***Supporting Statement for Paperwork Reduction Act Submissions***

# Medicare Enrollment Application for Physician and Non-Physician Practitioners

# CMS-855I/OMB control number: 0938-1355

## BACKGROUND

The primary function of the Form CMS-855I Medicare enrollment application for physicians and non-physician practitioners is to gather information from an individual supplier that tells us who the person is, whether the individual meets certain qualifications to be a Medicare health care supplier, where the person practices or renders services, and other information necessary to establish correct claims payments.

The purpose of this Information Collection Request (ICR) submission is to request approval of revisions to the Form CMS-855I as well as a 3-year extension. In general, these changes will gather and clarify certain data to help: (1) Medicare Administrative Contractors (MACs) validate the accuracy and completeness of the information the supplier furnishes; and (2) ensure that payments are made only to qualified and legitimate suppliers.

**B. 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 allowing payment.

* 42 C.F.R. section 424.500 state the requirements for enrollment, periodic resubmission and certification of enrollment information for revalidation, and timely reporting of updates and changes to enrollment information. These requirements apply to all providers and suppliers except for physicians and practitioners who have entered into a private contract with a beneficiary as described in part 405, subpart D of this chapter. Providers and suppliers must meet and maintain these enrollment requirements to bill either the Medicare program or its beneficiaries for Medicare covered services or supplies.
* Sections 1814(a), 1815(a), and 1833(e) of the Act require the submission of information necessary to determine the amounts due to a provider or other person.
* 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 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.
* 42 C.F.R. section 424.502, defines enrollment and enrollment related terms.
* 42 C.F.R. section 424.80 addresses reassignments of benefits.
* The Patient Protection and Affordable Care Act (PPACA), section 6405 - "Physicians Who Order Items or Services Required to be Medicare Enrolled Physicians or Eligible Professionals" contains a requirement for certain physicians and other eligible professionals to enroll in the Medicare program for the sole purpose of ordering or certifying items or services for Medicare beneficiaries.
* Sections 1102 and 1871 of the Act, which provide general authority for the Secretary to prescribe regulations for the efficient administration of the Medicare program
* 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.
* 5 U.S.C. 522(b)(4) and Executive Order 12600 protect privileged or confidential commercial or financial information from public disclosure.

The Form CMS-855 applications collect this information, including the data necessary to uniquely identify and enumerate the provider/supplier. Additional information needed to ensure that providers and suppliers meet all applicable Medicare requirements and to process claims accurately and timely is also collected on the Form CMS-855 applications.

1. *Purpose and users of the information*

The Form CMS-855I is presently submitted by physicians, non-physician practitioners, and eligible professionals to initially enroll in Medicare, reassign their benefits under § 424.80, and, thereafter, to: (1) revalidate Medicare enrollment; (2) reactivate Medicare enrollment; (3) enroll as an individual practitioner if he/she is currently enrolled as an ordering/certifying supplier; (4) enroll with another MAC in a different geographic location; (5) report a change to current Medicare enrollment information; and (6) voluntary terminate the individual’s Medicare enrollment, as applicable.

The MAC establishes Medicare identification numbers. The MACs store these numbers and information in CMS’ Provider Enrollment, Chain and Ownership System (PECOS). CMS’ contractors use the application to collect data confirming that the applicant has the necessary information for unique identification and complies with all applicable requirements for enrollment. To help confirm such compliance, the MAC verifies the accuracy of the data furnished on the Form CMS-855I using various validation means. For instance, state licensing websites validate reported license numbers, and the Social Security Administration database validates SSNs.

The collection and verification of enrollment information is the first line of defense in protecting our beneficiaries and the Medicare Trust Funds from fraudulent activity and from unqualified physicians, non-physician practitioners, and other eligible professionals.  It gathers information that allow the MACs to ensure that only legitimate physicians, non-physician practitioners, and other eligible professionals enroll in the Medicare program and are not sanctioned from the Medicare and/or Medicaid program(s), or debarred, or excluded from any other Federal agency or program. This is the sole instrument implemented for this purpose.

1. *Improved Information Techniques*

This collection lends itself to electronic collection methods and is presently available through the CMS website. 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. In addition, PECOS is an electronic Medicare enrollment system through which providers and suppliers can submit Medicare enrollment applications, view and print enrollment information, update enrollment information, complete the enrollment revalidation process, voluntarily withdraw from the Medicare program, and track the status of a submitted Medicare enrollment application. The data stored in PECOS mirrors the data collected on the various Form CMS-855 applications and is maintained indefinitely as both historical and current information. At present, approximately 67% of individual suppliers use the electronic method of enrolling in Medicare via PECOS.

