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

BACKGROUND

1. Reinstatement Request and Request for Approval of Additional CMS-855A Revisions

The primary function of the CMS-855A Medicare enrollment application is to gather information from a certified provider or certified supplier (hereafter occasionally and collectively referenced as "provider(s)") that tells us who it is, whether it meets certain qualifications to be a health care provider, where it practices or renders services, the identity of its owners, and other information necessary to establish correct claims payments.

This collection of information reinstatement request is associated in part with our December 28, 2020 (85 FR 84472) final rule (CMS-1734-F, RIN 0938-AU10). The collection of information changes stemming from this final rule were approved by OMB on September 28, 2021 (ICR Reference No.: 202103-0938-010). As this approval was only through March 30, 2022, this collection of information request seeks to reinstate this approval through March 30, 2025.

As part of this request, and as described further below, we also seek final approval for additional changes to the CMS-855A. We published a 60-day notice in the Federal Register on December 15, 2022 (87 FR 76626) seeking public comment on our proposed Form CMS-855A changes.

2. Changes Associated with December 28, 2020 Final Rule

Existing § 424.67 outlines a number of enrollment requirements for opioid treatment programs (OTPs). One requirement, addressed in § 424.67(b)(1)(i), is that OTPs must maintain and submit to CMS a list of all physicians, other eligible professionals, and pharmacists who are legally authorized to prescribe, order, or dispense controlled substances on the OTP's behalf; the list must include the person's first and last name and middle initial, social security number, National Provider Identifier, and license number (if applicable). This reinstatement request will add these data elements to the CMS-855A, which OTPs must complete if they wish to bill for OTP services via an institutional claim form (specifically, the 837I).

3. Changes Associated with November 23, 2022 Final Rule with Comment Period

On November 23, 2022, CMS published in the **Federal Register** a final rule with comment period rule titled "Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Acquisition; Rural Emergency Hospitals: Payment Policies, Conditions of Participation, Provider Enrollment, Physician Self-Referral; New Service Category for Hospital Outpatient Department Prior Authorization Process; Overall Hospital Quality Star Rating; COVID-19" (CMS-1772-FC) (87 FR 71748). This final rule with comment period outlined requirements that rural emergency

hospitals (REHs) – a new Medicare provider type established pursuant to Section 125 of Division CC of the Consolidated Appropriations Act, 2021 – must meet in order to bill Medicare for REH services; in accordance with new section 1861(kkk) of the Social Security Act, a facility is eligible to convert to an REH if it was a critical access hospital (CAH) or rural hospital with less than 50 beds as of December 27, 2020. CMS-1772-FC's REH requirements include those necessary to enroll as an REH. The most pertinent of these is that a CAH or rural hospital seeking REH enrollment submits a CMS-855A change of information application and need not submit a full, initial CMS-855A application. This reinstatement request will address the expected REH burden associated with completing these CMS-855A changes of information.

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.
- 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.
- 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 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. Section 6401 of the Affordable Care Act (which amended section 1866(j) of the Social Security Act) outlines requirements for the enrollment of providers and suppliers into the Medicare program.
- 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 data required to uniquely identify and enumerate the provider/supplier. Additional information needed 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 Medicare enrollment. 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 neither sanctioned from the Medicare program nor 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 and transmit it to the Medicare contractor database for processing; the data is then 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.

4. Duplication and Similar Information

There is no duplicative information collection instrument or process.

5. Small Business

The data collections associated with the CMS-855 application process impacts small businesses. However, because of the relative infrequency with which the information needs 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 required for enrollment in the Medicare program. It is essential to collect this data 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 will require an information collection to be conducted in a manner that requires respondents to:

- 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: (1) that is not supported by authority established in statute or regulation; (2) that is not supported by disclosure and data security policies consistent with that pledge; and/or (3) which unnecessarily impedes the 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

a. December 28, 2020 Final Rule

Serving as the 60-day notice, the aforementioned proposed rule (CMS-1734-P, RIN 0938-AU10) was 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) was published in the Federal Register on December 28, 2020 (85 FR 84472).

b. November 23, 2022 Final Rule

Serving as the 60-day notice, the aforementioned proposed rule (CMS-1772-P, RIN 0938-AU82) was filed for public inspection on July 15, 2022, and was published in the Federal Register on July 26, 2022 (87 FR 44502). We did not receive any PRA-related comments.

The final rule, as previously noted, was published in the Federal Register on November 23, 2022.

c. In addition to the aforementioned rulemaking documents, the 60-day notice for the current iteration of this information collection request published on December 15, 2022 (87 FR 76626). Included with this OMB submission is a document that summarizes and responds to the public comments received in response to the notice. The 30-day notice published on May 4, 2023.

