traverse data obtained earlier in the day.''

10. On page 4990, in the third column, paragraph 5.1.1.3, in line 1, remove the word ''velocity.''

11. On page 4990, in the second column, paragraph 5.1.1.5, in lines 2 and 3, remove the words ''before sampling.''

12. On page 4992, in the first column, paragraph 5.1.2.2, in line 2, the words ''and turn'' are corrected to read ''and seal the port. Turn.''

13. On page 4993, in the second column, paragraph 1.2, in line 7, the word ''bathreduces'' is corrected to read ''bath reduces.''

14. On page 4993, in the second column, paragraph 2.2, in line 1, the words ''Preciser Tensiometer: A Preciser'' are corrected to read ''Tensiometer: A.''

15. On page 4993, in the second column, paragraph 3.1, in lines 2 and 5, remove the words ''Preciser.''

16. On page 4993, in the third column, paragraph 3.2.(b), in line 2, the figure ''40'' is corrected to read ''45.''

17. On page 4993, in the third column, paragraph 4.2, in line 6, remove the word ''Preciser.''

[FR Doc. 95–15430 Filed 6–26–95; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 413

[BPD–689–F]

RIN 0938–AE80

Medicare Program; Uniform Electronic Cost Reporting System for Hospitals

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final rule.

SUMMARY: This final rule responds to comments on the May 25, 1994, final rule with comment period that implemented a standardized electronic cost reporting system for all hospitals under the Medicare program. In that rule, we solicited comments on the requirement that cost reporting software be able to detect changes made to the electronic file after the provider has submitted it to the fiscal intermediary. This final rule responds to comments on that requirement and clarifies that although changes to the ''as-filed'' electronic cost report are prohibited, an intermediary makes a working copy of the as-filed electronic cost report for use in the settlement process.

EFFECTIVE DATE: These regulations are effective on July 27, 1995.

FOR FURTHER INFORMATION CONTACT: Thomas Talbott (410) 966–4592.

SUPPLEMENTARY INFORMATION:

I. Background

A. General

Under Medicare, hospitals are paid for inpatient hospital services that they furnish to beneficiaries under Part A (Hospital Insurance). Currently, most hospitals are paid for their inpatient hospital services under the prospective payment systems for operating and capital costs in accordance with sections 1886(d) and (g) of the Social Security Act (the Act) and 42 CFR Part 412. Under these systems, Medicare payment is made at a predetermined, specific rate for each hospital discharge based on the information contained on actual bills submitted.

Section 1886(f)(1)(A) of the Act provides that the Secretary will maintain a system for reporting costs of hospitals paid under the prospective payment systems. Section 412.52 requires all hospitals participating in the prospective payment systems to meet the recordkeeping and cost reporting requirements of §§ 413.20 and 413.24, which include submitting a cost report for each 12-month period.

The hospitals and hospital units that are excluded from the prospective payment systems are generally paid an amount based on the reasonable cost of services furnished to beneficiaries. The inpatient operating costs of these hospitals and hospital units are subject to the ceiling on the rate of hospital cost increases in accordance with section 1886(b) of the Act and § 413.40.

Sections 1815(a) and 1833(e) of the Act provide that no payments will be made to a hospital unless it has furnished the information, requested by the Secretary, needed to determine the amount of payments due the hospital under the Medicare program. In general, hospitals submit this information through cost reports that cover a 12-month period.

All hospitals participating in the Medicare program, whether they are paid on a reasonable cost basis or under the prospective payment systems, are required under § 413.20(a) to ''maintain sufficient financial records and statistical data for proper determination of costs payable under the program.'' In addition, hospitals must use standardized definitions and follow accepted accounting, statistical, and reporting practices. Under the provisions of §§ 413.20(b) and 413.24(f), hospitals are required to submit cost reports annually, with the reporting period based on the hospital's accounting year.

Section 1886(f)(1)(B)(i) of the Act provides that the Secretary will place into effect a standardized electronic cost reporting format for hospitals under Medicare. This standardized electronic cost reporting format does not require any additional data from hospitals. Section 1886(f)(1)(B)(ii) of the Act provides that the Secretary may delay or waive the implementation of the electronic format in instances where such implementation would result in financial hardship for a hospital (for example, a hospital with a small percentage of inpatients entitled to Medicare benefits). These provisions apply to hospital cost reporting periods beginning on or after October 1, 1989.

