SUPPORTING STATEMENT FOR FORM CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT

A. Background

CMS is requesting the Office of Management and Budget (OMB) review and approve an extension to OMB. No. 0938-0050, Form CMS-2552-10, Hospital and Hospital Health Care Complex Cost Report. Hospitals and hospital health care complexes (hospitals) participating in the Medicare program file these cost reports annually to report cost and statistical data used by CMS to determine reasonable costs.

B. Justification

1. Need and Legal Basis

Under the authority of sections 1815(a) and 1833(e) of the Act, CMS requires that providers of services participating in the Medicare program submit information to determine costs for health care services rendered to Medicare beneficiaries. CMS requires that providers follow reasonable cost principles under 1861(v)(1)(A) of the Act when completing the Medicare cost report. Under the regulations at 42 CFR 413.20 and 413.24, CMS defines adequate cost data and requires cost reports from providers on an annual basis.

The Form CMS-2552-10 cost report is needed to determine a provider's reasonable cost incurred in furnishing medical services to Medicare beneficiaries and calculate the hospital settlement amounts. These providers, paid under the inpatient prospective payment system (IPPS) and the outpatient prospective payment system (OPPS), may receive reimbursement outside of the PPS for hospital-specific adjustments such as Medicare reimbursable bad debts, disproportionate share, uncompensated care, direct and indirect medical education costs, and organ acquisition costs.

The Form CMS-2552-10 cost report is also used for rate setting and payment refinement activities, including developing a hospital market basket. Additionally, the Medicare Payment Advisory Commission (MedPAC) uses the hospital cost report data to calculate Medicare margins, to formulate recommendations to Congress regarding the IPPS and OPPS, and to conduct additional analysis of the IPPS and OPPS.

2. Information Users

The primary function of the cost report is to determine provider reimbursement for services rendered to Medicare beneficiaries. Each hospital submits the cost report to their Medicare Administrative Contractor (MAC) for reimbursement determination. The functions of the MAC are described in section 1874A of the Act.
Hospitals must follow the principles of cost reimbursement which require that hospitals

maintain sufficient financial records and statistical data for proper determination of costs. The S series of worksheets collects statistical data such as the provider's location, CBSA, date of Medicare certification, provider operations, and utilization data. The A series of worksheets collects the provider's trial balance of expenses for overhead costs, and revenue and non-revenue generating cost centers. The B series of worksheets allocates the overhead costs to revenue and non-revenue generating cost centers using functional statistical bases. The C series of worksheets collects charges for revenue generating cost centers and computes the cost-to-charge ratios used to apportion Medicare inpatient and outpatient costs on the D series of worksheets. The E series of worksheets calculates the reimbursement settlement. The G series of worksheets collects financial data from a provider's balance sheet and income statement. A hospital reports the costs of a hospital-based home health agency on the H series of worksheets and the costs of a hospital outpatient renal dialysis department on the I series of worksheets. A hospital reports the costs of a hospital-based community mental health center on the J series of worksheets and the costs of a hospital-based hospice on the O series of worksheets. The L series of worksheets calculates a hospital's capital payment. A hospital reports the costs of a hospital-based rural health clinic or a federal qualified health center on the M and N series of worksheets, respectively.

Additionally, CMS uses the cost report data to support program operations; payment refinement activities, including the development of the hospital market basket; and to make Medicare Trust Fund projections.

3. Use of Information Technology

Hospital providers are required by 42 CFR § 413.24(f)(4) to submit cost reports in an electronic format.

4. Duplication of Efforts

This information collection does not duplicate any other effort and the information cannot be obtained from any other source.

5. Small Businesses

CMS requires all hospitals, regardless of size, to complete the cost report. CMS designed this cost report with a view toward minimizing the reporting burden for small hospitals. The form is collected as infrequently as possible (annually) and only those data items necessary to determine the appropriate reimbursement rates are required.

6. Less Frequent Collection

If the annual cost report is not filed, CMS will be unable to determine whether proper payments are being made under Medicare. A hospital that fails to file a cost report by

the statutory due date is notified that interim payments will be reduced, suspended or deemed overpayments.

7. Special Circumstances

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

8. Federal Register Notice

   The 60-day Federal Register notice was published on November 20, 2018(83FR58572) and the 30-day Federal Register Notice published on January 31, 2019(84FR734) and no comments were received.

