Dated: May 22, 1995.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

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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.

II. Summary of Proposed Rule

On October 9, 1991, we published a proposed rule (56 FR 50834) to revise § 413.24 by adding a new paragraph to describe the conditions under which certain accrued costs would be recognized for purposes of Medicare payment. Our intention in specifying these conditions was not to change policy. Rather, it was to incorporate into the regulations our longstanding policy on the timely liquidation of liabilities, as contained in sections 704.3, 704.5, 906.4, 2140, 2144.8, 2144.9, 2146, 2162.9, and 2305 of the Provider Reimbursement Manual. Under this longstanding policy, accrued costs are included in Medicare allowable costs in the year of accrual, provided the related liabilities are liquidated timely, in accordance with the liquidation requirements for the particular type of accrued cost. If the liabilities are not liquidated timely, an adjustment is required to disallow the costs. Generally, the adjustment is made in the year of accrual except for vacation and all-inclusive paid days off, in which case the adjustment generally is made in the year in which the payment for the accrued vacation or all-inclusive paid days off should have been made. (The Provider Reimbursement Manual provides additional instructions, not incorporated in the regulations, regarding later recognition, if any, with respect to costs associated with liabilities not liquidated in accordance with the liquidation of liabilities requirements.)

As we indicated in the proposed rule, we believe this clarification will significantly contribute to the uniform application of our policies concerning recognizing accrued costs for Medicare payment and will preclude misinterpretation of the policies in the future. A change to the regulations is necessary to ensure that providers are paid for their actual costs as intended under section 1861(v)(1)(A) of the Act, and 42 CFR 413.9(c)(3), which state that the reasonable cost basis of payment contemplates that providers of services are to be paid the actual costs of providing quality care.

Accordingly, in order for accrued costs to be recognized for Medicare payment, we proposed that the following requirements be met with respect to the liquidation of liabilities:

- In a new § 413.24(c)(3)(i), we proposed that a short-term liability generally must be liquidated within 1 year after the end of the cost reporting period in which the liability is incurred, with an exception in cases in which the intermediary is furnished, within the 1-year time limit, sufficient written justification, based upon documented evidence, for nonpayment. An extension not to exceed 3 years beyond the end of the cost reporting year in which the liability was incurred could be granted for good cause.
- In a new § 413.24(c)(3)(ii), we proposed that if the provider's vacation policy is consistent for all employees, we would require that payment be made within the period provided for by that policy. If the provider's vacation policy is not consistent for all employees, we would require that payment be made within 2 years after the close of the cost reporting period in which the liability is accrued. Under this paragraph, we also proposed that the policy applicable to vacation pay also would apply to all-inclusive paid days off (for example, total time off in a given period for unspecified occasions, including illness, vacations, and family bereavement).
- In a new § 413.24(c)(3)(iii), we proposed that if sick pay is vested and funded in a deferred compensation plan, liabilities related to the contributions to the fund would be liquidated in accordance with the policy stated above for a short-term liability. However, if the sick leave plan grants employees the right to demand cash payment for unused sick leave at the end of each year, we proposed that the sick pay be includable in allowable costs, without funding, in the cost reporting period when it is earned.
- In a new § 413.24(c)(3)(iv), with regard to compensation of owners other than sole proprietors and partners (that is, employees, officers and directors owning stock in closely-held corporations or with a substantial ownership or equity in publicly-traded corporations, and certain employees of trusts), we proposed that any related accrued liability be liquidated within 75 days after the close of the cost reporting period in which the liability occurs.
- In a new § 413.24(c)(3)(v), we proposed that obligations incurred under a legally-enforceable agreement to remunerate an organization of nonpaid workers be discharged no later than the end of the provider's cost reporting period following the period in which the services were furnished.
- In a new § 413.24(c)(3)(vi), we proposed that the employer's share of FICA and other payroll taxes that the provider becomes obligated to remit to governmental agencies may be included in allowable costs only during the cost reporting period in which payment, upon which the tax is based, is actually made to the employee. For example, no legal obligation exists for the provider-employer to pay FICA taxes until such time as the employee is paid and the specific amount of payroll liability is known.
- In a new § 413.24(c)(3)(vii), we proposed that accrued liabilities related to contributions to a funded deferred compensation plan must be liquidated in accordance with the policy stated above in § 413.24(c)(3)(i) for a short-term liability. However, if the plan is not funded, reasonable provider payments made to employees under deferred compensation plans would be considered an allowable cost only during the cost reporting period in which actual payment is made to the participating employee.
- In a new § 413.24(c)(3)(viii), we proposed that accrued liability related to contributions under a self-insurance program that are systematically made to a funding agency, and that cover malpractice and comprehensive general liability, unemployment compensation, workers' compensation insurance losses, or employee health benefits, must be liquidated within 75 days after the close of the cost reporting period.

