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

A. Background

CMS is requesting expedited review and approval by the Office of Management and Budget (OMB) for this reinstatement with revisions of the OMB. No. 0938-0050, Form CMS-2552-10, Hospital and Hospital Health Care Complex Cost Report. We request expedited review due to the revisions that incorporate reasonable cost reimbursement for allogeneic hematopoietic stem cell transplant (HSCT) acquisition costs effective for cost reporting periods beginning on or after October 1, 2020. We published this package for 60-day comment on November 10, 2020, but due to administrative issues and numerous public comments, we were unable to process responses for the 30-day comment period prior to March 31, 2022, when the Form CMS-2552-10 expired. Hospitals and hospital health care complexes (hospitals) participating in the Medicare program submit these cost reports annually to report cost and statistical data used by CMS to determine reasonable costs. In this Paperwork Reduction Act (PRA) package, the Form CMS-2552-10 is amended to:

- Revise Worksheet S-2, Part I, Hospital and Hospital Healthcare Complex Identification Data, to:
    - add lines 88 and 89 to record permanent adjustments to the TEFRA target amount per discharge;
    - add Exhibit 3A, Listing of Medicaid Eligible Days for DSH Eligible Hospital, and instructions to §4004.1 to facilitate compliance with acceptable cost report submission requirements in 42 CFR 413.24(f)(5)(i)(C) for DSH eligible Medicaid days reported on Worksheet S-2, Part I, lines 24 and 25.

- Revise Worksheet S-2, Part II, Hospital and Hospital Health Care Complex Reimbursement Questionnaire, to:
    - add Exhibit 2A, Listing of Medicare Bad Debts, and instructions to §4004.2 to facilitate compliance with acceptable cost report submission requirements in 42 CFR 413.24(f)(5)(i)(B) for Medicare bad debt claimed.

- Revise Worksheet S-3, Part I, Hospital and Hospital Health Care Complex Identification Data, to add line 34 to report COVID-19 PHE temporary expansion hospital beds.

- Revise Worksheet S-10, Hospital Uncompensated and Indigent Care Data, and instructions to:
    - Designate Worksheet S-10 as Worksheet S-10, Part I, and revised the Part I instructions to:
        - exclude charges for services for which the hospital received payment from the Provider Relief Fund;
        - apply the cost-to-charge ratio CCR to charity care given to uninsured patients and insured patients not covered for the entire hospital stay;
        - recognize an inferred contractual relationship between an insurer and a provider; and
        - add Exhibits 3B and 3C, pursuant to providers' requests for standardized formats (83 FR 41681-41685 (August 17, 2018)) to report information required

to support uncompensated care reported on the Worksheet S-10.
    - Add Part II and instructions to record charity care charges, uninsured discounts, payments, bad debts and the (CCR) for only the general short-term hospital inpatient and outpatient services billable under the hospital CCN.

- Revise Worksheets A; B, Parts I and II; B-1; and C, Parts I and II; to:
    - clarify instructions for line 77 for allogeneic HSCT acquisition costs;
    - add line 78 for chimeric antigen receptor T-cell (CAR T-cell) immunotherapy costs;
    - add line 102 for Opioid Treatment Program costs.

- Revise Worksheet D, Parts II, IV, and V, to add line 78 for CAR T-cell immunotherapy.

- Revise Worksheet D-1, Computation of Inpatient Operating Cost, Part II, to add line 48.01 for Program inpatient cellular therapy acquisition cost and lines 55.01 and 55.02 for permanent and temporary adjustments to the TEFRA target amount per discharge, to properly calculate the TEFRA limit for inpatient costs.

- Revise Worksheet D-4, Computation of Organ Acquisition Costs, and instructions for counting organs, including total usable organs, Medicare usable organs, organs for Medicare Advantage patients, and organs when there is a primary and secondary payer.

- Add Worksheet D-6, Computation of Acquisition Costs, and instructions, to calculate the inpatient routine, ancillary, and other costs associated with the acquisition of allogeneic hematopoietic stem cells for transplant as required under Section 108 of the Further Consolidated Appropriations Act, 2020 (Pub. L. 116-94) (see FY 2021 IPPS Final Rule 85 FR 58835-58844, (September 18, 2020)).

- Revise Worksheet E-3, Part V, Calculation of Reimbursement Settlement - Cost Reimbursement, to add line 3.01 for cellular therapy acquisition cost.

