Supporting Statement for Paperwork Reduction Act Submissions

Medicare Enrollment Application: Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers
CMS-855S/OMB Control Number: 0938-1056)

A. BACKGROUND

The primary function of the Form CMS-855S Medicare enrollment application for suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) is to gather information from the supplier that tells us who the supplier is, whether the supplier meets certain qualifications to be a Medicare DMEPOS supplier, where the supplier practices or renders services, and other information necessary to establish correct claims payments.

This Paperwork Reduction Act (PRA) submission revises the Form CMS-855S to: (1) to replace references thereon to the National Supplier Clearinghouse with the identities of the new Medicare contractors that will process Form CMS-855S enrollment applications; (2) add a new product listing to Section 2E4 of the application for "Lymphedema Compression Treatment Items"; and (3) add checkboxes for suppliers to disclose the reason for which they are exempt from the DMEPOS accreditation requirements in § 424.58. Several other very minor edits to the form are included in this revision. In addition, this submission will recalculate the total burden hours and costs of completing the Form CMS-855S based on the most recent statistics. It also seeks an extension of the current OMB approval, which expires on October 31, 2024.

The aforementioned form changes are addressed in more detail in the attached spreadsheet.

B. JUSTIFICATION

1. Need and Legal Basis

As identified below, the Social Security Act (Act), the Code of Federal Regulations (CFR), and the United States Code (U.S.C.) require providers/suppliers to furnish financial institution information concerning electronic payment to individuals or entities that submit Medicare claims for reimbursement.

- 42 CFR Part 424, subpart P 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, who must meet and maintain these enrollment requirements to bill the Medicare program.
- Title XVII of the Act ensures that the data collected allows CMS to make correct payments to providers and suppliers in the Medicare program.
- 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 enrollment forms.

- 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).
- 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 1834(a)(20)(G)(i) of the Act 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 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 1834(j) of the Act states that no payment may be made for items furnished by a supplier of durable medical equipment, prosthetics, and supplies (DMEPOS) unless that supplier obtains, and renews at such intervals as we may require, a billing number. In order to issue a billing number, we need to collect information unique to that supplier.
- Section 1866(j) of the Act requires the revalidation of all provider and supplier enrollment data every five years – every three years for DMEPOS suppliers.
- 42 C.F.R. Section 424.57 requires DMEPOS suppliers comply with 30 specific standards in order to receive and maintain Medicare billing privileges.
- 42 C.F.R. Section 424.58 requires accreditation in order to qualify for the Medicare program.
- 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.
- 5 U.S.C. 522(b)(4) requires privileged or confidential commercial or financial information be protected from public disclosure.

2. Information Users

The Form CMS-855S is submitted by DMEPOS suppliers to initially apply for a Medicare billing number, revalidate Medicare enrollment, reactivate Medicare enrollment, report a change to current Medicare enrollment information, and to voluntary terminate the supplier's Medicare enrollment, as applicable. The collection and verification of the information provided on the Form CMS-855S application protects Medicare beneficiaries and the Medicare Trust Funds from unqualified DMEPOS suppliers. This is sole instrument used for this purpose.

The National Supplier Clearinghouse (NSC) formerly processed Form CMS-855S applications. These applications are now processed by one of two Medicare Administrative Contractors (MACs): (1) National Provider Enrollment (NPE) West (Palmetto Government Benefits Administrators); and (2) NPE East (Novitas Solutions).

3. Improved Information Techniques

This collection lends itself to electronic collection methods. The Provider Enrollment, Chain and Ownership System (PECOS) (SORN number 09-70-0532) 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 PECOS data is restricted to CMS and the MACs. Providers/suppliers can submit a Form CMS-855S (i) electronically via PECOS or (ii) via paper.

4. Duplication and Similar Information

The data captured on this form is not duplicated through any other public information collection. No similar data can be modified to capture the information on this form.

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 Funds; the enrollment process therefore affects small businesses that seek a Medicare billing number. However, these businesses have always been required to provide CMS with provider enrollment information to help ensure the provider/supplier is 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 Form CMS-855S is necessary for initial enrollment in the Medicare program. It is essential to collect this information the first time a DMEPOS supplier enrolls with a Medicare contractor, so that CMS' contractors can: (1) uniquely identify the supplier; (2) confirm the supplier's eligibility and legitimacy; and (3) collect relevant information to process the supplier's claims in a timely and accurate manner.