III. Discussion of Public Comments

In response to the October 9, 1991 proposed rule, we received 17 timely items of correspondence. The comments were submitted by eight providers or provider associations, two trade associations, five consultants or accounting firms, one State, and one law firm. Our responses are presented below:

A. General

Comment: Several commenters raised questions regarding the relationship between Medicare payment policy and generally accepted accounting principles (GAAP). Some commenters believe that the proposed rule conflicts with GAAP and that HCFA is bound to use GAAP.

Response: The regulations at § 413.24(a) establish the general principle that cost data be based on the accrual basis of accounting, a concept also integral to GAAP. However, regarding application of the accrual basis of accounting, Medicare payment policy does not always follow GAAP exactly because Medicare payment policy and GAAP have different objectives. Medicare's objective for cost payment purposes is to pay providers appropriately for the reasonable and proper cost of furnishing services to Medicare beneficiaries in a specific fiscal period. On the other hand, the primary goal of GAAP is the full and proper presentation of accounting data through statements and reports.

Medicare's longstanding position on the relationship between Medicare payment policy and GAAP is that GAAP will be followed only in cost situations not covered by the Medicare statute, regulations, rulings, manual provisions, or program policy (*American Medical Int'l v. Secretary of Health, Educ., and Welfare*, 466 F. Supp. 605, 624 n.21 (D.D.C. 1979), *aff'd* 677 F.2d 118 (D.C. Cir. 1981)). This position has long been stated in the Foreword to the Provider Reimbursement Manual and elsewhere (41 Fed. Reg. 46, 291–2 (Oct. 20, 1976)) and is consistent with the Medicare statute.

Section 1861(v)(1)(A) requires the Secretary, in defining reasonable cost, to ''consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles).* * *'' At most, the statute requires the Secretary to consider certain principles. Moreover, the principles that must be considered are not generally accepted accounting principles, but are payment principles developed by national insurance or prepayment organizations in the health services sector. Therefore, we disagree with the commenter's belief that HCFA is bound to use GAAP in determining what costs are allowable. Instead, GAAP, which includes accrual accounting, is used by providers in maintaining their records and reporting their costs. When reporting their costs, providers register their trial balance in accordance with their records and subsequently make reclassification and adjustments to the trial balance in certain situations (for example, when Medicare payment policies depart from GAAP). (See section 2407 of the Provider Reimbursement Manual, Part II.)

The Supreme Court recently upheld Medicare's longstanding position on the relationship between Medicare Payment Policy and GAAP in *Shalala* v. *Guernsey Memorial Hosp.*, 115 S. Ct. 1232 (1995). The Court agreed that neither the Medicare statute nor the regulations (42 C.F.R. §§ 413.20 and 413.24) mandate Medicare payment according to GAAP. The Court also accepted the Secretary's position that the regulations require only that providers use GAAP for recordkeeping.

Because of the apparent confusion regarding the relationship between Medicare payment policy and GAAP, we have decided to move the provisions beginning with § 413.24(b)(3) of the proposed rule into a new § 413.100, Special Treatment of Certain Accrued Costs, in 42 CFR Subpart F, Specific Categories of Costs. We believe that leaving these payment provisions in § 413.24 of Subpart B, Accounting Records and Reports, which does not address allowable Medicare costs, would continue to create confusion about the role of GAAP in determining whether a cost is allowable under the Medicare program. Leaving the provisions in § 413.24 would fail to recognize the distinction between the role of GAAP in recordkeeping and reporting, where providers adhere to GAAP (including accrual accounting), and the role of GAAP in determining allowable costs, where GAAP applies only if there is no Medicare policy covering the cost situation. (See section IV of this preamble for a crosswalk between the regulation text citations for provisions of the proposed rule and the corresponding provisions of the final rule.)