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. CMS-855A Collection of Information Requirements and Burden Estimates Associated with This Reinstatement Request

a. Form Changes

The following CMS-855A collection of information and burden analysis addresses the changes to the CMS-855A for which we seek approval. The reasons for each of these changes are discussed in the data element subsection to which the change and reason applies.

Some of the CMS-855A revisions simply involve: (1) clarifying existing instructions without changing the data to be reported (i.e., helping the provider better understand what is required); (2) moving existing data elements without change to different sections of the form; and (3) rewording questions/data elements to make them clearer without changing the information to be disclosed. These are summarized in the attachment to this Supporting Statement. The requirements and burden estimates discussed below are restricted to additional data that must be reported per our form changes.

After additional reflection, we believe that some of our estimates in the proposed PRA package published for public comment on December 15, 2022 were much too low with respect to the number of providers that will have to furnish the data in question. The projections below therefore reflect our final and, in some cases, changed estimates. The changes are based on more accurate internal CMS data regarding the number of providers that submit a Form CMS-855A

each year, as shown in the following chart:

Table 1: Form CMS-855A Annual Application Submission

	OMB Control No.	Number of Respondents	Number of Responses
Initial Form CMS-855A Applications	0938-0685	6,462	6,462
Form CMS-855A Change of Ownership	0938-0685	3,105	3,105
Form CMS-855A Revalidation Applications	0938-0685	3,133	3,133
Form CMS-855A Reactivation Applications	0938-0685	610	610
Form CMS-855A Change of Information Applications *	0938-0685	27,000	27,000
TOTALS	**N/A**	**40,310**	**40,310**

* This reflects the annual number of change of information applications that report a change to the provider's ownership or managerial information in Section 5 or 6 of the Form CMS-855A.

12.1 - Wage Estimates

The following table presents the mean hourly wage provided by the Bureau of Labor Statistics (BLS) for May 2021 (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 2: National Occupational Employment and Wage Estimates

Occupation Title	Occupation Code	Mean Hourly Wage ($/hr)	Fringe Benefits and Overhead ($/hr)	Adjusted Hourly Wage ($/hr)
Other Office and Administrative Support Workers	43-9199	20.47	20.47	40.94

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 annual hour and cost burden associated with the completion of each new data element or series thereof. These are largely based on PECOS enrollment statistics, past estimates, and our longstanding experience. We note, though, that these numbers are merely averages; the actual numbers will vary each year.

12.2.1 Medical Record Correspondence Address

In Section 2(D) of the CMS-855A, we will request that the provider list the address where the MAC will send to the provider (a) medical record correspondence and (b) medical record review correspondence. This will help ensure that the MAC has a specific, accurate address to which it can send these materials to the provider.

Our proposed estimates were that it will take the provider 20 minutes (0.333 hr) to provide this information and that approximately 6,000 providers will complete this section on the CMS-855A each year. We are changing the 6,000 figure to 13,310. (From Table 1 above, this accounts for 6,462 initial applications, 3,105 CHOW applications, 3,133 revalidation applications, and 610 reactivation applications.) This results in a 4,436-hour burden (13,310 X 0.3333 hours) at a cost of $181,610 (4,436 X $40.94/hr).

12.2.2 Additional Final Adverse Actions

Section 3 of the CMS-855A lists a number of final adverse actions that must be disclosed if they pertain to the provider (e.g., the provider has had a felony conviction). We will add the following two final adverse actions to Section 3:

- Any crime, under federal or state law, which received a sentence of deferred adjudication, adjudication withheld, stay of adjudication, withholding of judgment, or order of deferral — regardless of whether the court dismissed the case upon completion of probation, and regardless of whether the felony was reduced to a misdemeanor.
- Any Medicaid exclusion, enrollment suspension, payment suspension, revocation, or termination of any billing number.

In addition, various parties with an ownership or managerial interest in the provider must be disclosed in Section 5 (for entities) and Section 6 (individuals); this includes reporting in those sections any final adverse action listed in section 3 that has been imposed against the owner or manager.

Disclosure of these two actions is important because they will help CMS determine whether the provider or an owner or manager thereof poses a risk to the Medicare program and, therefore, whether denial or revocation is warranted. (For example, we can revoke enrollment if the provider is terminated from Medicaid or deny enrollment if one of the provider's managing employees reported in section 6 has a felony conviction.)