9. Payments/Gifts to Respondents

   CMS makes no payments or gifts to respondents for completion of this data collection. The payments are made for services rendered to our beneficiaries. These reports collect the data to determine accurate payments to a hospital. If the hospital fails to submit the cost report, the MAC imposes a penalty by suspending claims payments until the report is submitted. Once the report is submitted, the MAC releases the suspended payments. If the hospital files the report timely, there are no payment or gifts and no interruption in the claims payments.

10. Confidentiality

    Confidentiality is not assured. Medicare cost reports (MCR) are subject to disclosure under the Freedom of Information Act.

11. Sensitive Questions

    There are no questions of a sensitive nature.

12. Burden Estimates (Hours & Cost)

Number of hospital facilities (as of 5/15/2018)		6,088
Hours burden per facility to complete the cost report:		673
Number of hours of reporting	136	
Number of hours of recordkeeping	537	
Total hours burden (6,088 facilities x 673 hours)		4,097,224
Cost per hospital		$31,411.36

Total annual cost estimate ($31,411.36 x 6,088 hospitals)	$191,232,360

Burden hours for each hospital estimate the time required (number of hours) to complete ongoing data gathering and recordkeeping tasks, search existing data resources, review instructions, and complete the Form CMS-2552-10. The most recent data from the System for Tracking Audit and Reimbursement, an internal CMS data system maintained by the Office of Financial Management (OFM), reports that 6,088 hospitals, the current number of Medicare certified hospitals, file Form CMS-2552-10 annually. We estimate an average burden per hospital of 673 hours (537 hours for recordkeeping and 136 hours for reporting). We calculated the annual burden hours as follows: 6,088 hospitals times 673 hours per hospital equals 4,097,224 annual burden hours.

The 537 hours for recordkeeping include hours for bookkeeping, accounting and auditing clerks; the 136 hours for reporting include accounting and audit professionals' activities. Based on the most recent Bureau of Labor Statistics (BLS) in its 2017 Occupation Outlook Handbook, the mean hourly wage for Category 43-3031 www.bls.gov/oes/current/oes433031.htm (bookkeeping, accounting and auditing clerks) is $19.76. We added 100% of the mean hourly wage to account for fringe and overhead benefits, which calculates to $39.52 ($19.76 + $19.76) and multiplied it by 537 hours, to determine the annual recordkeeping costs per hospital to be $21,222.24 ($39.52 x 537 hours).

The mean hourly wage for Category 13-2011 www.bls.gov/oes/current/oes132011.htm (accounting and audit professionals) is $37.46. We added 100% of the mean hourly wage to account for fringe and overhead benefits, which calculates to $74.92 ($37.46 + $37.46) and multiplied it by 136 hours, to determine the annual reporting costs per hospital to be $10,189.12 ($74.92 x 136 hours). We've calculated the total annual cost per hospital of $31,411.36 by adding the recordkeeping costs of $21,222.24 plus the reporting costs of $10,189.12. We estimated the total annual cost to be $191,232,359.68 ($31,411.36 times 6,088 hospitals).

13. Capital Costs

There are no capital costs.

14. Cost to Federal Government

Annual cost to MACs: MACs processing information on the forms based on estimates provided by OFM.	$60,900,395
Annual cost to CMS: CMS processing cost from the HCRIS Budget	$44,000
Total Federal cost	$60,944,395

15. Changes to Burden

The change in burden is due to increases in hourly rates and a decrease in the number of respondents. The hourly rates increased for categories 43-3031 (bookkeeping, accounting and auditing clerks) and 13-2011 (accounting and audit professionals) based on the BLS 2017 Occupation Outlook Handbook. The number of respondents decreased by 69 (from 6,157 in 2015, to 6,088 as of May 15, 2018), the net result of new hospitals certified to participate in the Medicare program and existing hospitals terminated from the Medicare program.

16. Publication/Tabulation Dates

The data submitted on the cost report is not published or tabulated.

17. Expiration Date

CMS displays the expiration date on the first page of the data collection instrument forms, in the upper right hand corner. The PRA disclosure statement with expiration date is included in the instructions on page 40-7.

18. Certification Statement

There are no exceptions to the certification statement.

C. Statistical Methods

There are no statistical methods involved in this collection.