Comment: Some commenters objected to the establishment of time limits for the liquidation of an accrued liability since such time limits are not required under GAAP. One commenter asserted that it was inefficient to require hospitals to follow Medicare's unique accrual policies when all other users of hospital financial statements accept GAAP.

Response: The fact that Medicare payment policies may at times differ from GAAP is neither unusual nor unintentional. This rule is a case in point. We recognize that the accrual basis of accounting, as defined in § 413.24(b)(2), is essential for the proper reporting of costs. However, as the commenters pointed out, GAAP does not impose time limits for liquidating accrued liabilities. Time limits for liquidating accrued liabilities are essential to ensure that Medicare recognizes only costs associated with a liability that is liquidated timely through an actual expenditure of funds. Medicare policy does not prevent a provider from maintaining its books and records in accordance with GAAP. Rather, for Medicare purposes, payment for a claimed accrual must be recovered if the accrual is not timely liquidated.

Comment: Some commenters stated that they opposed the proposal because it adds to the burden and cost to providers without any demonstrated need to do so, while providing relatively small benefit to HCFA.

Response: This rule should not add to the burden and costs to providers. It merely conforms regulations to present policies and longstanding practices regarding the circumstances under which Medicare recognizes, for purposes of program payment, a provider's claim for costs for which the provider has not actually expended funds during the current cost reporting period. It does not require changes in reporting or recordkeeping.

We do not agree that this rule provides a relatively small benefit to HCFA. Incorporation in the regulations of our longstanding policies will clarify that Medicare does not make payment for provider expenses for which the associated liabilities are not liquidated timely.

Comment: Several commenters stated that the proposed rule constituted a policy change, rather than just a codification of existing policy. They believe that the proposed changes to the regulations improperly deny payment for substantial costs incurred in furnishing services to Medicare beneficiaries. They opposed any changes to the existing definition of the accrual basis of accounting in regulations at § 413.24(b)(2). In addition, some commenters stated that we do not have authority to implement changes in Medicare regulations retroactively. They believe that this new provision may not be applied to services provided before the effective date of this final rule.

Response: This final rule does not implement a change in Medicare policy. Rather, it incorporates into the regulations our longstanding policy on the timely liquidation of liabilities, as contained in sections 704.3, 704.5, 906.4, 2140, 2144.8, 2144.9, 2146, 2162.9, and 2305 of the Provider Reimbursement Manual. Accordingly, this final rule does not represent a retroactive change in Medicare payment policy. Program manuals contain HCFA's guidelines for implementing the statute and regulations, that is, on how we interpret the statute and regulations. Our policy guidelines on the timely liquidation of liabilities have been included in the Provider Reimbursement Manual for many years. These guidelines are now being incorporated into the Code of Federal Regulations, as of the prospective effective date of this final rule.

Comment: One commenter believes the proposed rule places intermediaries in the role of ''policemen'' to determine whether a provider is a ''going concern''.

Response: Under this rule, providers simply would be required to liquidate liabilities timely in accordance with our longstanding policies, in order for them to be allowable costs for Medicare payment purposes. The rule adds no new requirements regarding whether a provider is a going concern. As always, intermediaries will monitor a provider's furnishing of patient care services. If a provider goes out of business, it is still necessary for the provider to timely

liquidate liability for expenses paid by the Medicare program.

Comment: According to one commenter, when HCFA implemented the prospective payment system for hospitals in 1983, we stated that after capital and outpatient cost reimbursement were folded into the prospective payment system, the hospital cost reports would become obsolete and could be phased out. In light of this statement, the commenter believes that the cost reporting burden on providers should not be expanded, and objects to HCFA's proposal to expand the burden of cost reporting by no longer allowing GAAP.