- Add Worksheet E-5, Outlier Reconciliation at Tentative Settlement, for contractor use to report the outlier reconciliation amount during cost report tentative settlement.

- Revise the Worksheet L-1, Part I, Allocation of Allowable Costs for Extraordinary Circumstances, to add lines 78 and 102 for CAR T-cell Acquisition and Opioid Treatment Program costs, respectively.

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 (MCR). Regulations at 42 CFR 413.20 and 413.24 require that providers submit acceptable cost reports on an annual basis and maintain sufficient financial records and statistical data, capable of verification by qualified auditors. In addition, the regulations require that providers furnish such information to the contractor as may be necessary to assure proper payment by the

program, receive program payments, and satisfy program overpayment determinations. In accordance with 42 CFR 413.20(a), CMS follows standardized definitions, accounting, statistics, and reporting practices that are widely accepted in the hospital and related fields. Changes in these practices and systems are not required in order to determine costs payable under the principles of reimbursement. Essentially the methods of determining costs payable under Medicare involve making use of data available from the institution's basis accounts, as usually maintained, to arrive at equitable and proper payment for services to beneficiaries.

CMS requires the Form CMS-2552-10 to determine a hospital's reasonable cost incurred in furnishing medical services to Medicare beneficiaries and calculate the hospital reimbursement. Hospitals paid under a prospective payment system (PPS) may receive reimbursement in addition to 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.

CMS uses the Form CMS-2552-10 for rate setting; payment refinement activities, including developing a hospital market basket; and Medicare Trust Fund projections; and to support program operations. Additionally, the Medicare Payment Advisory Commission (MedPAC) uses the hospital cost report data to calculate Medicare margins (a measure of the relationship between Medicare's payments and providers' Medicare costs) and analyze data to formulate Medicare Program recommendations to Congress.

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 its contractor for reimbursement determination. Section 1874A of the Act describes the functions of the contractor.

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, core-based statistical area, 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.

3. Use of Information Technology

CMS regulations at 42 CFR § 413.24(f)(4)(ii) require that each hospital submit an annual cost report to their contractor in a standard (ASCII) electronic cost report (ECR) 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. CMS collects the form as infrequently as possible (annually) and only those data items necessary to determine the appropriate reimbursement rates are required.

6. Less Frequent Collection

Under the authority of 1861(v)(1)(F) of the Act, as defined in regulations at 42 CFR 413.20 and 413.24, CMS requires that each hospital submit the cost report on an annual basis with the reporting period based on the hospital's accounting period, which is generally 12 consecutive calendar months. A less frequent collection would impede the annual rate setting process and adversely affect provider payments.

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 published on November 10, 2020 (85 FR 71653). Attached please find a document summarizing and responding to the comments we received.

The 30-day notice published on June 22, 2022 (87 FR 37338).

9. Payments/Gifts to Respondents

CMS makes no payments or gifts to respondents for completion of this data collection. CMS issues claims payments for covered services provided to Medicare beneficiaries. These reports collect the data to determine accurate payments to a hospital. If the hospital fails to submit the cost report, the contractor imposes a penalty by suspending claims payments until the hospital submits the cost report. Once the hospital submits the cost report, the contractor releases the suspended payments. A hospital that submits the cost report timely experiences no interruption in claims payments.

10. Confidentiality

Confidentiality is not assured. MCRs 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 5/5/2022)		6,075
Hours burden per facility to complete the cost report:		674
Number of hours of reporting	137	
Number of hours of recordkeeping	537	
Total hours burden (6,075 facilities x 674 hours)		4,094,550
Cost per hospital		$34,367.18
Total annual cost estimate ($34,367.18 x 6,075 hospitals)		$208,780,619

Only when the standardized definitions, accounting, statistics and reporting practices defined in 42 CFR 413.20(a) are not already maintained by the provider on a fiscal basis does CMS estimate additional burden for the required recordkeeping and reporting.

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 System for Tracking Audit and Reimbursement, an internal CMS data system maintained by the Office of Financial Management (OFM), tracks the current number of Medicare certified hospitals as 6,075, which file Form CMS-2552-10 annually. We estimate the changes to increase the average burden hours per facility by 1 hour, an average per provider increase of 0 hours for recordkeeping and 1 hour for reporting, for a total average burden per hospital of 674 hours (537 hours for recordkeeping and 137 hours for reporting). We recognize this average varies depending on the provider size and complexity. We invite public comment on the hours estimate as well as the staffing requirements utilized to compile and complete the Medicare cost report.