After the supplier's initial enrollment, the information is collected less frequently and often initiated by the supplier for reasons such as a change of information or to voluntarily withdraw from the Medicare program. It is also be collected as part of the enrollment revalidation process every three years.

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 May 30, 2023 (88 FR 34501). Two comments were received. Comments have been addressed.

The 30-day FR Notice published on September 8, 2023 (88 FR 62086).

No outside consultation was sought.

9. Payment/Gift to Respondents

No payments and/or gifts will be provided to respondents.

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)

As mentioned previously, there are three principal revisions associated with this PRA submission: (1) replacing references thereon to the National Supplier Clearinghouse with the identities of the new Medicare contractors that will process Form CMS-855S enrollment applications; (2) adding a new product to Section 2E4 of the application for "Lymphedema Compression Treatment Items;" and (3) adding checkboxes for suppliers to indicate the reason for which they are exempt from the DMEPOS accreditation requirement in § 424.58.

The first revision, as well as several other minor form edits, will not implicate any burden. These merely involve technical changes to the instructions and adding a checkbox (which had been inadvertently removed in a prior form revision) allowing the supplier to indicate whether he/she is a chiropractor. The second revision will impose additional burden, however. Section 2E4 contains an exhaustive listing of items via which a supplier can indicate the product(s) it furnishes. There are prospective DMEPOS suppliers that will enroll solely to furnish lymphedema compression treatment items (LCTI), meaning they will complete an initial Form CMS-855S enrollment application to furnish this product. This section 12 outlines the burden associated with this second revision and our third revision. It also recalculates our existing burden estimates for the Form CMS-855S based on new data.

12.1 - Wage Estimates

For purposes of this section 12, the following table presents the applicable mean hourly wages according to 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. The first three wage categories largely reflect those used in our current burden estimates. The fourth category (Office and Administrative Support Workers) will be used in our revised estimates.

Table 1: May 2021 BLS National Occupational Employment and Wage Estimates

Occupation Title	Occupation Code	Mean Hourly Wage ($/hr)	Fringe Benefits and Overhead ($/hr)	Adjusted Hourly Wage ($/hr)
Chief Executives	11-1011	102.41	102.41	204.82
Physicians	29-1210	121.38	121.38	242.76
General and Operations Managers	11-1021	55.41	55.41	110.82
Office and Administrative Support Workers, All Other	43-0000	20.47	20.47	40.94

12.2 LCTI

Based on internal CMS data, we estimate that approximately 5,285 suppliers will submit an initial Form CMS-855S enrollment application to furnish LCTIs. Consistent with our revised burden criteria in section 12.4.2 below, we project the following:

(a) It will take office/administrative staff 3.5 hours to complete the LCTI initial Form CMS-855S application. The application will be reviewed and signed by a physician (when the physician is enrolling as an LCTI supplier) or the authorized or delegated official of the enrolling or enrolled LCTI supplier organization, a task that will take 0.5 hours.

(b) 25% of all LCTI initial Form CMS-855S applications will be submitted by physicians and the remaining 75% by organizations. Signers of organizational applications will fall within the aforementioned "General and Operations Managers" BLS wage category.

The foregoing results in a total hour burden of 21,140 hours (5,285 x 4 hr), or 7,047 hours per year. Table 2 outlines the associated cost burden:

Table 2: Annual and Total (3-Year) Cost Burden of LCTI Form CMS-855S Initial Enrollment

Regulation Section(s)	Per Application Hour Breakdown Based on Wage Category	Per Application Cost Breakdown Based on Wage Category	Total Per Application Cost ($)	Number of Applications (Respondents)	Hour Burden	Cost (Rounded to Nearest Dollar) ($)
Physician Submission	Office and Administrative Support Workers (3.5 hours) Physician (0.5 hour)	Office and Administrative Support Workers ($143.29) Physician ($121.38)	264.67	1,321 (440 annual)	5,285 (1,761 annual)	$349,629 ($116,543 annual)
Organizational Submission	Office and Administrative Support Workers (3.5 hours) General and Operations Manager (0.5 hour)	Office and Administrative Support Workers ($143.29) General and Operations Manager ($55.41)	198.70	3,964 (1,321 annual)	15,856 (5,285 annual)	$787,647 ($262,549 annual)
Total	N/A	N/A	N/A	5,285 (1,761 annual)	21,140 (7,047 annual)	$1,137,276 ($379,092 annual)

12.3. Accreditation Checkbox

As mentioned previously, this checkbox will identify the reason for which the supplier is exempt from the DMEPOS accreditation requirements. This checkbox will most typically be completed as part of the DMEPOS supplier's initial enrollment. We estimate that it will take 5 minutes for the supplier's office staff---the persons most likely to complete the Form CMS-855S application, as explained further below----to complete this checkbox (0.0833 hours). Based on current statistics, we further project that approximately 1,685 newly enrolling DMEPOS suppliers per year will complete this checkbox. Using the aforementioned wage category of "Office and Administrative Support Workers, All Other," this results in an estimated annual burden of 140 hours at a cost of $5,732.

