prevention and Reconciliation Act of 2005 (TIPRA), section 511 requires us to collect information necessary to withhold 3% withholding tax from Medicare providers/suppliers.
- 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.
- Social Security Act, section 6401 - Provider Screening and Other Enrollment Requirements under Medicare, Medicaid, and CHIP.
- 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.
- We are authorized to collect information on the CMS-855 (Office of Management and Budget (OMB) approval number 0938-0685) to ensure that correct payments are made to providers and suppliers under the Medicare program as established by Title XVIII of the Act.

The CMS-855A application collects this information, including the information necessary to uniquely identify and enumerate the provider/supplier. Additional information necessary to process claims accurately and timely is also collected on the application.

2. Purpose and Users of the Information

The CMS-855A application is submitted at the time the applicant first requests a Medicare billing number. The application is used by Medicare contractors to collect data to ensure 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. It also gathers information that allows Medicare contractors to ensure that the provider/supplier is not sanctioned from the Medicare program, or debarred, suspended or excluded from any other Federal agency or program.

3. Improved Information Techniques

This collection lends itself to electronic collection methods. 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 data stored in PECOS mirrors the data collected on the CMS-855 (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, transmit it to the Medicare contractor database for processing and then the data is transferred from the Medicare contractor processing database into PECOS by the Medicare contractor. 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.

PECOS began housing provider/supplier information in 2003 in compliance with the Government Paperwork Elimination Act. However, until CMS adopts an electronic signature standard, providers/suppliers are required to submit a hard copy signature page of the applicable CMS-855 with an original signature.

4. Duplication and Similar Information

There is no duplicative information collection instrument or process.

5. Small Business

The data collections will impact small businesses. However, because of the relative infrequency with which the information will need to be submitted and the minimal time involved in each data collection, we believe that the overall impact on small businesses is extremely negligible. In addition, these businesses have been required to provide CMS with substantially the same information in order to enroll in the Medicare Program and for CMS to successfully process their claims.

6. Less Frequent Collections

This information is collected on an as needed basis. The information provided on the CMS-855 is necessary for 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 ensure that the provider/supplier meets all statutory and regulatory requirements necessary for enrollment and that claims are paid correctly.

In addition, to ensure uniform data submissions, CMS requires that all changes to previously submitted enrollment data be reported via the appropriate provider enrollment application.

7. Special Circumstances

There are no special circumstances that would require an information collection to be conducted in a manner that requires respondents to:

- Prepare a written response to a collection of information in fewer than 30 days after receipt of it;
- Submit more than an original and two copies of any document;
- Retain records, other than health, medical, government contract, grant-in-aid, or tax records for more than three years;
- Collect data in connection with a statistical survey that is not designed to produce valid and reliable results that can be generalized to the universe of study;
- Use a statistical data classification that has not been reviewed and approved by OMB;
- Include a pledge of confidentiality that is not supported by authority established in statute or regulation that is not supported by disclosure and data security policies that are consistent with the pledge, or which unnecessarily impedes sharing of data with other agencies for compatible confidential use; or
- Submit proprietary trade secret, or other confidential information unless the agency can demonstrate that it has instituted procedures to protect the information's confidentiality to the extent permitted by law.

8. Federal Register Notice/Outside Consultation

Serving as the 60-day notice, the proposed rule (CMS-1734-P, RIN 0938-AU10) filed for public inspection on August 4, 2020, and was published in the Federal Register on August 17, 2020 (85 FR 50074). We did not receive any PRA-related comments.

The final rule (CMS-1734-F, RIN 0938-AU10) published in the Federal Register on December 28, 2020 (85 FR 84472).

9. Payment/Gift to Respondents

N/A.

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.

11. Sensitive Questions

There are no sensitive questions associated with this collection. Specifically, the collection does not solicit questions of a sensitive nature, such as sexual behavior and attitudes, religious beliefs, and other matters that are commonly considered private.

12. Collection of Information Requirements and Burden Estimates

The following collection of information and burden analysis takes into account the impact of the CMS-1734-F final rule on our currently approved requirements/burden estimates. There are no impacts to the currently approved CMS-855A application, which is being submitted without

change.