B. Provisions of the August 19, 1991 Proposed Rule

On August 19, 1991, we published a proposed rule (56 FR 41110) to implement sections 1886(f)(1)(B)(i) and (ii) of the Act. We proposed that cost reports be submitted in a standardized electronic format. We proposed that the hospital's cost report software must be able to produce a standardized output file in American Standard Code for Information Interchange (ASCII) format. We proposed that all intermediaries have the ability to read this standardized file and produce an accurate cost report. We proposed rules for suspension of Medicare payment if a hospital refuses to submit the cost report electronically. We also specified that if a hospital believes that implementation of the electronic submission requirement would cause a financial hardship, the hospital should submit a written request for a waiver or a delay of these requirements, with supporting documentation, to the hospital's intermediary. See section III of the proposed rule (56 FR 41111 through 41112).

C. Provisions of the May 25, 1994 Final Rule With Comment Period

On May 25, 1994, we published a final rule with comment period to confirm the proposed regulations and respond to public comments on the proposed rule (59 FR 26960). As a result of public comments on the proposed rule, we eliminated the requirement that providers file a hard copy cost report in addition to the electronic file. Instead, we required that, in addition to the electronic file, a hospital must submit hard copies of a settlement summary, a statement of certain worksheet totals found in the electronic file, and a signed statement certifying the accuracy of the

electronic file or the manually prepared cost report.

The purpose of these changes was to reduce the burden on providers and ensure the accuracy of the data contained in the electronic file. However, we also needed to ensure the electronic cost report is not altered once it leaves the provider. Thus, in conjunction with the changes made based on public comments, we implemented several changes designed to preserve the integrity of the electronic cost report once the provider files it with the intermediary. We required in § 413.24(f)(4)(ii) that the provider's software must be capable of disclosing that changes have been made to the cost report file after the provider has submitted it to the intermediary. We stated that electronic cost reporting software will be modified so that the cost report will calculate a ''hash total,'' that is, a number representing the sum of the worksheet totals contained in the provider's as-filed cost report. If any data in the electronic file are changed after the hash total is calculated, the electronic file will disclose that a change has been made. We also required that an intermediary may not alter a cost report once it has been filed by a hospital and must reject any cost report that does not pass all specified edits and return it to the provider for correction.

Because providers may not have anticipated the changes needed to preserve the integrity of the cost report, we solicited comments on the requirement in § 413.24(f)(4)(ii) that all cost reporting software must be able to disclose changes made to the electronic file after the provider has submitted its cost report to the intermediary.

II. Discussion of Public Comments

In response to the May 25, 1994 final rule with comment period, we received three timely items of correspondence related to the requirement that cost reporting software be able to detect changes to the electronic cost report after the provider has submitted it to the intermediary.

Comment: One commenter pointed out that a strict interpretation of the requirement in § 413.24(f)(4)(ii) that the ''intermediary may not alter the cost report once it has been filed by the hospital'' would mean that the intermediary could not make audit adjustments to the provider's as-filed electronic cost report. Another commenter asked whether the intermediary can adjust the cost report for additional information not required for acceptability but needed in such cases as Hospital Cost Report Information System (HCRIS) preparation.

Response: We did not intend to imply that the intermediary may not make audit adjustments to a provider's cost report. To clarify this point, we are revising § 413.24(f)(4)(ii) to state that the as-filed cost report may not be altered, but the intermediary must make a working copy of the as-filed cost report to be used for the settlement process.

Specifically, we are revising § 413.24(f)(4)(ii) to require that—

- The fiscal intermediary store the hospital's as-filed electronic cost report and not alter that file for any reason.
- The fiscal intermediary make a working copy of the as-filed electronic cost report to be used, as necessary, throughout the settlement process (that is, desk review, processing audit adjustments, final settlement, etc).

The fiscal intermediary may also employ a working copy of the as-filed electronic cost report for making any adjustments needed for HCRIS purposes.

Comment: Two commenters suggested that, to maintain the integrity of the provider's electronic file, HCFA should require the establishment of a print file submitted on diskette as a substitute for the hard copy cost report. Another commenter supported the use of ''hash totals'' in the electronic cost report (ECR) if the vendors are able to create ECR files that cannot be edited without detection. The commenter suggested that the ''hash totals'' in the ECR be printed in cost report text and on the hard copy certification page. The commenter also indicated that time and date stamps on the ECR file and printed cost report are not useful.