1. *Duplication and Similar Information*

There is no duplicative information collection instrument or process.

1. *Small Business*

A Medicare billing number is required of all health care suppliers who wish to submit claims for Medicare; this ICR submission will therefore affect some small businesses in this category. However, these individuals have always been required to provide CMS with the same information in order to enroll in Medicare, to submit information for CMS to ensure the supplier is legitimate, and to collect information to successfully process their Medicare claims.

1. *Less Frequent Collections*

This information is collected on an as needed basis. The data provided on these forms 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 the MACs can: (1) uniquely identify the provider/supplier; (2) ensure the provider’s/supplier’s eligibility and legitimacy; (3) determine if the provider/supplier meets all statutory and regulatory requirements and are properly credentialed in their specialty (if applicable); and (4) collect relevant information to process the provider’s/supplier’s claims in a timely and accurate manner.

After initial enrollment, the information is collected less frequently and is typically initiated by the supplier for the reasons described in Section 2 above. To ensure uniform data submissions, CMS requires that all changes to previously submitted enrollment data be reported via this enrollment application or its equivalent in the PECOS system.

1. *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
* 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
* 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.

1. *Federal Register Notice/Outside Consultation*

A 60-day Notice will publish in the Federal Register on\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

No outside consultation was sought.

1. *Payment/Gift to Respondents*

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

1. *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.

1. *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 commonly considered private.

1. *Burden Estimates (hours and cost)*

a. Introduction and Wages

This Section 12 outlines our requested Form CMS-855I revisions that we believe will involve: (1) a change in burden for suppliers that complete this application; or (2) an explanation of why no burden change is involved. (Other application revisions not involving a burden change or requiring additional explanation are listed in the “Summary of Form CMS-855I Changes” Excel spreadsheet.)

As a baseline for calculating the cost impact of our Form CMS-855I changes, we will use the following median wage categories and hourly rates from the U.S. Bureau of Labor Statistics’ (BLS) May 2024 National Occupational Employment and Wage Estimates for all salary estimates (<http://www.bls.gov/oes/current/oes_nat.htm>):

**TABLE 1: NATIONAL OCCUPATIONAL EMPLOYMENT AND WAGE ESTIMATES**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Occupation Title** | **Occupation Code** | **Median Hourly Wage ($/hr)** | **Fringe Benefits and Overhead ($/hr)** | **Adjusted Hourly Wage ($/hr)** |
| Office and Administrative Support Workers | 43-0000 | 22.27 | 22.27 | 44.54 |
| Physicians | 29-1210 | 115.00 | 115.00 | 230.00 |
| Healthcare Diagnosing or Treating Practitioners | 29-1000 | 48.74 | 48.74 | 97.48 |

b. Assumptions

In calculating the estimated burden of our changes, we will assume the following

* Office and administrative personnel (code 43-0000 above) complete each application, and the physician (29-1210) or non-physician practitioner (29-1000)(hereafter “practitioner”) reviews and signs it.
* Consistent with prior estimates, two-thirds (67 percent) of applications are submitted by physicians and one-third (33 percent) by practitioners.
* Application Categories -- There are seven categories of Form CMS-855I applications:
  + Initial enrollments
  + Individual currently enrolled via the Form CMS-855O solely to order/certify services and items and now wants to enroll as an individual practitioner via the Form CMS-855I
  + Individual is enrolling with another MAC
  + Revalidations
  + Reactivations
  + Changes of information
  + Voluntary terminations

As we do not believe our Form CMS-855I changes will involve voluntary terminations, this category will not invoke any new burden. Except as otherwise noted, voluntary terminations will therefore not be addressed in this Supporting Statement.

c. Current Burdens

Tables 2 and 3 below outline, respectively, the current per-application hour burden associated with each Form CMS-855I and the existing total, OMB-approved hour and cost burdens for each application category. Each category includes applications submitted by physician and practitioners.

**TABLE 2 – CURRENT PER-APPLICATION HOUR BURDEN**

| **Reason for Submittal** | **Hours for Completion by Office/Admin Personnel** | **Hours for a Physician/Practitioner to Review and Sign CMS-855I** | **Total Hours per CMS-855I** |
| --- | --- | --- | --- |
| Initial Enrollment | 2.75 | 0.5 | 3.25 |
| Currently Enrolled via CMS-855O as Ordering/  Certifying Supplier and Now Enrolling as Individual Supplier | 1.5 | 0.5 | 2 |
| Enrolling with Another MAC | 1.5 | 0.5 | 2 |
| Revalidation | 1.5 | 0.5 | 2 |
| Reactivation | 1.5 | 0.5 | 2 |
| Change of Information | 0.75 | 0.25 | 1 |