As noted below in section 15, we are removing from this 0938-0685 control number the requirements, burden, and applications associated with CMS-855B (Medicare Enrollment Application for Clinics, Group Practices, and Certain Other Suppliers) and CMS-855I (Medicare Enrollment Application for Physicians and Non-Physician Practitioners). Importantly, both of those forms remain active. To avoid duplication, they are being removed since they are now approved separately under their own OMB control numbers: 0938-1377 for CMS-855B and 0938-1355 for CMS-855I.

12.1 Wage Estimates

The following table presents the mean hourly wage provided by the Bureau of Labor Statistics (BLS) for May 2019 (see https://www.bls.gov/oes/current/oes_nat.htm), the cost of fringe benefits and overhead (calculated at 100 percent of salary), and the adjusted hourly wage.

Table 1: National Occupational Employment and Wage Estimates

Occupation Title	Occupation Code	Mean Hourly Wage ($/hr)	Fringe Benefits and Overhead ($/hr)	Adjusted Hourly Wage ($/hr)
Office and Administrative Support Operations	43-9199	18.41	18.41	36.82

As indicated, we are adjusting our employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough 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, we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

In calculating our cost estimates, we determined that the CMS-855A application will likely be completed by office and administrative staff.

12.2 Requirements and Burden Estimates

The following estimates the number of providers and suppliers that will complete each form to include, as applicable, initially enrolling and revalidating providers and suppliers, as well as those submitting a change of information involving the submission in question. We note, though, that these numbers are merely averages; the actual numbers will vary each year.

In preparing the following OTP enrollment estimates, we: (1) reviewed internal PECOS and billing data concerning existing OTP Form CMS-855 enrollments and claim submissions; and (2) considered feedback recently received from the OTP community regarding potential billing and enrollment options. Based on this, we project that roughly one-half (or 33) of our currently approved estimate of 67 annually enrolling OTPs (that is, in Years 2 and 3 and beyond) would elect to complete a Form CMS-855A rather than a Form CMS-855B. Approximately 300 currently enrolled OTPs would change their enrollment from a Form CMS-855B to a Form

CMS-855A, or an average of 100 per year over each of the next 3 years. Overall we project an increase of 133 new respondents will complete the CMS-855A application each year, from 40,000 to 40,133 providers.

(1) Physician-Owned Hospital Checkbox (No Changes)

The checkbox in section 2A is intended to identify whether the hospital is a physician-owned hospital. Using our currently approved estimates that 2,000 providers will complete this checkbox and that it will take the provider 5 minutes (0.0833 hr) to complete the checkbox, this results in a 167-hour burden (2,000 providers X 0.0833 hours) at a cost of $6,148 (167 X $36.82/hr).

(2) Registration of Business (Revised burden)

To ensure compliance with section 511 of the Tax Increase Prevention and Reconciliation Act of 2005 (TIPRA), we require the provider in section 2B1 of the application to identify how its business is registered with the Internal Revenue Service (IRS).

We are using our currently approved estimate that it will take each provider 5 minutes to furnish this information. Using our revised estimate of 40,133 providers, this results in a 3,343-hour burden (40,133 providers X 0.0833 hours) at a cost of $123,089 (3,343 X $36.82/hr).

(3) Indian Health Facilities (No Changes)

To ensure that CMS-855A enrollment applications are routed to the correct Medicare contractor, we require the provider in section 2B1 of the application to answer the following question: "Is this provider an Indian Health Facility enrolling with Trailblazer Health Enterprises?"

We are using our currently approved estimate that it will take the provider 5 minutes to furnish this information. Using our revised estimate of 40,133 providers, this results in a 3,343-hour burden (40,133 providers X 0.0833 hours) at a cost of $123,089 (3,343 X $36.82/hr).

(4) Cost Report Date (No Changes)

This data element asks for the provider's year-end cost report date.

We estimate that it will take the provider 5 minutes to provide this information. Using our previous figure of 40,000 providers result in a 3,332-hour burden (40,000 X 0.0833 hours) at a cost of $122,684 (3,332 X $36.82/hr).