Response: As stated in the final rule with comment period, hospitals are no longer required to submit hard copies of the cost report in addition to the electronic file. We agree with the commenters' suggestion that an electronic file containing the complete printed text of the provider's cost report should be submitted in place of the hard copy. Since the ASCII file contains input data only, the print file will be helpful in settling discrepancies between the fiscal intermediary's settlement amounts and the provider's settlement amounts. Therefore, we intend to publish in the Provider Reimbursement Manual (HCFA Pub. 15–II) the requirement that providers submit an electronic file containing the entire printed text and an encryption file (hash totals) of the provider's cost report in addition to the ASCII file used for electronic cost reporting.

We disagree that the time and date stamps on the electronic cost report are not useful. The time and date stamps on the electronic cost report file must agree with the certification page that accompanies the electronic cost report file. This requirement assures us that the cost report has been reviewed and accepted and has not been altered after certification by the signing officer. This requirement coupled with the encryption file will ensure that the integrity of the file has been maintained.

Comment: One commenter suggested that the regulation mention what the responsibility of each of the 11 vendors will be to maintain consistency between software programs, particularly in the implementation of edits. The commenter indicated that if the ADR vendor establishes additional edits not specified by HCFA, the electronic cost report file created by the provider's software vendor system may result in rejection by the intermediary. This possibility places an undue burden on the provider who filed under the assumption that all errors were detected and corrected before submission.

Response: All vendors will be responsible for providing their clients with the software to create a print file, an encryption file, and the electronic cost report file. In addition, the three Automated Desk Review (ADR) vendors are responsible for developing a software program that will accept the filing of all three files, as mentioned above, with the intermediary. All of the software programs will maintain consistent edits that, when specified edits are failed, will result in the intermediary rejecting the cost report. These edits are established by HCFA and published in section 130 of the Provider Reimbursement Manual (HCFA Pub. 15–II). An ADR vendor may establish additional edits, but failure to meet such edits may not result in rejection of the cost report by the intermediary.

III. Technical Changes

We received several inquiries implying that it is unclear in the regulations when an electronic cost report is considered timely filed. Therefore, in § 413.24(f)(4)(ii), we are clarifying that, for purposes of the due date requirements specified in § 413.24(f)(2), an electronic cost report is not considered to be filed until it is accepted by the intermediary.

In the May 25, 1994 final rule with comment period, we eliminated the requirement that providers file a hard copy of the cost report. We stated that effective for cost reporting periods ending on or after October 1, 1994, this requirement is replaced with the submittal of a hard copy of a settlement

summary, a statement of certain worksheet totals found within the electronic file, and a certification statement. After publication, we realized that making this requirement effective for cost reporting periods ending on or after October 1, 1994, did not make sense since cost reporting periods generally end on the last day of a month. To eliminate any confusion associated with this requirement, we are making a technical correction to § 413.24(f)(4)(iii) to specify that the replacement of the submission of a hard copy of the cost report with the revised documentation is effective for cost reporting periods ending on or after September 30, 1994, rather than for periods ending on or after October 1, 1994.

IV. Collection of Information Requirements

As discussed in our May 25, 1994 final rule with comment period (59 FR 26963), § 413.24 contains information collection and recordkeeping requirements related to cost reporting that are subject to review by the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1980 (44 U.S.C. 3501 *et seq.*). The overall recordkeeping and information collection burden associated with filing the hospital cost report has been approved by OMB through August 31, 1996 under OMB No. 0938–0050.

In the May 25, 1994 final rule with comment period, we revised § 413.24 to implement the statutory requirement that hospitals submit their cost reports in a uniform electronic format. As we stated in the May 25, 1994 document, approximately 90 percent of hospitals participating in Medicare already file their cost reports electronically and thus are essentially unaffected by the requirement that hospitals submit cost reports in an electronic format. For the remaining hospitals, we stated that it was possible they would initially experience a small additional reporting burden. However, once these hospitals become familiar with electronic reporting, there will no longer be an additional burden and there may be a decrease in burden since the time needed to compute the cost report will no longer be required.