Response: Section 1886(f) of the Act requires the Secretary to maintain a system of cost reporting for hospitals receiving payments under the prospective payment system. Thus, the submission of cost reports continues to be a statutory requirement. Moreover, even if cost reporting were not necessary for prospective payment purposes, cost reporting continues to be required to determine Medicare payment for outpatient services in prospective payment hospitals and for services in other types of providers.

We are not expanding the burden of cost reporting. Providers have always been required to maintain sufficient financial records and statistical data of costs payable under the program (§ 413.20(a)). This rule simply codifies in the regulations Medicare's longstanding policy regarding the timing of payment for accrued costs by requiring timely liquidation of liabilities in order to receive Medicare payment. This policy is intended to prevent the outlay of Federal trust funds before they are needed to pay the costs of providers' actual expenditures. It does not require changes in reporting or recordkeeping and, therefore, does not expand the burden of cost reporting.

Comment: One commenter stated that the proposed rule conflicts with the requirements of the Medicare law and regulations, and noted that HCFA has recognized that the Medicare law requires it to determine payment in accordance with standardized accounting practices widely accepted in the hospital and related fields. Furthermore, the commenter pointed out that, in *National Medical Enterprises* v. *Bowen,* 851 F. 2d 291, 294 (9th Cir. 1988), the United States Court of Appeals for the Ninth Circuit concluded that the accounting standards used by hospitals to calculate and record costs are integral parts of Medicare regulations regarding what is a reasonable cost under Medicare.

Response: The rule implements already existing policy. We believe it does not conflict with the authority in the law or the regulations that implement the law. On the contrary, section 1861(v)(1)(A) of the Act defines reasonable cost as cost actually incurred, and states that reasonable costs shall be determined in accordance with regulations. Thus, the Secretary has broad discretion to define reasonable cost by regulation.

We are aware of the court's decision in *National Medical Enterprises* regarding the applicability of accepted accounting standards (such as GAAP) in determining reasonable cost under Medicare. However, *National Medical Enterprises* does not hold that generally accepted accounting principles supersede explicit Medicare instructions stated in the regulations. GAAP is important to a provider in maintaining its books and records and is relevant to the determination of Medicare payment when there is no Medicare policy on point. However, as discussed in our response to an earlier comment, GAAP and Medicare payment policy have different purposes. Unlike GAAP, which is intended to be used to present the financial position of an organization, Medicare policy specifically deals with paying providers for costs incurred in furnishing care to Medicare beneficiaries. For payment purposes, the Medicare Trust Funds should not be required to pay a provider for costs associated with liabilities that are not liquidated timely. Thus, we do not believe that Medicare policy must fully incorporate GAAP. To the extent that the *National Medical Enterprises* case differs with our policy on GAAP, we believe that case is inconsistent with the decision of the Supreme Court in *Shalala* v. *Guernsey Memorial Hosp.,* 115 S. Ct. 1232 (1995). (We note that we are developing a notice of proposed rulemaking to clarify the general applicability of GAAP to Medicare payment policy.)

Comment: One commenter asserted that HCFA's purpose in proposing the rule change is solely financial. The commenter stated further that courts have held that HCFA may not create an interpretation of the Medicare statute or regulations simply as a means of saving money (*Villa View Community Hospital, Inc.* v. *Heckler,* 720 F. 2d 1086, 1094 (9th Cir. 1983)).

Response: The primary purpose of the rule is to codify in regulations longstanding policy precluding Medicare payment for otherwise allowable costs in cases in which a provider has not liquidated timely the liability associated with the expense. For HCFA not to recover its payment for a cost accrued by a provider when the provider fails to make an expenditure to liquidate timely its liability on an obligation is not appropriate. In effect, the provider would be paid by Medicare for an expense for which it has had no outlay of funds, which is not consistent with the law. Thus, this rule does not constitute an interpretation of Medicare statute or regulations simply designed to save money, and, therefore, it is not in conflict with the reasoning of *Villa View Community Hospital.*

Comment: Several commenters stated that the proposal violates principles of accrual accounting and would force an already over-regulated industry to maintain two sets of books. They also alleged that provider costs would escalate dramatically as a result of providers being forced to spend untold hours converting to cash basis accounting.