(5) Effective Dates of Ownership or Managerial Control (Revised burden)

This data element requests the effective date of an entity/individual's ownership/managerial interest in the provider. This is to help verify the entity/individual's relationship with the provider.

We are using our currently approved estimate that it will take the provider 1 hour to disclose this information for all of its owners and managing employees. Using our revised estimate of 40,133 providers, this results in a 40,133-hour burden (40,133 X 1 hour) at a cost of $1,477,697 (40,133 X $36.82/hr).

(6) Percentage of Direct and Indirect Ownership (Revised burden)

In sections 5 and 6 of the Form CMS-855A, we request information on the percentage of direct or indirect ownership a particular entity or individual has in the provider. This is to help verify the extent of the entity/individual's ownership interest.

We are using our currently approved estimate that it will take the provider 30 minutes to provide this information for all of its owners. Using our revised estimate of 40,133 providers, this results in a 20,066-hour burden (40,133 providers X 0.5 hours) at a cost of $738,830 (20,066 X $36.82/hr).

(7) Purchase of Provider (No Changes)

Section 5 of the CMS-855A sets out a checkbox for the provider to indicate whether the owning entity was created for the purpose of acquiring the provider. To know the relationship of the owners of the providers is important in order to determine if fraudulent activity is occurring. For example, a provider cannot be owned by an excluded provider. CMS needs this information to determine if holding companies or shell companies who own the provider are excluded providers from any state or federal health care program. This is to help us determine whether the owner is a holding company.

We are using our currently approved estimate that it will take the provider 15 minutes to provide this information for all of its organizational owners. Using our revised estimate of 40,133 providers, this results in a 10,033-hour burden (40,133 X 0.25 hours) at a cost of $369,415 (10,000 X $36.82/hr).

(8) Contractual Services (No Changes)

In sections 5 and 6 of the CMS-855A, we request that the provider identify the type of contractual services (if any) that its managing organizations/employees furnish. This is to help verify the specific relationship the provider has with the managing entity/individual.

We are using our currently approved estimate that it will take the provider 20 minutes (0.333 hr) to provide this information for all of its managing organizations/individuals that provide contractual services. Using our revised estimate of 40,133 providers, this results in a 13,364-hour burden (40,133 X 0.333 hours) at a cost of $492,062 (13,364 X $36.82/hr).

(9) Billing Agent Date of Birth (No Changes)

Provides the billing agent's date of birth in section 8 of the CMS-855A if the provider has a billing agent who is an individual. This is necessary for the verification of the agent's tax

identification number (TIN) PECOS and to ensure consistency between the CMS-855A paper and electronic forms.

We are using our currently approved estimates that 4,000 providers will have an individual billing agent and that it will take the provider 10 minutes (0.1666 hr) to furnish this information. This results in a 667-hour burden (4,000 X 0.1666 hours) at a cost of $24,559 (667 X $36.82/hr).

(10) IRS Determination Letter (No Changes)

To ensure compliance with section 511 of TIRPA, we require the provider to submit a copy of its "IRS Determination Letter" if it is registered with the IRS as a non-profit entity.

We are using our currently approved estimates that 6,000 providers will provide this letter (which is based on how many providers submit copies of this letter in accordance with the IRS) and that this requirement will take the provider 10 minutes to fulfill. This results in a 1,000-hour burden (6,000 X 0.1666 hours) at a cost of $36,820 (1,000 X $36.82/hr).

(11) Submission of Additional Documents (No Changes)

Section 17 of the CMS-855A provides a statement to the effect that the Medicare contractor may request from the provider additional documents not listed in section 17. This is to ensure that the provider is in compliance with all enrollment requirements.

We are using our currently approved estimates that 8,000 providers will be requested to submit additional verifying documentation and that it will take the provider 10 minutes to produce this information. This results in a 1,333-hour burden (8,000 providers X 0.1666 hours) at a cost of $49,082 (1,333 X $36.82/hr).