**TABLE 3 – CURRENT OMB-APPROVED TOTAL HOUR AND COST BURDEN**

|  |  |  |  |
| --- | --- | --- | --- |
| **Reason for Submittal** | **Total Number of CMS-855Is Processed Per Year** | **Total Hour Burden Per Year (Total Number Processed x Hours Per CMS-855I Submission Reason from Table 2)** | **Total Cost Burden Per Year (Hours x Hourly Wage)** |
| Initial Enrollment | 188,443 | 612,440 | $36,804,897 |
| Currently Enrolled via CMS-855O as Ordering/  Certifying Supplier and Now Enrolling as Individual Supplier | 6,190 | 12,380 | $966,171 |
| Enrolling with Another MAC | 1,088 | 2,176 | $161,033 |
| Revalidation | 101,890 | 203,780 | $15,080,566 |
| Reactivation | 18,053 | 36,106 | $2,671,994 |
| Reporting a Change of Medicare Enrollment Information | 479,544 | 479,544 | $35,490,620 |
| **GRAND TOTAL (Includes Current Voluntary Termination Burden)** | **812,975** | **1,355,310** | **$91,717,033** |
| **3 YEAR TOTAL (Grand Total x 3)** | **2,438,925** | **4,065,930** | **$275,151,099** |

d. Specific Form Changes

This Section 12(d) et seq. addresses the changes we are proposing to the Form CMS-855I application. Note that:

* None of our new/revised data elements will trigger the need to complete any application in full other than a change of information. The only additional burden for these other five application types (e.g., initials, enrolling with another MAC) will include the new data element itself. To illustrate, one of our new data elements might take a supplier 3 minutes to complete on an initial application. The burden would not be 3.25 hours – the standard burden for completing an initial application – because the data element is not triggering the initial application; rather, the supplier’s desire to enroll in Medicare is. The only new burden would be the 3 minutes it would take the supplier to address the new data element when completing the full application. However, for changes of information triggered by a change in the supplier’s information regarding one of our proposed new data elements, the full, 1-hour burden will be applied.
* For all application categories other than changes of information, we will only use the above-referenced $44.54 wage for administrative staff. We will not use the physician or practitioner wages. This is because the signature burden for physicians and practitioners is already included in the current OMB-approved burden; the only changed burden will, again, involve the revised section of the application that administrative staff will complete. For instance, suppose a supplier is submitting a Form CMS-855I reactivation application. As part of this, it must complete a new data element in Section 2. The new burden will only involve administrative staff’s furnishing of this information. The physician or practitioner will not have additional burden, for said person will still sign the application regardless of whether the new data element was added to the form.
* The only proposed data elements addressed in this Section 12 are those that: (1) impose new burden; or (2) require additional explanation as to why no additional burden will ensue. All other changes (e.g., revisions to the Form CMS-855I instructions) are outlined in the “List of Changes” spreadsheet associated with this PRA submission.

1. Additional Reasons for Submittal of Application (Section 1(A))

Section 1(A) of the Form CMS-855I lists the seven reasons (outlined in Section 12(b) above) for the individual’s submission of the application. The individual must indicate the submittal reason. We are adding two new reasons to Section 1(A):

* Solely enrolling in Medicare to participate in Medicaid or another health care program and will not be billing Medicare.
* Enrolling to file claims for emergency/urgent care services while opted-out

We anticipate no burden changes from this addition. It merely gives the individual additional options for identifying the submission reason.

(2) Drug Enforcement Administration (DEA) Registration Information (Section 2(B)(3))

If the physician or practitioner has a DEA Certificate of Registration, it must in Section 2(B)(3) list the DEA registration number, the certificate’s effective date, and the state where it was issued. We are adding the following language below this section: “NOTE: If this section is completed, submit a copy of your DEA registration.” This will not result in additional burden because these persons must already submit these certificates.

(3) Physician Specialties (Section 2(G))

Physicians must check the appropriate box in Section 2(G) indicating their specialty. We are adding the following specialties to Section 2(G): dental anesthesiology, dental public health, endodontics, epileptologists, oral and maxillofacial pathology, oral and maxillofacial radiology, oral and maxillofacial surgery, oral medicine, orofacial pain, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics, and prosthodontics. We are also removing the specialties of (i) maxillofacial surgery and (ii) oral surgery.

We do not anticipate any change in burden from these revisions. They merely give physicians more options with which to identify their specialty.