Response: This change does not violate the principles of accrual accounting; rather, it provides time limitations by which liabilities must be liquidated in order to receive Medicare payment for the year of accrual. Providers initially record their costs in their books and records in accordance with GAAP and, subsequently, make necessary reclassifications and adjustments in their Medicare cost reports to conform with Medicare policy. The incorporation into regulations of already-functioning time limitations related to accrued costs would not change providers' established accounting systems or their preparation of Medicare cost reports. Therefore, a provider would not have to maintain two sets of books to comply with this regulation, nor would the regulations require conversion to cash basis accounting.

Comment: One commenter stated that the proposed change will prove to be detrimental to providers due to the wide variety of possible interpretations by fiscal intermediaries.

Response: We believe that the commenter's contention that this rule raises the possibility of a wide variety of interpretations by fiscal intermediaries is unfounded. The purpose of the rule is to avoid this possibility by explicitly setting forth in regulations longstanding policy that mandates specific time frames for liquidation of liabilities.

Comment: One commenter suggested that we include in the final rule examples of workers' compensation plans structured to lend themselves to unwarranted payment of Federal funds, for example, (1) situations in which a provider's workers' compensation

insurance premium payments are funneled back to a reinsurer related to the provider, or (2) situations in which a provider may have the option of paying less than the insurance premium billed to it (that is, claim an accrual for the billed premium but eventually pay the insurer a smaller amount). The commenter felt the regulations should be clear that a provider's costs are payable only to the extent that the provider has actually paid a premium.

Response: We have chosen not to incorporate the commenter's examples in the regulations. However, we agree that Medicare cannot properly pay a provider unless the provider has actually incurred a cost. In the first example, the provider's intermediary must examine the situation of an insurer reinsuring with a party related to the provider. To the extent the intermediary determines the provider's premiums are unnecessarily or improperly funneled back to a party related to the provider, the premiums would be unallowable. In the second example, to the extent that a provider does not fully liquidate its accrual, that portion of the accrual would be unallowable.

Comment: One commenter took exception to the proposal's claim that no additional information collection requirements would be imposed as a result of the proposed changes to the regulations. The commenter stated that the requirement that unfunded deferred compensation (for example) be an allowable cost only during the period in which actual payment was made to the employee would necessitate additional recordkeeping by providers who must convert their financial reporting systems.

Response: Medicare policy for unfunded deferred compensation plans remains unchanged. If deferred compensation is unfunded, Section 2140.2 of the Provider Reimbursement Manual has long indicated that the provider does not claim an expense until actual payment is made to the employee (or accrued and liquidated timely). Any necessary recordkeeping should already be in place to comply with existing policy. No new or additional recordkeeping would be required under this rule.

Comment: One commenter believes the proposal addressed a concern with over-accrual of costs but failed to provide for under-accrual of costs. The commenter indicated that if payment subsequent to filing the cost report exceeds the accrual, there is no ready mechanism to correct the under-accrued costs and to obtain proper payment. Similarly, the rule should be clarified to allow the provider to increase its interest expense in a situation in which accrued investment income is offset against interest costs but payment is not subsequently received.

Response: If the amount actually expended is greater than the accrual, the excess amount may be treated as paid on a cash basis. Similarly, if the amount of investment income actually realized is less than the amount of the accrual, the amount received serves as the basis for making an appropriate adjustment (that is, to allow additional interest expense).

Comment: One commenter stated that if this rule were adopted, providers would incur costs in treating Medicare patients that would not be paid by Medicare, thus forcing providers to shift incurred costs to other patients. The commenter noted that such cost shifting is prohibited by section 1861(v)(1)(A) of the Act.

Response: In accordance with our policy involving the accrual basis of accounting, Medicare has always paid a provider for incurred costs for which the related liability has been properly accrued, even though the provider has not transferred actual assets to satisfy its obligation. That is, Medicare, through interim payments and eventually through the cost report settlement process, has paid its share of the cost even though the provider in some cases has not yet expended any funds. To the extent that Medicare pays before the provider expends funds, Medicare has made an advance payment for the cost. The purpose of this rule is to recover Medicare's payment after permitting the provider a reasonable period of time in which to liquidate its obligation, if liquidation has not occurred within the required time period. To recover Medicare payments for costs for which the provider has not timely liquidated its obligation does not shift incurred costs to non-Medicare patients.