(12) Confirmation of LLC/Disregarded Entity Status (No Changes)

In section 17 under the title "Mandatory, if Applicable," we added a checkbox stating that "Written confirmation from the IRS confirming your Limited Liability Company (LLC) is automatically classified as a Disregarded Entity" may be required. This is to verify the provider's "disregarded entity" status.

We are using our currently approved estimates that 2,000 providers will be requested to submit IRS documentation verifying the provider's "disregarded entity" status and that it will take the provider 10 minutes to produce this information. This results in a 333-hour burden (2,000 X 0.1666 hours) at a cost of $12,261 (333 hr X $36.82/hr).

Burden Summary

Table 2 below outlines the revised burden associated with furnishing the CMS-855A information as discussed above:

Table 2 – Summary of Annual Burden Estimates

Provision	Respondents	Total	Burden	Total	Hourly	Total Annual

		Responses	per Response (hours)	Annual Time (hours)	Labor Cost ($/hr)	Cost ($)
Physician-Owned Hospital Checkbox	2,000	2,000	0.0833 (5 min)	167	36.82	6,148
Registration of Business	40,133	40,133	0.0833 (5 min)	3,343	36.82	123,089
Indian Health Facilities	40,133	40,133	0.0833 (5 min)	3,343	36.82	123,089
Cost Report Dates	40,000	40,000	0.0833 (5 min)	3,332	36.82	122,684
Effective Dates of Ownership	40,133	40,133	1	40,133	36.82	1,477,697
Percentage of Direct and Indirect Ownership	40,133	40,133	0.5	20,066	36.82	738,830
Purchase of Provider	40,133	40,133	0.25	10,033	36.82	369,415
Contractual Services	40,133	40,133	0.3333 (20 min)	13,376	36.82	492,504
Billing Agent DOB	4,000	4,000	0.1666 (10 min)	667	36.82	24,559
IRS Determination Letter	6,000	6,000	0.1666 (10 min)	1,000	36.82	36,820
Submission of Additional Documents	8,000	8,000	0.1666 (10 min)	1,333	36.82	49,082
Confirmation of LLC Status	2,000	2,000	0.1666 (10 min)	333	36.82	12,261
TOTAL	**40,133**	**302,798**	**Varies**	**97,126**	**36.82**	**3,576,179**

13. Cost to Respondents (Capital)

There are no capital costs associated with this collection.

14. Cost to Federal Government

There is no additional cost to the Federal government. Applications are processed in the normal course of Federal duties.

15. Changes in Burden/Program Changes

The changes in this collection of information request are associated with our December 28, 2020 (85 FR 84472) final rule (CMS-1734-F, RIN 0938-AU10).

As explained earlier in this Supporting Statement, existing § 424.67 outlines a number of enrollment requirements for OTPs. One requirement, addressed in § 424.67(b)(1), is that OTPs must complete the Form CMS-855B application (Medicare Enrollment Application: Clinics/Group Practices and Certain Other Suppliers; OMB Control Number: 0938-1377) to enroll in Medicare. The reference to the Form CMS-855B was predicated in part on the assumption that OTPs would generally submit the CMS-1500 claim form (Health Insurance

Claim Form; OMB Control Number: 0938-1197) to receive payment for their services. However, as mentioned in the final rule, we have received requests to allow OTPs to bill for services on an institutional claim form (specifically, the 837I). To do so, these OTPs would have to enroll in Medicare via the Form CMS-855A (Medicare Enrollment Application for Institutional Providers (OMB Control Number: 0938-0685). To account for circumstances where an OTP wishes to pursue Form CMS-855A enrollment for the reason stated above, we have finalized these changes.

Additionally, we foresee three main implications associated with our changes to § 424.67. First, newly enrolling OTPs would be able to complete and submit a Form CMS-855A (Medicare Enrollment Application - Institutional Providers) instead of a Form CMS-855B. Second, we anticipate that numerous OTPs that are currently enrolled via the Form CMS-855B would terminate the latter enrollments and complete/submit a Form CMS-855A application in order to bill for OTP services via the 837I. (As stated in revised § 424.67(c), an OTP cannot be enrolled via both the Form CMS-855A and Form CMS-855B; it must choose one of these two enrollment mechanisms.) Third, it is possible that some OTPs that enroll using the Form CMS-855A (pursuant to revised § 424.67(b)) would later change their enrollment to a Form CMS-855B. We estimate a burden of 333 new respondents in the next 3 years. We are not making any changes to the CMS-855A application. See Tables 3a, 3b, and 3c.

