Supporting Statement for Paperwork Reduction Act Submissions
Provider Agreement –CMS Form 1561 and 1561A

A. Background

Providers and rural health clinics applying to participate in the Medicare program are required to agree to provide services in accordance with Federal requirements. This health insurance benefits agreement is essential for the Centers for Medicare and Medicaid Services (CMS) to ensure that applicants to the Medicare program are aware of and have made a binding commitment to comply with all applicable Federal requirements. Applicants will be required to sign the completed form and provide operational information to CMS to assure they continue to meet all Federal requirements following their approval. The form is signed when the applicant and CMS enter into agreement at the beginning of the applicant's participation in Medicare. The agreement remains in force so long as it's not terminated by either party; thus the collection is made one time only during the course of the applicant's participation in Medicare.

B. Justification

1. Need and Legal Basis

For the CMS-1561, in accordance with Section 1866 of the Social Security Act (the Act) and the implementing regulations at 42 CFR Part 489, to participate in the Medicare program all applicants must agree to comply with the requirements specified therein.

For the CMS-1561A, in accordance with Section 1861(aa)(2)(K)(ii) of the Act and the implementing regulations at 42 CFR Part 405 Subpart X and 42 CFR Part 491, to participate in the Medicare program as a rural health clinic all applicants must agree to comply with the requirements specified therein.

2. Information Users

This collection will be used by CMS to assure that each provider or rural health clinic applicant seeking to participate in the Medicare program has made a binding commitment in writing to comply with the applicable provisions of Sections 1861 and 1866 of the Act and the applicable regulations in 42 CFR.

3. Improved Information Technology

This collection does not lend itself to electronic submission at this time.

4. Duplication of Similar Information
There is no duplication of similar information.

5. Small Businesses

These requirements do affect small businesses; however, the information collection is necessary for the business to participate in the Medicare program. These paperwork requirements are minimal and are necessary to meet the participation requirements of the law.

6. Less Frequent Collection

This information is collected one time only over the course of the duration of the agreement between CMS and the applicant. It is necessary to prevent fraud and abuse in the Medicare program and to assure that providers and rural health clinics understand they must comply with all applicable Federal requirements and make a binding commitment to compliance throughout their participation in the Medicare program. If the information were collected less frequently, CMS would not have a binding commitment on the part of providers or rural health clinics to comply with all applicable Medicare requirements. The presence of unsafe, fraudulent, or abusive entities in the Medicare program puts patients/residents at risk of harm and diverts resources from the Medicare Trust Funds that are needed to reimburse legitimate claims for medical care provided to Medicare beneficiaries.

7. Special Circumstances

There are no special circumstances pertaining to this collection.

8. Federal Register Notice/Outside Consultation
A 60-day Federal Register notice was published on November 1, 2013. There were no public comments.

9. Payments/Gifts to Respondents

There will be no payment or gifts provided to respondents, except for reimbursement for covered services as provided for under the law via normal reimbursement procedures.

10. Confidentiality

We make no pledges of confidentiality.

11. Sensitive Questions

There are no questions of a sensitive nature.

12. Burden Estimate (Total Hours and Wages)

It would take the facility 5 minutes to review and sign the CMS 1561 or CMS 1561A, and an additional 5 minutes to file the document when fully executed.

There are approximately 3,000 new providers/Changes of Ownership (CHOWs) completing the CMS 1561 or CMS 1561A yearly. Ten minutes/facility times 3,000 = 500 hours.

The cost to each facility for reviewing and signing the form has been calculated assuming the national average executive salary of $85.02 per hour, since a Chief Executive Officer or comparable senior official authorized of the facility would be expected to sign the document. 250 hours times $85.02 = $21,255.

The cost to each facility for filing the document has been calculated assuming the national average salary of $13.48 per hour, since office administrative staff would be expected to file the agreement. 250 hours times $13.48 = $3,370.

The total burden cost is estimated to be $24,625.

13. Capital Costs

There are no capital costs associated with this collection.

14. Costs to the Federal Government

The CMS Regional Offices are responsible for approving the CMS 1561 and 1561A. Accepting these forms on behalf of the Secretary, counter-signing and issuing them follows a review of the file for a new Medicare provider applicant or for a CHOW. The amount for completion of forms was calculated using an average salary of $44.65 an hour for a Regional Office reviewer who takes 30 minutes to review the file. The annual Federal processing cost is $22.32/ agreement times 3000 = $66,960.00. The annual printing cost for CMS 1561 is $500.00 and CMS 1561A is $400.00, totaling $900.00.

The estimated total annual Federal cost is $67,860.

15. Changes in Program/Burden

There are no program changes; however, due to changes in average salaries, there is a slight increase in burden.

16. Publication and Tabulation Dates

There are no publication and/or tabulation dates.

17. Expiration Date

CMS does not want to display the expiration date, as it would result in the potential destruction of too many blank forms. This form is used continuously