12.4 Revision of Burden Estimates

12.4.1 Current Burden Estimates for the Form CMS-855S

Table 2 below outlines the current OMB-approved Form CMS-855S annual burden estimates. These are based on the following:

- The May 2017 BLS hourly wage amounts
- 50 percent of the applications are completed by individuals in the "Chief Executives" BLS category, 25% are completed by persons in the "Physicians" BLS category, and 25% are completed by individuals in the "General and Operations Managers" BLS category.

Table 3: Current OMB-Approved Form CMS-855S Burden Estimates

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 Enrollment	0938-1056	3,429	3,429	4	13,716	Chief Executives (50%) $754.00 Physicians and Surgeons (25%) $825.76 total General and Occupational Managers (25%) $474.80 total $2,055.00 total	28,186,380
Adding a New Business Location	0938-1056	1,242	1,242	1	1,242	Chief Executives (50%) $188.50 Physicians and Surgeons (25%) $206.44 total General and Occupational Managers (25%) $118.70 total $514.00 total	638,388
Reactivation	0938-1056	2,378	2,378	4	9,512	Chief Executives (50%) $754.00 Physicians and Surgeons (25%) $825.76 total General and Occupational Managers (25%) $474.80 total $2,055.00 total	19,547,160
Revalidation	0938-1056	25,956	25,956	2	51,912	Chief Executives (50%) $377.00 Physicians and Surgeons (25%) $412.88 total General and Occupational Managers (25%) $237.40 total	53,365,536

						$1,028.00 total	
Reporting a Change of Information	0938-1056	12,105	12,105	1	12,105	Chief Executives (50%) $188.50 Physicians and Surgeons (25%) $206.44 total General and Occupational Managers (25%) $118.70 total $514.00 total	6,221,970
Voluntarily Withdrawing from Medicare	0938-1056	7	7	0.5	3.5	Chief Executives (50%) $94.25 Physicians and Surgeons (25%) $103.22 total General and Occupational Managers (25%) $59.35 total $257.00 total	900
Annual Total		45,117	45,117	N/A	88,490.5	N/A	107,960,334
3-year total	**0938-1056**	**135,351**	**135,351**	**N/A**	**265,471.5**	**Chief Executives (50%) $7,068.75** **Physicians and Surgeons (25%) $7,741.50 total** **General and Occupational Managers (25%) $1,483.75 total** **$16,294.00 total**	**323,881,002**

12.4.2 – Revised Burden Estimates

Our revised burden estimates are based on the following considerations:

- Up-to-date statistics from PECOS regarding the number of annual Form CMS-855S submissions
- The May 2021 BLS wage estimates (as opposed to the May 2017 figures)

- Incorporation of the aforementioned "Adding a New Business Location" category into the "Reporting a Change of Information" category. (The application receipts and costs for both categories will be combined. (The change of information category hour burden, however, will remain at 1 hour.) We believe that combining the two categories is appropriate since both involve the effective reporting of changed data.)

- As noted in section 12.2:

  (i) Each application (regardless of transaction type) will be completed by office staff, which is consistent with the approach we have taken with most of our provider enrollment related applications. The application will be signed by a physician (when the physician is enrolling as a DMEPOS supplier) or the authorized or delegated official of the enrolling or enrolled DMEPOS supplier organization.

  (ii) The "Hourly Labor Cost of Reporting" Category below outlines the amount of time that: (1) office personnel spends completing each application; and (2) the physician or managerial personnel (as applicable) spends reviewing and signing the application.

- For our current OMB-approved Form CMS-855S burden estimates, we projected that 50% of these applications are completed by large organizations, 25% by retail store managers, and 25% by physicians. Consistent with these figures, we will project for our revised estimates that 25% of all Form CMS-855S applications (regardless of transaction type) are submitted by physicians and the remaining 75% by organizations. Signers of organizational applications will fall within the aforementioned "General and Operations Managers" BLS wage category.