We estimate that it will take the provider 45 minutes (0.75 hr) to furnish information on either of these adverse actions on the CMS-855A and to submit supporting documentation. (Disclosure of an adverse action requires the provider to submit documentation providing background on the adverse action.) We believe that about 200 providers per year will be required to report this data and furnish the applicable documentation (i.e., a total of 200 providers or their owning or managing individuals or entities will have had either of these actions imposed again them). This results in a 150-hour burden (200 X 0.75 hours) at a cost of $6,141 (150 X $40.94/hr).

12.2.3 Primary Practice Location

In Section 4(A) of the CMS-855A, we will request that the provider identify via a new checkbox whether the practice location it has listed is the provider's primary practice location. This question's purpose is to help CMS identify, for instance, the location most suited for a site visit.

We estimate that it will take the provider 5 minutes (0.08333 hr) to provide this information and that approximately 13,310 providers (rather than the 6,000 we estimated in the proposed PRA package) will complete this section on the CMS-855A each year. This results in a 1,109-hour burden (13,310 X 0.08333 hours) at a cost of $45,402 (13,310 X $40.94/hr).

12.2.4 Date First Patient Seen

In Section 4(A) of the CMS-855A, we will request that the provider disclose the date on which it saw its first Medicare patient at the location in question. This will help CMS determine the effective date of the provider's enrollment or participation. We project that it will take the provider 10 minutes (0.1666 hr) to provide this information and that approximately 13,310 providers (instead of the 6,000 we proposed) will complete this section on the CMS-855A each year. This results in a 2,217-hour burden (13,310 X 0.1666 hours) at a cost of $90,764 (2,217 X $40.94/hr).

12.2.5 Provider-Based Data

In Section 4(A), we will add checkboxes via which the provider will identify whether the practice location in question is provider-based under 42 CFR § 413.65 and, if so, what type of provider-based location it is. (The boxes will only need to be checked if the location is indeed provider-based.) This information will help CMS ensure that payments are correctly made for services furnished at the provider-based location and the parent provider (e.g., at a hospital and its provider-based physician group location).

We had proposed that it would take the provider 15 minutes (0.25 hr) to provide this information. After reviewing the public comments, we have increased this to 30 minutes. We also project that approximately 1,500 providers with provider-based locations will complete this section on the CMS-855A each year. This results in a 750-hour burden (1,500 X 0.5 hours) at a cost of $30,705 (750 X $40.94/hr).

12.2.6 Medical Record Storage

Section 4(C) of the current CMS-855A asks providers to report the address at which it stores its medical records. This is for paper records. We would add a new question asking whether the provider also stores records electronically. If it does, the provider must, as stated on the proposed form revision, "identify where/how these records are stored below. This can be a website, URL, in-house software program, online service, vendor, etc. This must be an electronic storage site that can be accessed by CMS or its designees, if necessary." Based on public comments we received in response to our proposed language, we are changing this quoted language to read: "[I]f yes, identify the service used to store these records below. This can be an in-house software program, online service, vendor, etc." An actual website need not be disclosed but only a general reference to the type of electronic storage (e.g., "online service").

We estimate that 13,310 providers annually (rather than the 6,000 we proposed) will check "yes" or "no" to the question regarding whether they store records electronically and that it will take the provider 5 minutes (0.08333 hr) to do so. This results in a 1,109-hour burden (13,310 X 0.08333 hours) at a cost of $45,402 (1,109 X $40.94/hr).

We further project that of the aforementioned 13,310 providers, approximately 12,000 (as opposed to the 5,000 we proposed) will respond that they do have electronic record storage and, in turn, will identify the service used to store the records. We believe it will take the provider 10 minutes (0.1666 hr) to provide this information. This results in a 1,999-hour burden (12,000 X 0.1666 hours) at a cost of $81,839 (1,999 X $40.94/hr).

12.2.7 Geographic Location for Mobile Providers

Section 4(F) of the existing CMS-855A asks home health agencies (HHAs) and mobile/portable providers to identify the cities/towns, states, and zip codes in which the provider performs services. The revised CMS-855A will also ask these providers to report the counties in which the disclosed cities/towns are located. This will help ensure that Medicare payments are correctly made.

We estimate that 2,000 HHAs (instead of the 1,000 we proposed) and mobile/portable providers will be required to furnish the counties of service in Section 4(F) and that it will take the provider 10 minutes (0.1666 hr) to provide this information. This results in a 333-hour burden (2,000 X 0.1666 hours) at a cost of $13,633 (333 X $40.94/hr).