(4) Practitioner/Eligible Professional Specialty Type (Section 2(H))

Similar to Section 2(G), practitioners must indicate their supplier type in Section 2(H). We are: (1) adding marriage and family therapists as well as mental health counselors as supplier types; and (2) change the “qualified speech language pathologist” type to “speech language pathologist in private practice”. There will be no burden changes associated with these revisions; we will only be furnishing practitioners additional options for selection.

(5) Final Adverse Actions (Section 3)

Sections 3 of the Form CMS-855I requires the physician /practitioner to identify any of the final adverse actions listed in Section 3 (e.g., felony conviction). One such action, listed in Section 3(B)(6), is any current or past Medicaid exclusion, revocation, or termination of any billing number. We are changing this to include exclusions, revocations, and terminations from any federal health care program, not simply Medicaid. As physicians and practitioners have not previously been required to report non-Medicaid federal health care program exclusions, revocations, or terminations in Section 3 of the Form CMS-855I, we have no historical data upon which we can base a projected burden in reporting the information. We request comments from stakeholders on the potential burden.

(6) Beneficiary Records Storage Address (Section 4(D)) and Rendering Services in Patients’ Homes (Section 4(E))

Section 4(D) has two subsections: 4(D)(1) and 4(D)(2). There are checkboxes at the top of Section 4(D) via which the supplier can indicate whether they are reporting a change to any of their current Section 4(D) data. We are moving and duplicating these boxes such that one set will be immediately above Section 4(D)(1) and another above Section 4(D)(2). This will make it clearer which of the two subsections has the changed data. We do not foresee any burden change from this revision. It only adds more checkboxes by which the supplier can report the requested change.

For the same reason, we are making similar revisions to Section 4(E) by adding “Change” checkboxes under each subsection rather than having a sole checkbox at the top of Section 4(E). No burden change is anticipated.

(7) Beneficiary Records – Electronic Storage (Section 4(D)(2))

If the supplier stores patient records electronically, the supplier must currently explain where/how the records are stored (e.g., website). We are revising Section 4(D)(2) to instead require the supplier to list the legal business name, tax identification number, and address of the company the supplier uses for record storage. This change would give us more robust data about the storage entity. We believe this additional required information will result in an increased burden. Table 4 outlines said burden. It is based primarily on the following:

* For Applications Other Than Changes of Information
  + We estimate that 80 percent of Form CMS-855I initial, revalidation, and reactivation applications -- as well as enrollments with another MAC and those from formerly CMS-855O enrolled individuals -- would list an address in Section 4(D)(2).
  + It would take an individual 2 minutes (0.0333/hr.) longer to submit the address than to explain where/how the records are stored.
  + The aforementioned $44.54 wage figure will be used, since administrative personnel will furnish this additional data when completing the application.
* For Changes of Information - We have no historical data to help us predict the number of changes of information that will be submitted to report a revision to the new data in Section 4(D)(2). Solely as a means of soliciting comment on the possible burden, we estimate that 1,000 such changes will be submitted per year – 333 for practitioners and 667 for physicians, resulting in an annual hour burden of 1,000 (1,000 submissions x 1 hour).) For practitioners, the annual cost burden would be $19,241 ((.25/hr. x $97.48) + (.75/hr. x $44.54) x 333 applications). For physicians, the cost burden is $60,546 ((.25/hr. x $230.00) + (.75/hr. x $44.54) x 666). The total cost burden is thus $79,787.

**TABLE 4 – BURDEN OF REVISION TO SECTION 4(D)(2)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Reason for Submittal** | **Total Number of Impacted CMS-855Is** | **Total Hour Burden Per Year (Reflects the Total Number Impacted x 0.0333); Does Not Include Changes of Information)** | **Total Cost Burden Per Year (Reflects Total Hours x $44.54; Does Not Include Changes of Information)** |
| Initial Enrollment \* | 150,754 | 5,020 | $223,591 |
| Currently Enrolled via CMS-855O as Ordering/  Certifying Supplier and Now Enrolling as Individual Supplier \* | 4,952 | 165 | $7,349 |
| Enrolling with Another MAC \* | 870 | 29 | $1,292 |
| Revalidation \* | 81,512 | 2,714 | $120,882 |
| Reactivation \* | 14,442 | 481 | $21,424 |
| Reporting a Change of Medicare Enrollment Information | 1,000 | 1,000 | $79,787 |
| **TOTALS** | **N/A** | **9,409** | **$454,325** |

\* As noted, these figures represent 80 percent of the currently approved application totals in Table 3 (e.g., 188,443 x .80). These are not new application submissions but merely represent current application submissions that will report the new Section 4(D)(2) data. That is, the “total applications processed” figures in Table 3 for these five application categories are not changing, for these applications would be submitted anyway. Only the additional 2 minute burden reflects a change, as evidenced in the new burden projections.