- The "Initial Enrollment" category below includes the above-referenced estimates for the accreditation checkbox and the annual LCTI initial enrollment applications.

12.4.2.1 – Revised Hour Burden Estimates

Table 3 outlines our requested revised Form CMS-855S hour burden estimates.

Table 4: Revised Form CMS-855S Annual Hour Burden Estimates -- Hours

Regulation Section(s)	Number of Respondents	Number of Responses	Burden per Response (hours)	Hour Breakdown Per Personnel Category	Total Annual Burden (hours)
Initial Enrollment	6,716	6,716	4	Office and Administrative Support Workers (3.5 hours) Physician or Managerial Personnel (0.5 hour)	26,864
Reactivation	2,508	2,508	4	Office and Administrative Support Workers (3.5 hours) Physician or Managerial Personnel (0.5 hour)	10,032
Revalidation	8,099	8,099	2	Office and Administrative Support Workers (1.75 hours) Physician or Managerial Personnel (0.25 hour)	16,198
Reporting a Change of Information	14,117	14,117	1	Office and Administrative Support Workers (0.8 hours) Physician or Managerial Personnel (0.2 hour)	14,117
Voluntarily Withdrawing from Medicare	1,350	1,350	0.5	Office and Administrative Support Workers (0.4 hours) Physician or Managerial Personnel (0.1 hours)	675
Annual Total	32,790	32,790	Varies	N/A	67,886
3-year total	**98,370**	**98,370**	**Varies**	**N/A**	**203,658**

12.4.2.2 – Revised Cost Burden Estimates

12.4.2.2.1 – Physicians Applications Only

Table 5 outlines the annual projected Form CMS-855S costs for applications submitted by physicians. The "Number of Respondents" and "Number of Responses" categories (see Table 4 above) are combined into a single category titled, "Number of Applications." The figures in this category are 25% of those in each of the above "Number of Respondents" and "Number of Responses" categories (which reflects that 25% of applications are submitted by physicians). For instance, the latter two categories listed 6,716 initial enrollment applications. The number of initial enrollment applications listed in Table 4 is 1,679, or 25% of 6,716.

Table 4: Revised Form CMS-855S Cost Burden Estimates – Physicians Only

Regulation Section(s)	Per Application Hour Breakdown Based on Wage Category	Per Application Cost Breakdown Based on Wage Category	Total Per Application Cost	Number of Applications	Total Cost (Rounded to Nearest Dollar)
Initial Enrollment	Office and Administrative Support Workers (3.5 hours) Physician (0.5 hour)	Office and Administrative Support Workers ($143.29) Physician ($121.38)	264.67	1,679	444,381
Reactivation	Office and Administrative Support Workers (3.5 hours) Physician (0.5 hour)	Office and Administrative Support Workers ($143.29) Physician ($121.38)	264.67	627	165,948
Revalidation	Office and Administrative Support Workers (1.75 hours) Physician (0.25 hour)	Office and Administrative Support Workers ($71.65) Physician ($60.69)	132.34	2,025	267,989
Reporting a Change of Information	Office and Administrative Support Workers (0.8 hours) Physician (0.2 hour)	Office and Administrative Support Workers ($32.75) Physician ($48.55)	81.30	3,529	286,908
Voluntarily Withdrawing from Medicare	Office and Administrative Support Workers (0.4 hours) Physician (0.1 hours)	Office and Administrative Support Workers ($16.38) Physician ($24.28)	40.66	338	13,743
Annual Total	N/A	N/A	N/A	8,198	1,178,969
3-year total	**N/A**	**N/A**	**N/A**	**24,594**	**3,536,907**

12.3.2.2.2 – Organizational Applications

Table 5 outlines the annual projected Form CMS-855S costs for applications submitted by organizations. As with Table 4, the "Number of Respondents" and "Number of Responses" categories are combined into a single category titled, "Number of Applications." The figures in this category are 75% of those in each of the "Number of Respondents" and "Number of Responses" categories. To illustrate, the number of initial enrollment applications listed in Table 5 is 3,716, or 75% of 4,955.