The increase in the burden hours estimate was based on the addition of Worksheet S-10, Part II, which affects 3,120 hospitals eligible for the uncompensated care adjustment and the addition of Worksheet D-6, which affects 125 hospitals providing allogeneic HSCTs. We estimated no additional burden for the exhibits added to the cost report, exhibits standardized in response to public comments on the 2019 Inpatient PPS Proposed Rule, 83 FR 20164 (May 7, 2018). The exhibits provide a standardized format for the provider to report data, as we stated in the 2019 Inpatient PPS final rule, 83 FR 41677-41687 (August 17, 2018), already recorded and maintained by the provider to complete the cost report. Furthermore, as we stated in the 2019 Inpatient PPS final rule, since the existing burden estimate for a hospital's cost report already reflects the requirement that these hospitals collect, maintain, and submit these data when requested, these exhibits impose no additional burden.

We calculated the annual burden hours as follows: 6,075 hospitals multiplied by 674 hours per hospital equals 4,094,550 annual burden hours.

The 537 hours for recordkeeping include hours for bookkeeping, accounting and auditing clerks; the 137 hours for reporting include accounting and audit professionals' activities. Based on the most recent Bureau of Labor Statistics (BLS) in its 2021 Occupation Outlook Handbook, the mean hourly wage for Category 43-3031 https://www.bls.gov/oes/current/oes433031.htm (bookkeeping, accounting and auditing clerks) is $21.70. We added 100% of the mean hourly wage to account for fringe and overhead benefits, which calculates to $43.40 ($21.70 plus $21.70) and multiplied it by 537 hours, to determine the annual recordkeeping costs per hospital to be $23,305.80 ($43.40 per hour multiplied by 537 hours).

The mean hourly wage for Category 13-2011 www.bls.gov/oes/current/oes132011.htm (accounting and audit professionals) is $40.37. We added 100% of the mean hourly wage to account for fringe and overhead benefits, which calculates to $80.74 ($40.37 plus $40.37) and multiplied it by 137 hours, to determine the annual reporting costs per hospital to be $11,061.38 ($80.74 per hour multiplied by 137 hours).

We calculated the total average annual cost per hospital of $34,367.18 by adding the recordkeeping costs of $23,305.80 plus the reporting costs of $11,061.38. We estimated the total annual cost to be $208,780,619 ($34,367.18 cost per hospital multiplied by 6,075 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.	$60,311,180
Annual cost to CMS: CMS processing cost from the HCRIS Budget	$44,000
Total Federal cost	$60,355,180

15. Changes to Burden

The changes in burden and cost for the Form CMS-2552-10 are a result of three factors:

- The number of respondents decreased by 13 (from 6,088 in 2018 to 6,075 in 2022), the net result of new hospitals certified to participate in the Medicare program and existing hospitals terminated from the Medicare program.

- The hourly rates and associated administrative/overhead costs increased based on data from the BLS 2021 Occupation Outlook Handbook (for categories 43-3031, bookkeeping, accounting and auditing clerks, and 13-2011, accounting and audit professionals) that resulted in an increased cost per provider from $31,411.36 in 2018 to $34,367.18 in 2022.

- The per-respondent burden increased by 1 hour (from 673 hours in 2018 to 674 hours in 2022), the result of adding the Worksheet S-10, Part II, for hospitals to report the hospital uncompensated and indigent care data for the hospital CCN, and adding the Worksheet D-6, Parts I, II, and III, for hospitals to report the acquisition cost of allogeneic hematopoietic stem cells for transplant.

16. Publication/Tabulation Dates

    CMS requires that each Medicare-certified provider submit an annual cost report to their contractor. The cost report contains provider information such as facility characteristics, utilization data, cost and charges by cost center, in total and for Medicare, Medicare settlement data, and financial statement data. The provider must submit the cost report in a standard (ASCII) ECR format. CMS maintains the cost report data in the Healthcare Provider Cost Reporting Information System (HCRIS). The HCRIS data supports CMS's reimbursement policymaking, congressional studies, legislative health care reimbursement initiatives, Medicare profit margin analysis, market basket weight updates, and public data requirements. CMS publishes the HCRIS dataset for public access and use at https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports/ .

17. Expiration Date

    CMS displays the expiration date on the first page of the data collection instrument in the upper right corner. CMS also displays the PRA disclosure statement with expiration date 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.