12.2.8 Reporting Organizational Owners/Managers' Phone Numbers and Electronic Addresses

The current CMS-855A requires the provider to report in Section 5(B) information about all organizations with certain ownership or managerial interests in the provider. This information includes, for example, the entity's legal business name and address, but it does not include the telephone number, e-mail address, or fax number. Our CMS-855A revision will request that the provider furnish these three data elements (if applicable to the owning/managing entity) to help us better identify and scrutinize those parties that own or oversee the provider.

We estimate that 40,310 (13,310 + 27,000 changes of information per Table 1) providers annually will furnish this data regarding their owners and that it will take the provider 12 minutes (0.2 hr) to do so. (We proposed 6,000 affected providers.) This results in an 8,062-hour burden (40,310 X 0.2 hours) at a cost of $330,058 (8,062 X $40.94/hr).

12.2.9 Reporting Limited Partnerships

In Sections 5(B) and 6(B) of the existing CMS-855A, the provider must report all organizations and individuals who have at least a 10 percent limited partnership interest in the provider. Our CMS-855A revision will change this to all limited partnership interests, regardless of the percentage. This is because section 1124 of the Social Security Act requires all limited partnerships to be disclosed irrespective of percentage.

We estimate that 500 providers (as opposed to the 50 we proposed) will have to report limited partnership interests of between 1 and 9 percent and that it will take the provider 30 minutes (0.5 hr) to provide this information. This results in a 250-hour annual burden (500 X 0.5 hours) at a cost of $10,235 (250 X $40.94/hr).

12.2.10 Identifying Indirect Owners

Our CMS-855A revision will require the provider to check "Yes" or "No" to a new question in Section 5(A) that asks whether the reported organization owner is itself owned by another organization or individual. Using our aforementioned 40,310 estimate in lieu of our proposed 6,000-provider projection and estimating that it will take the provider 12 minutes (0.2 hr) to furnish the required data, this results in an 8,062-hour burden (40,310 X 0.2 hours) at a cost of $330,058 (8,062 X $40.94/hr).

12.2.11 Identifying Type of Owning/Managing Organization

Section 5(B) of the current CMS-855A contains checkboxes outlining types of owning/managing organizations, such as holding companies. The provider must check the box(es) that apply to its owning/managing organizations. Our CMS-855A revision will: (1) require the provider to actually check "Yes" or "No" next to each type of organization the CMS-855A lists; and (2) add "private-equity company" and "real estate investment trust" to this list of types of organizations.

We estimate that 40,310 providers annually (rather than the 6,000 we proposed) will furnish this data regarding their organizational owners/managers and that it will take the provider 12 minutes (0.2 hr) to do so. This results in an 8,062-hour burden (40,310 X 0.2 hours) at a cost of $330,058 (8,062 X $40.94/hr).

12.2.12 Ordering/Dispensing/Prescribing Personnel

As already mentioned, § 424.67(b)(1)(i) requires OTPs to maintain and submit to CMS a list of all physicians, other eligible professionals, and pharmacists who are legally authorized to prescribe, order, or dispense controlled substances on the OTP's behalf; the list must include the person's first and last name and middle initial, social security number, National Provider Identifier, and license number (if applicable). New Section 10 of the CMS-85A will capture this data along with the individual's practitioner type, which is needed to help CMS monitor the individual's Medicare enrollment if or she is indeed enrolled.

We project that approximately 100 OTPs will complete Section 10 each year and that it will take each OTP 50 minutes (0.8333 hr) to do so. This results in an annual burden of 83 hours (100 X 0.8333 hours) at a cost of $3,398 (83 x $40.94/hr).

12.2.13 Documentation of Ownership Change

Per Section 17 of the existing CMS-855A, a provider undergoing a change of ownership under 42 CFR § 489.18 must currently submit a copy of the sales agreement with its application. Our

CMS-855A revisions will require the submission of a sales agreement for all ownership changes that must be reported, even those as small as 5 percent. This will help us verify information regarding the incoming owner.

In lieu of our proposed 600-provider estimate, we project that 27,000 providers will submit this information for non-§ 489.18 ownership changes. We believe it will take the provider 10 minutes (0.1666 hr) to do so. The annual burden will thus be 4,498 hours (27,000 x 0.1666) at a cost of $184,148 (4,498 x $40.94/hr).