Table 5: Revised Form CMS-855S Cost Burden Estimates -- Organizations

Regulation Section(s)	Per Application Hour Breakdown Based on Wage Category	Per Application Cost Breakdown Based on Wage Category	Total Per Application Cost	Number of Applications	Total Cost (Rounded to Nearest Dollar)
Initial Enrollment	Office and Administrative Support Workers (3.5 hours) General and Operations Manager (0.5 hour)	Office and Administrative Support Workers ($143.29) General and Operations Manager ($55.41)	198.70	5,037	1,000,852
Reactivation	Office and Administrative Support Workers (3.5 hours) General and Operations Manager (0.5 hour)	Office and Administrative Support Workers ($143.29) General and Operations Manager ($55.41)	198.70	1,881	373,755
Revalidation	Office and Administrative Support Workers (1.75 hours) General and Operations Manager (0.25 hour)	Office and Administrative Support Workers ($71.65) General and Operations Manager ($27.71)	99.36	6,074	603,513
Reporting a Change of Information	Office and Administrative Support Workers (0.8 hours) General and Operations Manager (0.2 hour)	Office and Administrative Support Workers ($32.75) General and Operations Manager ($22.16)	54.91	10,588	581,387
Voluntarily Withdrawing from Medicare	Office and Administrative Support Workers (0.4 hours) General and Operations Manager (0.1 hours)	Office and Administrative Support Workers ($16.38) General and Operations Manager ($11.08)	27.46	1,013	27,817

Annual Total	N/A	N/A	N/A	24,593	2,587,324
3-year total	**N/A**	**N/A**	**N/A**	**73,779**	**7,761,972**

12.3.2.2.3 – Total Revised Cost Burden

Table 6 combines the total costs outlined in Table 4 and 5.

Table 6: Revised Total Form CMS-855S Cost Burden Estimates

Regulation Section(s)	Total Cost (Rounded to Nearest Dollar)
Initial Enrollment	1,445,233
Reactivation	539,703
Revalidation	871,502
Reporting a Change of Information	868,295
Voluntarily Withdrawing from Medicare	41,560
Annual Total	3,766,293
3-year total	**11,298,879**

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 accreditation exemption checkbox data and processing LCTI initial Form CMS-855S applications. Our estimates are as follows:

(i) As previously mentioned, 1,685 initially enrolling DMEPOS suppliers will complete the accreditation checkbox per year. We project that it will take the MAC 5 minutes (or 0.0833 hours) to process this information.

(ii) Also, as already noted, 1,761 suppliers per year will submit an LCTI initial Form CMS-855S application. We estimate that it will take the MAC 6 hours to process each application.

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 $377,614 ((1,685 x $35.27 x 0.0833) + (1,761 x 6 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; and (3) performing outreach as needed. 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 30 hours. This results in a total cost of $1,825.

15. Changes in Burden/Program Changes

This section 15 outlines the burden changes from our May 2017 OMB-approved estimates outlined Table 7:

15.1 Hour Burden Changes

Table 7: Change in Form CMS-855S Hour Burden

Regulation Section(s)	Currently Approved Estimates	Revised Estimates	Net Change
Initial Enrollment	13,716	26,864	+ 13,148
Adding a New Business Location	1,242	0	- 1,242
Reactivation	9,512	10,032	+ 520
Revalidation	51,912	16,198	- 35,714
Reporting a Change of Information	12,105	14,117	+ 2,012
Voluntarily Withdrawing from Medicare	3.5	675	+ 671.5
Annual Total	88,490.5	67,886	- 20,604.5
3-year total	**265,471.5**	**203,658**	**- 61,813.5**

15.2 Cost Burden Changes

Table 8: Change in Form CMS-855S Cost Burden

Regulation Section(s)	Currently Approved Estimates	Revised Estimates	Net Change
Initial Enrollment	28,186,380	1,445,233	- 26,741,147
Adding a New Business Location	638,388	0	- 638,388
Reactivation	19,547,160	539,703	- 19,007,457
Revalidation	53,365,536	871,502	- 52,494,034
Reporting a Change of Information	6,221,970	868,295	- 5,353,675
Voluntarily Withdrawing from Medicare	900	41,560	+ 40,660
Annual Total	107,960,334	3,766,293	- 104,194,041
3-year total	**323,881,002**	**11,298,879**	**- 312,582,123**

The large reduction in cost burden is due almost exclusively to our more accurate per application costs. To illustrate, our current OMB-approved per application cost for initial enrollments is $2,055. (See Table 2.) Our revised estimate is $198.70, which is more consistent with our per application costs for other CMS-855 forms.

16. Publication/Tabulation

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

17. Expiration Date

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