Table 5 outlines our requested new ICR burdens. They reflect the following:

* Excluding changes of information, the “total number processed” category has the same figures as in Table 3. For changes of information, the category reflects the currently-approved total of 479,544 (see Table 3) plus 1,000 new submissions (see Table 4).
* The “total hour burden” and “total cost burden” categories reflect the combination of the figures in the same two categories of Tables 3 and 4 (e.g., for enrollments with another MAC, combines 2,176 hours (Table 3) + 29 hours (Table 4), totaling 2,205 hours.

**TABLE 5 – FINAL OMB-REQUESTED HOUR AND COST BURDEN**

|  |  |  |  |
| --- | --- | --- | --- |
| **Reason for Submittal** | **Total Number of CMS-855Is Processed Per Year** | **Total Hour Burden Per Year** | **Total Cost Burden Per Year** |
| Initial Enrollment | 188,443 | 617,460 | $37,028,488 |
| Currently Enrolled via CMS-855O as Ordering/  Certifying Supplier and Now Enrolling as Individual Supplier | 6,190 | 12,545 | $973,520 |
| Enrolling with Another MAC | 1,088 | 2,205 | $162,325 |
| Revalidation | 101,890 | 206,494 | $15,201,448 |
| Reactivation | 18,053 | 36,587 | $2,693,418 |
| Reporting a Change of Medicare Enrollment Information | 480,544 | 480,544 | $35,570,407 |
| VT | 17,767 | 8,884 | $541,752 |
| **GRAND TOTAL (Includes Current Voluntary Termination Burden)** | **813,975** | **1,364,719** | **$92,171,358** |
| **3 YEAR TOTAL (Grand Total x 3)** | **2,441,925** | **4,094,157** | **$276,514,074** |

1. *Cost to Respondents (Capital)*

There are no capital costs associated with this collection.

1. *Cost to Federal Government*

*14.1 MACs*

We anticipate additional costs to the MACs in processing the above-referenced 1,000 Form CMS-855I initial enrollment applications. Total costs are based on a MAC hourly wage equivalent to a GS-9, Step 5 (Washington/Baltimore/Arlington locality), which is $37.97. (See <https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/25Tables/html/DCB_h.aspx>.) Although the figure often varies by particular application, it normally takes a MAC approximately 2 hours to process a Form CMS-855I change of information application. This would result in an additional burden to the MACs of $75,940 (1,000 x 2 x $37.97).

*14.2 Federal Government*

The cost to the Federal government will mostly involve the ICR process associated with this data submission. The hourly wage of said employee is at a GS-13, Step 5 level (Washington/Baltimore/Arlington locality), or $65.48. (See <https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2023/DCB_h.pdf>.) We estimate that the applicable tasks will take a total of 60 hours. This results in a total cost of $3,929.

1. *Changes in Burden/Program Changes*

Table 6 in this Section 15 outlines the response, respondent, and burden changes associated with this ICR.

**TABLE 6 – BURDEN CHANGES**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Application Type** | **Data Category** | **Current Burden** | **New Burden** | **Net Change** |
| Initial Application | Hour Burden | 612,440 | 617,460 | + 5,020 hours |
| Initial Application | Cost Burden | $36,804,897 | $37,028,488 | + $223,591 |
| CMS-855O Enrollee Initially Enrolling Via CMS-855I | Hour Burden | 12,380 | 12,545 | + 165 hours |
| CMS-855O Enrollee Initially Enrolling Via CMS-855I | Cost Burden | $966,171 | $973,520 | + $7,349 |
| Enrolling w/Another MAC | Hour Burden | 2,176 | 2,205 | + 29 hours |
| Enrolling w/Another MAC | Cost Burden | $161,033 | $162,325 | + $1,292 |
| Revalidation | Hour Burden | 203,780 | 206,494 | + 2,714 hours |
| Revalidation | Cost Burden | $15,080,566 | $15,201,448 | + $120,882 |
| Reactivation | Hour Burden | 36,106 | 36,587 | + 481 hours |
| Reactivation | Cost Burden | $2,671,994 | $2,693,418 | + $21,424 |
| Change of Information | Hour Burden | 479,544 | 480,544 | + 1,000 |
| Change of Information | Cost Burden | $35,490,620 | $35,570,407 | + $79,787 |
| Change of Information | Respondents | 479,544 | 480,544 | + 1,000 |
| Change of Information | Responses | 479,544 | 480,544 | + 1,000 |

1. *Publication/Tabulation*

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

1. *Expiration Date*

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