Comment: One commenter stated that the rule should be clarified to reflect that providers are entitled to be paid for the current period's amortized portion of costs that are not liquidated within 1 year, such as bond discount or bond issue costs.

Response: We do not agree that clarification is necessary. The regulation addresses costs for which liabilities are incurred and must be liquidated timely in order to receive Medicare payment for the year of accrual. It is not intended to apply to the current year's amortized portion of costs, which do not require current liquidation.

Comment: One commenter believed that the savings to the program cited in the proposed rule are suspect because in the vast majority of cases for the items in question, payment to the provider merely will be deferred to a later period. Therefore, a savings to the government would not be permanent.

Response: We did not identify any ''savings'' in the proposed rule. Rather, we stated that the lack of clarification in the regulations involving the accrual basis of accounting forced the Medicare program to settle cases involving accrued sick leave, FICA taxes, deferred compensation, and unpaid mortgage interest. We indicated our belief that without a change to the regulations, the Medicare program could be forced to pay additional amounts of accrued liabilities even though providers may not liquidate the liabilities on a current (that is, timely) basis.

This rule will result in a clearer statement in the regulations of our policy precluding Medicare payment for expenses in a cost reporting period for which the associated liability is not liquidated timely. If the liability is not liquidated timely, Medicare will recover payment it made for the year of accrual. (Generally, recovery is applicable to the actual year of accrual, although it could apply to a later period in some cases, such as for vacation pay.) Should the liability thereafter be liquidated and our policy provides for Medicare payment in that subsequent period, there will be a Medicare outlay for that period. In cases in which the liability is never liquidated, Medicare does not share in the cost, in the current period or a later period.

B. Self-Insurance

Comment: Some commenters noted that under the proposal, self-insurance program costs would have to be paid within 75 days after the close of the cost reporting period. They suggested that we modify the proposed change to allow program payment in the cost reporting period in which the provider incurs the cost, provided that payment by the provider is made within the timeframes specified in the provider's self-insurance funding plan.

Response: The commenter suggests that the program should recognize a provider's own established time frames in liquidating liabilities for contributions to a self-insurance fund. This would defeat the purpose of the rule, which requires a consistent time frame to be used by all providers, in accordance with longstanding program policy.

Comment: One commenter stated that the proposed rule was not clear as to Medicare's policy in cases in which a self-insurer provides advance funding under State law, and the account is

maintained and administered by the provider.

Response: By definition, self-insurance is a means whereby a provider undertakes the risk of protecting itself against anticipated liabilities by providing equivalent funds to liquidate those liabilities. In order for the contributions to a self-insurance fund to be recognized under Medicare, the self-insurance fund must be established with an independent fiduciary such as a bank, a trust company, or a private benefit administrator. In the case of a State or local governmental provider or pool, the State in which the provider or pool is located may act as a fiduciary. In either case, section 2162.7 of the Provider Reimbursement Manual sets forth stringent criteria that must be met in order to gain program recognition as a self-insurance fund. These criteria are designed to ensure the soundness and independent integrity of the fund. The situation alluded to, in which the account is maintained and administered by the provider, would not qualify.

C. All-Inclusive Paid Days Off

Comment: One commenter suggested that we modify the proposal to allow for differences in benefit plans across entities within a company. In some of the provider's facilities, according to the commenter, the benefit plan permits employees to accrue leave or payment in lieu of leave for any combination of types of leave, with some employees accruing leave over an extended period of time. The commenter believes that the proposal creates discrimination among employees even when the different plans do not, and that the proposed change may cause companies to remove the flexibility and control that employees currently have over their benefit plans.

Response: Our intent is not to remove the flexibility a provider's employees may have over their benefit plans. If a provider's vacation policy or its all-inclusive paid days off policy is consistent among all employees, liquidation of the liability is not limited by the proposal. The accrued costs of benefits in the period earned remain costs of that period provided that liquidation of the benefits is made within the period provided for by the provider's policy. Consistent application under a policy may provide for increased benefits based on years of service, provided it applies in the same manner to all employees.