This final rule responds to comments on the May 25, 1994 document and makes only minor technical changes to § 413.24. We received no comments relating to the discussion in the May 25, 1994 document of the information collection and recordkeeping burden. The technical changes contained in this final rule have no effect for information collection and recordkeeping purposes. However, as stated in the May 25, 1994 final rule with comment period, the information collection and recordkeeping requirements contained in § 413.24 are not effective until they have been approved by OMB. A notice will be published in the **Federal Register** when approval is obtained. Organizations and individuals desiring to submit comments on the information collection and recordkeeping requirements set forth in § 413.24 should direct them to the Office of Information and Regulatory Affairs, Office of Management and Budget, Human Resources and Housing Branch, Room 10235, New Executive Office Building, Washington, D.C. 20503, Attention: Allison Herron Eydt, HCFA Desk Officer.

V. Impact Statement

Unless we certify that a final rule will not have a significant economic impact on a substantial number of small entities, we generally prepare a regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612). For purposes of the RFA, all hospitals and small businesses that distribute cost-report software to hospitals are considered to be small entities. Intermediaries are not included in the definition of a small entity.

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a final rule may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that has fewer than 50 beds and is located outside of a Metropolitan Statistical Area.

This final rule is merely making clarifying and technical changes to the regulations and will not have a significant effect on Medicare-participating hospitals or software suppliers. Therefore, a regulatory flexibility analysis is not required. We are not preparing a rural impact statement since we certify that this final rule will not have a significant economic impact on the operation of a substantial number of small rural hospitals.

In accordance with the provisions of Executive Order 12866, this regulation was not reviewed by the Office of Management and Budget.

List of Subjects in 42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR part 413 is amended as follows:

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES

1. The authority citation for part 413 continues to read as follows:

Authority: Secs. 1102, 1122, 1814(b), 1815, 1833(a), (i), and (n), 1861(v), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1302a–1, 1395f(b), 1395g, 13951(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww).

Subpart B—Accounting Records and Reports

2. In § 413.24, the headings for paragraphs (f) and (f)(4) are republished, paragraph (f)(4)(ii) and the first sentence of paragraph (f)(4)(iii) are revised to read as follows:

§ 413.24 Adequate cost data and cost finding.

* * * * *

(f) *Cost reports.* * * *

(4) *Electronic submission of cost reports.* * * *

(ii) The fiscal intermediary stores the hospital's as-filed electronic cost report and may not alter that file for any reason. The fiscal intermediary makes a ''working copy'' of the as-filed electronic cost report to be used, as necessary, throughout the settlement process (that is, desk review, processing audit adjustments, final settlement, etc). The hospital's electronic program must be able to disclose if any changes have been made to the as-filed electronic cost report after acceptance by the intermediary. If the as-filed electronic cost report does not pass all specified edits, the fiscal intermediary rejects the cost report and returns it to the hospital for correction. For purposes of the requirements in paragraph (f)(2) of this section concerning due dates, an electronic cost report is not considered to be filed until it is accepted by the intermediary.

(iii) Effective for cost reporting periods ending on or after September 30, 1994, a hospital must submit a hard copy of a settlement summary, a statement of certain worksheet totals found within the electronic file, and a statement signed by its administrator or chief financial officer certifying the accuracy of the electronic file or the manually prepared cost report. * * *

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance)

Dated: May 22, 1995.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

[FR Doc. 95–14782 Filed 6–26–95; 8:45 am]

BILLING CODE 4120–01–P

42 CFR Part 413

[BPD–366–F]

RIN 0938–AD01

Medicare Program; Clarification of Medicare's Accrual Basis of Accounting Policy

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final rule.

SUMMARY: This final rule revises the Medicare regulations to clarify the concept of ''accrual basis of accounting'' to indicate that expenses must be incurred by a provider of health care services before Medicare will pay its share of those expenses. This rule does not signify a change in policy but, rather, incorporates into the regulations Medicare's longstanding policy regarding the circumstances under which we recognize, for the purposes of program payment, a provider's claim for costs for which it has not actually expended funds during the current cost reporting period.

EFFECTIVE DATE: This final rule is effective July 27, 1995.

FOR FURTHER INFORMATION CONTACT: John Eppinger, (410) 966–4518.

