Supporting Statement
Medicare Participation Agreement for Physicians and Suppliers
CMS-460; OMB# 0938-0373

Background

CMS is requesting a revision for CMS-460; OMB#0938-0373. Language related to opting out of Medicare is being removed. It had been included for informational purposes in a previous iteration, but has been deemed unrelated going forward. Additionally, all references to the term, "carrier" have been removed, as it is outdated and no longer in use by CMS. The term MAC (Medicare Administrative Contractor) is used in its place. Form CMS-460 is the agreement a physician, supplier, or their authorized official signs to become a participating provider in Medicare Part B. By signing the agreement to participate in Medicare, the physician, supplier, or their authorized official agrees to accept the Medicare-determined payment for Medicare covered services as payment in full and to charge the Medicare Part B beneficiary no more than the applicable deductible or coinsurance for the covered services. For purposes of this explanation, the term "supplier" means certain other persons or entities, other than physicians, that may bill Medicare for Part B services (e.g., suppliers of diagnostic tests, suppliers of radiology services, durable medical suppliers (DME) suppliers, nurse practitioners, clinical social workers, physician assistants). Institutions that render Part B services in their outpatient department are not considered "suppliers" for purposes of this agreement.

Since 1984, physicians and suppliers have had the opportunity each year to enroll or dis-enroll from the Medicare participating physician and supplier program. The Deficit Reduction Act of 1984 (Public Law 98-369) created this program. Under the participation program, a physician or supplier enters into an agreement to accept assignment in all cases involving Medicare beneficiaries during the next calendar year. To accept assignment means to request direct payment from the Medicare program and to agree to accept the Medicare approved amount as payment in full for the covered services. The approved amount is composed of the Medicare Part B payment and the applicable deductible and coinsurance. A physician or supplier who accepts assignment may not collect from the beneficiary more than the applicable coinsurance and deductible. A nonparticipating physician and supplier may still accept assignment on Medicare claims on a case-by case basis.

To implement the participation program, each year Medicare sends a postcard to all physicians directing them to their contractor's website, information about the participation program, i.e., the Dear Doctor Announcement, supplemental information regarding the Medicare program, as well as the CMS-460. The CMS-460 Form is on the CMS website, as well as the contractor's website, as an interactive form. Providers may electronically complete all information except the signature. Providers must submit an original signature on the CMS-460 Form.

In the case of suppliers, letters are sent explaining how participation in the program will affect their Medicare payment. Blank participation agreements (CMS-460) are sent to nonparticipating suppliers.

The postcard or CMS-460 Form is sent to each physician or supplier late each year after the next year's payment amounts are published or during the year when a newly licensed physician or supplier acquires a National Provider Identifier or establishes a business new to the Medicare Administrative Contractor's (MACs) area. Nonparticipating physicians and suppliers may sign participation agreements at the end of the year for a 12-month period starting in January of the following year. Newly licensed entities or entities that are establishing a new business may sign one when they acquire a National Provider Identifier for billing purposes. The participation agreement is automatically renewed each year unless the physician or supplier revokes it for the forthcoming year. Incentives for physicians and suppliers to participate include:

- Inclusion in a directory of physicians and suppliers who participate in Medicare. The directories are provided to libraries, senior citizen programs, Social Security Offices and other locations for use by beneficiaries.

- Provision of "Medicare Participating Physician/Supplier" emblems that can be displayed in participating physician and supplier offices or businesses.

There are additional benefits associated with payment for services paid under the Medicare Physician Fee Schedule. Payments made to participating physician/suppliers under the Medicare Physician Fee Schedule are based on 100 percent of the Medicare fee schedule amount, while the Medicare fee schedule payment for services by nonparticipating physicians and suppliers is based on 95 percent of the fee schedule amount. Physicians and suppliers who do not participate in Medicare are subject to limits on their actual charges for unassigned claims for services. These limits, known as limiting charges, cannot exceed 115 percent of the non-participant fee schedule, which is set at 95 percent of the full fee schedule amount. (**NOTE:** For suppliers that are paid on the basis of other than the Medicare Physician Fee Schedule, electing to sign the CMS-460 and accepting assignment has no effect on their payment amount.)

In addition, if a physician or supplier does not accept assignment on a claim for Medicare payment, the physician or supplier must collect payment from the beneficiary. If the physician or supplier accepts assignment on the claim, Medicare pays its share of the payment directly to the physician or supplier, usually resulting in faster and more certain payment.

