Supporting Statement For Paperwork Reduction Act Submissions For FORM CMS-2552-96

General Instructions

A Supporting Statement, including the text of the notice to the public required by 5 CFR 1320.5(a)(I)(iv) and its actual or estimated date of publication in the Federal Register, must accompany each request for approval of a collection of information. The Supporting Statement must be prepared in the format described below, and must contain the information specified in Section A below. If an item is not applicable, provide a brief explanation. When Item 17 of the OMB Form 83-I is checked "Yes," Section C of the Supporting Statement must be completed. OMB reserves the right to require the submission of additional information with respect to any request for approval.

Specific Instructions

A. Background

1. CMS is requesting the Office of Management and Budget (OMB) review and approval of for Form CMS-2552-96, Hospital and Health Care Complex Cost Report. Revisions have been made to the original forms and have been incorporated within this request for approval. This Cost Report Forms is filed annually by freestanding providers participating in the Medicare program to effect year end cost settlement for providing services to Medicare beneficiaries.

   42 CFR 413.20 and 413.24 require adequate cost data and cost reports from providers on an annual basis. The data submitted on the cost reports supports management of Federal programs.

   Providers receiving Medicare reimbursement must provide adequate cost data based on financial and statistical records, which can be verified by qualified auditors.

B. Justification

1 . Need and Legal Basis

Providers of services participating in the Medicare program are required under sections 1815(a) and 1861(v)(1)(A) of the Social Security Act (42 USC 1395g) to submit annual information to achieve settlement of costs for health care services rendered to Medicare beneficiaries.

The CMS-2552-96 cost report is needed to determine the amount of reimbursable cost, based upon the cost limits, that is due these providers furnishing medical services to Medicare beneficiaries.

2. Information Users

In accordance with sections 1815(a), 1833(e) and 1861(v)(1)(A) of the Social Security Act, providers of service in the Medicare program are required to submit annual information to achieve reimbursement for health care services rendered to Medicare beneficiaries. In addition, 42 CFR 413.20(b) requires that cost reports will be required from providers on an annual basis. Such cost reports are required to be filed with the provider's fiscal intermediary/contractor. The functions of the fiscal intermediary are described in section 1816 of the Social Security Act.

The Fiscal Intermediary uses the cost report not only to make settlement with the provider for the fiscal period covered by the cost report, but also in deciding whether to audit the records of the provider. 42 CFR 413.24(a) requires providers, receiving payment on the basis of reimbursable cost, to provide adequate cost data based on their financial and statistical records which must be capable of verification by qualified auditors.

Besides determining program reimbursement, the data submitted on the cost reports supports management of the Federal programs. These data are extracted from the cost report, by the fiscal intermediaries/contractors, for transmission to CMS, and are used by the Office of the Actuary in making projections of Medicare Trust Fund requirements and by CMS to develop the cost limits per discipline. In addition, the data is available to Congress, researchers, universities, and other interested parties.

However, the collection of data is a secondary function of the cost report, whose primary function is the reimbursement of providers for services rendered to program beneficiaries.

3. Use of Information Technology

Consideration has been given to reduction of burden by the use of improved information technology to report required cost data. While some providers compute the cost report manually, the majority of providers use an automated cost report preparation process. The use of a computer in the preparation results in a significant reduction of burden. CMS has, in the past, encouraged providers to submit their cost reports using automated cost report preparation packages on a voluntary basis. However, for cost reporting periods ending on or after March 31, 1997, Skilled Nursing Facilities and Home Health Agencies are required to submit via an electronic medium.

On August 22, 2003, CMS published a final rule in the Federal Register (Vol. 68 No 163) to

add the requirement that for cost reporting periods ending on or after December 31, 2004, Hospice, Organ Procurement Organization/ Histocompatibility Laboratory (OPO), Independent Rural Health Clinic (RHC), Federally Qualified Health Center (FQHC), Outpatient Rehabilitation for Community Mental Health Clinic (CMHC), and Independent End-Stage Renal Dialysis Facility (ESRD), providers must submit cost reports in a standardized electronic format.