SUPPLEMENTARY INFORMATION:

I. Background

Generally, under the Medicare program, health care providers not subject to prospective payment are paid for the reasonable costs of the covered items and services they furnish to Medicare beneficiaries. This policy pertains to all services furnished by providers other than inpatient hospital services (section 1886(d) of the Social Security Act (the Act)) and certain inpatient routine services furnished by skilled nursing facilities choosing to be paid on a prospective payment basis (section 1888(d) of the Act.) Additionally, there are other limited services not paid on a reasonable cost basis, to which this policy would not apply. Section 1861(v)(1)(A) of the Act defines reasonable cost as the cost actually incurred, excluding any cost unnecessary in the efficient delivery of needed health services. That section of the Act also provides that reasonable costs must be determined in accordance with regulations that establish the methods to be used and the items to be included for purposes of determining which costs are allowable for various types or classes of institutions, agencies, and services. In addition, section 1861(v)(1)(A) of the Act specifies that regulations implementing the principles of reasonable cost payment may provide for the use of different methods in different circumstances. Implementing regulations at 42 CFR 413.24 establish the methods to be used and the adequacy of data needed to determine reasonable costs for various types or classes of institutions, agencies, and services.

Section 413.24(a) requires providers receiving payment on the basis of reasonable cost to maintain financial records and statistical data sufficient for the proper determination of costs payable under the program and for verification of costs by qualified auditors. The cost data are required to be based on an approved method of cost finding and on the accrual basis of accounting. Currently, § 413.24(b)(2) provides that under the accrual basis of accounting, revenue is reported in the period in which it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

As explained in the October 9, 1991 proposed rule (56 FR 50834), under the current definition of the accrual basis of accounting, some providers have claimed costs without evidence of having incurred actual expenditures or the assurance that liabilities associated with accrued costs will ever be fully liquidated through an actual expenditure of funds. For example, under the terms of some provider employment contracts, nonprobationary employees are entitled to accumulate a certain number of sick leave days annually and carry forward a maximum accumulated amount of unused sick leave time. These sick leave days are typically vested (although not funded) but nevertheless are subject to forfeiture. That is, unused accumulated sick leave days are subject to redemption for cash if the employee retires, resigns, or is discharged in good standing, but may be forfeited if the employee is discharged for cause. In the latter case, under the current rule, some providers have sought Medicare payment for sick leave days for which the provider never became liable.

As a result of the lack of clarification in the regulations regarding Medicare payment for certain accrued costs, the Medicare program has settled approximately $4.0 million worth of accrued costs in sick leave, FICA taxes, deferred compensation, and unpaid mortgage interest expense cases. We believe that a clarification to the regulations to incorporate longstanding Medicare policy regarding timely liquidation of liabilities associated with these accrued costs will minimize the unwarranted payment of Federal funds. That is, the regulations will clarify that in cases in which a provider does not timely liquidate the liabilities, Medicare recovers its payment for the accrued costs claimed by the provider.

As discussed in the proposed rule, an alternative would be to forego incorporating in regulations our policy regarding the circumstances under which Medicare accepts a provider's claim for costs for which it has not actually expended funds during the current reporting period.

However, without a change to the regulations, some providers would believe that, for Medicare purposes, they could continue to rely solely upon the generic definition of the accrual basis of accounting, whereby revenue is reported in the period it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid. HCFA would have to continue to defend the policy without specific support in the regulations. To the extent that challenges to this policy were successful, we would be forced to pay currently for accrued liabilities that either may not be liquidated timely or may never be liquidated. Although we believe that, in light of the recent decision of the United States Supreme Court in *Shalala* v. *Guernsey Memorial Hosp.*, 115 S. Ct. 1232 (1995), the likelihood of successful challenges has decreased, we believe it is appropriate to publish these regulations to avoid any confusion regarding the policy.

In summary, despite the clear statements of Medicare payment principles found in Medicare manuals (for example, section 2305 of the Provider Reimbursement Manual), the lack of clarification to the regulations continues to impair HCFA's ability to defend against challenges to the regulations for accrued costs of sick pay, vacation pay, FICA and other payroll taxes, owners' compensation, deferred compensation, pension plans, nonpaid workers' services, and unpaid mortgage interest, as well as other accrued costs. The end result, to the extent that HCFA cannot defend challenges to the policy, is that the Medicare program makes payments for costs not incurred by providers, in violation of section 1861(v)(1)(A) of the Act.