We are seeking re-approval of the information which is collected on the CMS-460 form. The information associated with Form CMS-460 is collected and maintained in the Provider

Enrollment Chain and Ownership System (PECOS) System of Records (09-70-0532)[1]The following identifies and justifies each question:

1. Name of Participant, Person or Organization

This is identifying information to be printed in the directory.

2. Address/Addresses

All addresses under which the physician/supplier does business within the MACs jurisdiction are needed for the directory.

3. National Provider Identifier

This is necessary to ensure that proper payment is made since the physician's or supplier's National Provider Identifier is carried in the claims processing system.

4. Signature and title of participant or authorized representative of participating organization

This is necessary to signify that the physician or supplier agrees to the terms of the agreement and to identify the authorized representative, if there is one.

5. Date

This is the date that the agreement is signed. This is necessary to establish the validity of the agreement and its proper effective date. This is important because physicians and suppliers have a long time period in which to submit claims and the agreement relates to services provided on or after the effective date of the agreement. It is particularly important when the agreement is being signed by a newly licensed physician or supplier or a physician or supplier who is new to the MAC's service area.

6. Office phone Number

This is to be printed in the directory so that beneficiaries can contact participating physicians and suppliers to arrange to receive services.

A. Justification

1 https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-andSystems/Privacy/Systems-of-Records-Items/09-70-0532-PECOS.html?DLPage=1&DLEntries=10&DLFilter=PECOS&DLSort=0&DLSortDir=descending

1. Need and Legal Basis

Section 1842(h) of the Social Security Act permits physicians and suppliers to voluntarily participate in Medicare Part B by agreeing to take assignment on all claims for services to Medicare beneficiaries. The law also requires that the Secretary provide specific benefits to the physicians, suppliers and other persons who choose to participate. The CMS-460 is the agreement by which the physician or supplier elects to participate in Medicare.

2. Information Users

The information is used by the following:

- Medicare contractors: to provide the benefits the law provides for participating entities and to enable contractors to enforce the Medicare limiting charge for physicians, suppliers and other persons who do not participate

- Medicare beneficiaries: to assist them in locating physicians who will accept Medicare assignment on claims for services and therefore save them money.

-CMS: to gauge the effectiveness of the efforts by CMS and our contractors to increase participation in Medicare.

3. Improved Information Technology

The CMS-460 Form is an interactive form on the CMS website and the contractor's website. However, at this time, CMS does not have the ability to receive electronic signatures.

4. Duplication Similar Information

There is no duplication of similar information.

5. Small Business

Many of the affected entities are small businesses (e.g., physician practices), but the burden is very small compared to the financial benefits to the physician, supplier or other person who chooses to participate. The agreement is very simple and contains the minimum amount of information to permit us to comply with the law.

6. Less Frequent Collection

We would be in violation of the law. Moreover, if we were to permit nonparticipating physicians and suppliers to choose to participate less frequently than once a year or upon starting a new business in the area, physicians, suppliers and other persons would have to wait longer to

participate. The benefits of participation to beneficiaries and to the physicians and suppliers would be lost for that period of time.

7. Special Circumstances

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

- Report information to the agency more often than quarterly;
- 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

The 60-day Federal Register notice published in the Federal Register 05/04/2022 (87 FR 26359). No comments were received during the comment period.

The 30-day Federal Register notice published in the Federal Register 07/15/2022 (87 FR 42484).

This agreement is defined in law and no consultation with outside groups is needed.

9. Payment/Gift to Respondent

The benefits of participation are specified in law. We do not consider them to be payment or a gift for responding.

10. Confidentiality

The decision to participate in Medicare is not confidential. To the contrary, the statute requires that the names of participating physicians, suppliers and other persons be published in the

Medicare participating physician directory and made available to beneficiaries on request via a toll-free phone number. This is viewed as a desirable benefit by physicians and suppliers.

11. Sensitive Questions

There are no sensitive questions.

12. Burden Estimate (Hours & Wages)

Our annual hour burden estimate remains unchanged since the last submission. We estimate that the completion of the participation agreement will take the physician, supplier or other person approximately 15 minutes (0.25 hrs). In 2021, approximately 36,000 entities (6% annual increase since the previous collection) submitted new participation agreements for a total burden to the public of 9,000 hours.