Burden Summary

Table 3 below outlines the revised burden associated with furnishing the CMS-855A information as discussed above:

Table 3 – Summary of CMS-855A Annual Burden Estimates for Form Changes

Provision	Respondents	Total Responses	Burden per Response (hours)	Total Annual Time (hours)	Hourly Labor Cost ($/hr)	Total Annual Cost ($)
Medical Record Correspondence Address	13,310	13,310	0.333 (20 min)	4,436	40.94	181,610
Additional Final Adverse Actions	200	200	0.75 (45 min)	150	40.94	6,141
Primary Practice Location	13,310	13,310	0.0833 (5 min)	1,109	40.94	45,402
Date First Patient Seen	13,310	13,310	0.1666 (10 min)	2,217	40.94	90,764
Provider-Based Data	1,500	1,500	0.5 (30 min)	750	40.94	30,705
Medical Record Storage (Yes/No for E-Storage)	13,310	13,310	0.0833 (5 min)	1,109	40.94	45,402
Medical Record Storage (Reporting E-Storage Address)	12,000	12,000	0.1666 (10 min)	1,999	40.94	81,839
Geographic Location for Mobile Providers	2,000	2,000	0.1666 (10 min)	333	40.94	13,633
Owning/Managing Entities' Phone Numbers and E-Addresses	40,310	40,310	0.2 (12 min)	8,062	40.94	330,058
Limited Partnerships	500	500	0.5 (30 min)	250	40.94	10,235
Identifying Indirect Owners	40,310	40,310	0.2 (12 min)	8,062	40.94	330,058
Identifying Type of Owning or Managing Organization	40,310	40,310	0.2 (12 min)	8,062	40.94	330,058
Ordering, Dispensing, and	100	100	0.8333 50 min)	83	40.94	3,398

Prescribing Personnel						
Documentation of Ownership Change	27,000	27,000	0.1666 (10 min)	4,498	40.94	184,148
TOTAL	**217,470**	**217,470**	**Varies**	**41,120**	40.94	**1,683,451**

b. Expected Burden Changes Pursuant November 23, 2022 Final Rule with Comment Period

As we stated in CMS-1772-FC rule, we expect that 68 REHs will seek to convert from either a CAH or rural hospital via a CMS-855A change of information. We believe all of these facilities will do so within the first year of our REH enrollment requirements and, consistent with our longstanding estimates for completing a CMS-855A change of information, that it will take 1 hour to complete the application. This results in an estimated Year 1 burden involving this requirement of 68 hours (68 applications x 1 hour) at a cost of $2,784. Over a 3-year period, this results in an annual burden of 23 hours at a cost of $928.

Table 4 – Summary of CMS-855A Annual Burden Estimates for REH Completion of CMS-855A Change of Information

	Respondents	Total Responses	Burden per Response (hours)	Total Annual Time (hours)	Hourly Labor Cost ($/hr)	Total Annual Cost ($)
Completion of CMS-855A Change of Information	23	23	1	23	40.94	928

13. Cost to Respondents (Capital)

There are no capital costs associated with this collection.

14. Cost to Federal Government

14.1 MACs

We anticipate additional costs to the MACs with respect to processing the aforementioned: (1) Form CMS-855A data element additions; and (2) the REH change of information applications. We projected above an annual provider burden for the former of 41,120 and the latter of 23, for a total of 41,143 hours. Given our experience, we estimate it will take the MACs 1.5 times this figure to process this data, or 61,715 hours.

The applicable MAC hourly is wage equivalent to a GS-9, Step 5 (Washington/Baltimore/Arlington locality), which is $35.27. (See https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2023/DCB_h.pdf.) This results in an annual MAC cost of $2,176,688 (61,175 x $35.27).

14.2 Federal Government

The cost to the Federal government will mostly involve: (1) the PRA process (e.g., preparing the PRA package); (2) posting the revised form documents to CMS.gov; (3) performing outreach as needed; and (4) responding to inquiries. CMS employees will perform these tasks. The hourly wage of said employee is at a GS-13, Step 5 level (Washington/Baltimore/Arlington locality), or $60.83. (See https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2023/DCB_h.pdf.) We estimate that the foregoing tasks will take a total of 150 hours. This results in a total cost of $9,125.

15. Annual Changes in Burden/Program Changes

As shown in Tables 3 and 4, there will be a burden increase associated with this request for reinstatement, addition of data elements, and burden changes pursuant to two final rules. We proposed that the number of: (1) respondents and responses would increase by 45,473; (2) hours would increase by 9,356; and (3) cost would increase by $383,022. Pursuant to the data in Tables 3 and 4, we are revising these estimates as shown below:

Form	Respondents	Total Responses	Total Annual Time (hours)	Total Annual Cost ($)
CMS-855A	+ 217,493	+ 217,493	+ 41,143	+ 1,684,379

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.