We are also removing the requirements, burden, and applications associated with CMS-855B (Medicare Enrollment Application for Clinics, Group Practices, and Certain Other Suppliers) and CMS-855I (Medicare Enrollment Application for Physicians and Non-Physician Practitioners). Importantly, both of those forms remain active. To avoid duplication, however, they are being removed from this 0938-0685 control number since they are now approved separately under their own separate control numbers, namely: 0938-1377 for CMS-855B and 0938-1355 for CMS-855I. See Table 5.

Overall, the changes amount to a reduction of 1,430,602 responses, 192,267 hours, and $17,144,125 (from $20,720,304 to $3,576,179).

Table 3a: Registration of Business

CMS-855A	**Respondents**	**Responses**	**Burden per Response (hours)**	**Total Annual Burden (hours)**
Currently Approved by OMB	40,000	40,000	0.0833	3,332
CMS-1734-F	40,133	40,133	0.0833	3,343
CHANGE	+133	+133	No change	+11

Table 3b: Indian Health Facilities

CMS-855A	**Respondents**	**Responses**	**Burden per Response (hours)**	**Total Annual Burden (hours)**
Currently Approved by OMB	40,000	40,000	0.0833	3,332
CMS-1734-F	40,133	40,133	0.0833	3,343
CHANGE	+133	+133	No change	+11

Table 3c: Effective Dates of Ownership or Managerial Control

CMS-855A	**Respondents**	**Responses**	**Burden per Response (hours)**	**Total Annual Burden (hours)**
Currently Approved by OMB	40,000	40,000	1	40,000
CMS-1734-F	40,133	40,133	1	40,133
CHANGE	+133	+133	No change	+133

Table 3d: Percentage of Direct and Indirect Ownership

CMS-855A	**Respondents**	**Responses**	**Burden per Response (hours)**	**Total Annual Burden (hours)**
Currently Approved by OMB	40,000	40,000	0.5	20,000
CMS-1734-F	40,133	40,133	0.5	20,066
CHANGE	+133	+133	No change	+66

Table 3e: Purchase of Provider

CMS-855A	**Respondents**	**Responses**	**Burden per Response (hours)**	**Total Annual Burden (hours)**
Currently Approved by OMB	40,000	40,000	0.25	10,000
CMS-1734-F	40,133	40,133	0.5	10,033
CHANGE	+133	+133	No change	+33

Table 3f: Contractual Services

CMS-855A	**Respondents**	**Responses**	**Burden per Response (hours)**	**Total Annual Burden (hours)**
Currently Approved by OMB	40,000	40,000	0.3333	13,333
CMS-1734-F	40,133	40,133	0.3333	13,376
CHANGE	+133	+133	No change	+43

Table 4: Total Change (CMS-855A, -855B, and -855I)

Provision	**Respondents**	**Responses**	**Total Annual Burden (hours)**
CMS-855A (Registration of Business)	+133	+133	+11
CMS-855A (Indian Health Facilities)		+133	+11
CMS-855A (Effective Dates of Ownership or Managerial Control)		+133	+133
CMS-855A (Percentage of Direct and Indirect Ownership)		+133	+66
CMS-855A (Purchase of Provider)		+133	+33
CMS-855A (Contractual Services)		+133	+43
CMS-855B	n/a	(711,400)	(98,232)
CMS-855I	n/a	(720,000)	(94,332)
TOTAL	+133	(1,430,602	(192,267)

16. Publication/Tabulation

N/A.

17. Expiration Date

We are planning on displaying the expiration date.

18. Certification Statement

There are no exceptions to the certification statement.

B. Collections of Information Employing Statistical Methods

This collection does not employ statistical methods.