We believe that consistent application of the provider's policy ensures that an employee actually takes the vacation or all-inclusive paid days off benefits for the costs that are claimed.

D. Short-Term Liability

Comment: One commenter believes that if consistency and assurance of payment for actual costs are the goals, it is inappropriate to allow a 3-year extension for ''good cause'' for payment of short-term liabilities. The commenter views such a determination as being highly subjective and largely dependent upon the good will of the fiscal intermediary. Instead, the commenter suggested that we allow liquidation of liabilities consistent with GAAP and in conformity with existing provider agreements and policies regardless of whether those policies cover accrued benefits, self-insurance, or deferred compensation payments.

Response: We do not agree with the commenter's suggestion to allow liquidation of liabilities in accordance with GAAP and in conformity with existing provider agreements and policies. The purpose of the regulation is to assure that Medicare recognizes only costs associated with a liability that is timely liquidated through an actual expenditure of funds. GAAP does not offer this assurance for Medicare.

Although the end of the year following the year of accrual permits adequate time for timely liquidation of liabilities in the vast majority of cases, we believe that an extension of up to 2 additional years is appropriate if a provider can support its need for additional time in accordance with instructions in the Provider Reimbursement Manual. We do not believe the granting of an extension is subjective or dependent on the goodwill of the intermediary.

Comment: One commenter suggested that we clarify that if short-term liabilities are the subject of dispute or litigation, they need not be discharged within 1 or even 3 years.

Response: Even in disputed cases or cases that are in litigation, our policy on the timely liquidation of liabilities still applies. The policy does not disadvantage a provider even if the liability is not discharged within 1 year, or up to 3 years in the case of an extension granted by the intermediary for cause. While the cost cannot be paid by Medicare in the year of accrual in the absence of timely liquidation of the liability, the cost can be claimed in the cost reporting period when the liquidation of the liability occurs, that is, when an actual expenditure takes place, as currently described in section 2305 of the Provider Reimbursement Manual.

Comment: One commenter suggested that we permit providers terminated from Medicare to obtain payment for all properly accrued costs incurred during their final cost reporting period (together with costs incurred after termination authorized under section 2176 of the Provider Reimbursement Manual).

Response: All properly accrued allowable costs are recognized for a provider that is terminating from the Medicare program. However, the rules for liquidation of liabilities contained in the proposed regulation continue to apply. That is, although a provider is terminating, the intermediary must still assure that the liability is timely liquidated.

Comment: One commenter suggested that the final rule should explicitly provide that the regulations are intended to address only short-term liabilities, that is, amounts normally paid within 1 year of the date the cost report is filed, and not the discharge of long-term liabilities.

Response: In this final rule, we have revised § 413.24(c)(3)(i) of the proposed rule (now § 413.100(c)(2)(i)) to provide that short-term liabilities include the current portion of long-term liabilities, such as the mortgage interest due to be paid in the current year. That is, the portion of a long-term liability due in the current year is a short-term liability for the year. Section 413.100(c)(2)(i) of this rule does not apply to portions of long-term liabilities due in future periods.

E. Compensation of Owners

Comment: One commenter stated that the proposed rule appears to indicate that the liability must be liquidated in the form of cash within 75 days after the close of the cost reporting period. The commenter noted that section 906.4 of the Provider Reimbursement Manual recognizes a promissory note as liquidation and recommended that the language in the regulations should be consistent with that in the Provider Reimbursement Manual. Another commenter stated that if we intend to propose more restrictive requirements on compensation of owners, we should also specifically provide in regulations that the issuance of an enforceable note to the owner for the amount of compensation should constitute liquidation of the accrued liability.

Response: The proposed rule stated simply that liquidation of an owner's compensation accrual must occur within 75 days after the close of the cost reporting period in which the liability occurs. We do not plan to specify in the regulations the manner of liquidation,

but rather have chosen to continue to address those specifics in the Provider Reimbursement Manual. Therefore, the proposed regulation did not provide a more restrictive liquidation policy than existing policy in the Provider Reimbursement Manual.