We estimate the cost to a physician, supplier or other person who chooses to participate to be $63.20 for the 15 minutes it will take to complete and sign the form, have someone make a copy, file the copy, and for the envelope and postage needed to mail it. This estimate is based upon the national Medicare payment rate for 2021 for a 15-minute, face to face physician visit in a facility setting. (For estimation purposes, we are equating the cost of the 15 minutes it takes for the physician to complete the 460 form to the Medicare facility payment rate for a physician's time spent with a patient for 15 minutes under CPT code 99213. We are applying the Medicare facility payment rate because we believe this is a better reflection of a billing provider's time than a non-facility payment rate, which typically incorporates the costs of disposable supplies, nursing time, and other practice-related expenses. CPT code 99213 at a facility relative value unit is 1.95. When multiplied by the 2021 conversion factor of $32.4085, the Medicare facility payment is $63.20. The participation decision is likely to be made or approved, completed and signed by the practitioner (in the case of a solo practice), or by the Chief Executive Officer or Chief Financial Officer of a group practice or supplier because of its significant impact on the payments that will be made by Medicare.

We estimate the total national cost to physicians, suppliers and other persons who sign participation agreements each year to be about $1,820,160. We calculated this amount by multiplying $63.20, per agreement, times 36,000 agreements ($2,275,200) and reducing it by 20 percent ($455,040). The 20 percent reduction is needed to recognize that Medicare payments include payment for the practice expense involved in running the practice or business (such as making the decision to participate). Therefore, Medicare pays part of the physician's or supplier's cost of signing the agreement in its payment for Medicare covered services.

Calculation = $63.20 x 36,000 = $2,275,200 x 20% = $455,040 then $2,275,200 – $455,040 = $1,820,160

13. Capital Costs

There are no capital costs.

14. Cost to Federal Government

We estimate that the total cost to the Federal government attributable to these agreements for 2021 was $471,645. There are three components of cost to the Federal government: cost to Medicare contractors to print the agreement, the portion of the cost of completing the agreement that is a cost of business in which the Medicare program shares, and the cost to Medicare contractors for processing the signed agreements.

Calculation = $4,680+$455,040+$11,925= $471,645

Administrative cost for printing the agreement: We estimate a printing cost to Medicare contactors of $.13 per agreement. The MACs are required to have 2 percent of the "Dear Doctor" hard copy packages on hand, which includes the agreement, to be mailed to any physician/supplier who requests a hardcopy. Based on these assumptions, we estimate that approximately 1,800,203 total physicians/suppliers received postcards. MACs kept on hand 36,004 hardcopies packages; we estimate the cost of producing these to be $4,680.

Program cost: As discussed above, we estimate that Medicare's program payment for services (which includes a practice expense component) picks up 20 percent of the cost to the physician, supplier or other person of completing the agreement. Based on this assumption, as indicated above, we estimate the Medicare program payment portion related to signing the participation agreement to be $455,040**.**

Administrative cost for processing the agreement upon receipt: We estimate that there are approximately 86 keystrokes per each of 36,000 forms or 3,096,0000 total keystrokes. We estimate that a data input clerk can do approximately 5000 keystrokes per hour and is paid at the rate of a GS 4 step 5 or $19.26 per hour (2021 general schedule rate for the locality pay area of Washington-Baltimore-Arlington, DC-MD-VA-WV-PA). Dividing the total keystrokes by the number a clerk can do per hour and multiplying by the estimated hourly salary results in an estimated total processing cost of $11,925.

15. Program Changes

There are no program changes. Language related to opting out of Medicare is being removed. It had been included for informational purposes in a previous iteration, but has been deemed unrelated. Additionally, all references to the term, "carrier" have been removed, as it is outdated and no longer in use by CMS. The term MAC (Medicare Administrative Contractor) is used in its place. The burden per response remains unchanged as well. However, the cost burden has been adjusted based on the availability of recent data.

	2018	2021
Respondents	29,000	36,000
Hourly Burden	7,250	9,000
Cost	$313,885	$471,645

16. Publication and Tabulation Dates

The form that will be mailed to the contractors as part of the 2022 "Dear Doctor" letter in anticipation of the 2022 participation period includes the required OMB paperwork burden disclosure notice and is attached; this is the notice that will be sent to physicians and suppliers as soon as possible following the publication of the Medicare Physician Fee Schedule final rule which is on or about November 1. None of the information collected via the CMS-460 is released to the public.

17. Expiration Date

CMS will display the expiration date. In addition to adding placeholders for the expiration date in the text of the PRA Disclosure Statement and in upper right header of the document, we also post the expiration date on the CMS web site where the form can be obtained[2]. Upon approval, the date will be updated in all locations.

18. Certification Statement

There are no exceptions to the certification statement.

2 https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS007566.html