4. Duplication of Efforts

The cost report is a unique form that does not duplicate any other CMS information collection. This form specifically provides for the reimbursement methodology that is unique to freestanding home health agencies. No other existing form can be modified for this purpose.

5. Small Businesses

This form has been designed with a view towards minimizing the reporting burden for small providers. Worksheets are completed on an as-needed basis which is dependent on the complexity of the provider. Consequently, the burden imposed on them is minimized. A provider may submit its own computer generated forms for their use only in lieu of the forms provided by CMS. These computer prepared cost reports, however, must be reviewed by CMS or affected intermediary/contractor before being placed into use.

6. Less Frequent Collection

If the annual cost reports are not filed, the Secretary will be unable to determine whether proper payments are being made under Medicare. If a provider fails to file a cost report by the statutory due date, it is notified that interim payments are reduced unless a cost report is filed. If the report is not filed within another 30 days, interim payments are suspended. Finally, if a provider fails to file a cost report, all interim payments made since the beginning of the cost reporting periods may be deemed to be overpayments, and recovery action may be initiated.

7. Special Circumstances

This information collection complies with all general information collection guidelines in 5 CFR 1320.6.

8. Federal Register/Outside Consultation

CMS has published a 60-day Federal Register notice on November 29, 2007.
CMS consulted with the hospice associations to seek their advice on this form when it was developed. No other consultation has taken place since then.

9. Payments/Gifts to Respondents

There is no payment/gift to respondents.

10. Confidentiality

Confidentiality is not pledged. Medicare cost reports are subject to disclosure under the Freedom of Information Act.

11. Sensitive Questions

There are no sensitive questions.

12. Burden Estimates (Hours & Wages)

Hospital Cost Report

It takes, on average, a hospital 662 hours to fill out a cost report. There are 6,175 hospitals, so the annual national burden will be 4,090,474 hours. The number of hospital has increased by 66 causing an increase in the hourly burden. Thus, the previous total estimate of burden of 4,046,782 hours of record keeping and reporting burden representing will increase by 43,692 hours.

The cost of burden is calculated as the number of hours of paperwork burden of 4,090,474 times the standard rate of $12 per hour, or $49,085,688. This represents an increase of $524,304.

13. Capital Costs

There are no capital costs.

14. Cost to Federal Government

Hospital Cost Report

Annual Cost:
Cost associated with distribution of forms and instructions:

Printing initial distribution 6,175 copies of Form CMS-2552-96 forms and instructions will be issued as a part of the Provider Reimbursement Manual. Accordingly when changes are made to the forms and/or instructions only the pages changed will require reprinting not the entire cost report or instructions.	$30,000.00

Annual cost to intermediaries:
Annual costs incurred are related to processing information contained on the forms,

particularly associated with achieving settlements. Intermediaries handling costs are based on what intermediaries spent in 2007. This information comes from the latest available Contractor Audit and Settlement Reports, CMS-1525A, maintained by the Office of Financial Management.
$102,000,000.00

Annual cost to CMS:

Total CMS processing cost (HCRIS Budget)	$42,000.00
Total Federal Cost	$102,072,000.00

15. Changes to Burden

The burden increase is due to an increase in the number of respondents from 6,111 (as of 11/18/2004) to 6,175 as of 09/27/2007. There is an increase of 66 additional providers completing the cost report from the last time the cost report was renewed in 2004. The increase involves an increase of 43,692hours at $12 per hour resulting in added burden of $524,304.

16. Publication/Tabulation Dates

The data submitted on the cost report supports management of the Federal programs. These data are extracted from the cost report, by the fiscal intermediaries, for transmission to CMS, and are used by the Office of the Actuary in making projections of Medicare Trust Fund requirements. In addition, the data is available to Congress, researchers, universities, and other interested parties. CMS now offers some public use data files via the Internet and through mail order.

17. Expiration Date

We request an exception to displaying the expiration date since the forms are changed so infrequently.

18. Certification Statement

There are no exceptions to the certification statement.