However, we intend to revise section 906.4 of the Provider Reimbursement Manual to deny recognition of the liquidation of liabilities by use of a promissory note without the actual transfer of assets within 75 days of the close of the cost reporting period. Revised section 906.4 then will be consistent with instructions in section 2305 of the Provider Reimbursement Manual concerning requirements for liquidating liabilities. Those instructions (albeit with different time limitations) require that a liability actually be liquidated by the end of the appropriate time period, rather than being extended by way of another liability, for example, a promissory note.

F. FICA and Other Payroll Taxes

Comment: One commenter asserted that accrual of employer-related FICA liabilities is clearly appropriate under GAAP as well as under § 413.24(b)(2), and that HCFA should continue to allow recognition of these costs especially as they relate to the accrual of year-end wages.

Response: We believe that employer-related FICA taxes should be accrued and claimed for Medicare payment only in the period in which actual payment to the employee is made. It is not until that point that the liability for the employer-related FICA tax is incurred.

Comments: One commenter pointed out that the preamble language in the proposed rule stated that FICA and other payroll taxes related to vacation pay and nonpaid workers would be paid only in the period in which payment is actually made to the employee. Yet, the language of proposed § 413.24(c)(3)(vi) indicated that all FICA and payroll taxes would be handled in the same way. The commenter suggested that we clarify the discrepancy in the final rule.

Response: Even though the preamble language for the proposed rule specifically addressed only payroll taxes related to vacation pay and nonpaid workers, our intent was to prohibit the accrual and claim for Medicare payment of such taxes for all types of payments until the period in which payment (on which the tax is based) is actually made to the employee. Thus, as the commenter suggests, and as the regulations text has always specified, this policy applies to all FICA and payroll taxes.

Comment: Some commenters stated that the applicable FICA and other payroll taxes should be accrued during the same period that the employee benefits are earned and accrued. One commenter stated that FICA and other payroll accruals apply equally to accrued vacation, holiday, and sick pay benefits. Another commenter suggested that if such payments are not made to employees in subsequent years, Medicare may recover the excess cost in subsequent years.

Response: We continue to believe that such taxes should not be accrued and claimed for Medicare payment until the period in which actual payment to the employees is made. It is at that point that the liability for the related payroll taxes is incurred.

G. Sick Pay

Comment: Regarding the sick leave example in the proposed rule (56 FR 50835), one commenter believes that providers would not typically accrue for forfeitable sick leave. Even if providers do so, the commenter believes that Medicare could avoid payment by requiring forfeitures to be offset against subsequent sick pay costs.

Response: We agree with the commenter that providers should not accrue forfeitable sick leave. However, we disagree that where forfeitable sick leave is accrued and claimed for Medicare payment, Medicare would avoid payment by requiring forfeitures to be offset against sick pay costs incurred during the period in which the forfeitures occur. Handling forfeitable sick leave in this manner would result in Medicare recognizing and paying for excessive sick leave costs up until the point of forfeiture.

As a result of this comment, we have made two revisions to this final rule. First, we have clarified under § 413.100(c)(2)(iii)(A) that if sick leave is funded in a deferred compensation plan, the contributions to the fund must take into account forfeitures. Second, if an employee has the right to demand cash payment at the end of the year, we believe that forfeitures are not an issue because the employee has earned a nonforfeitable right. Accordingly, we also have specified under § 413.100(c)(2)(iii)(B) that if a provider's sick leave plan grants employees the nonforfeitable right to demand cash payment for unused sick leave at the end of each year, sick pay is includable in allowable costs, without funding, in the cost reporting period in which it is earned.

Comment: One commenter asserted that providers should not be financially disadvantaged by disallowance of accrued benefits that are vested but subject to forfeiture clauses. The commenter stated that such clauses are financially prudent and result in lower Medicare program costs.

Response: We believe the commenter is concerned that if forfeitures are possible, Medicare would not recognize any accrual of sick leave. On the contrary, as discussed in the response to the preceding comment, if sick leave is funded in a deferred compensation plan, the contributions to the fund must take into account forfeitures. That is, the accrual of the contributions to the deferred compensation fund reflects anticipated forfeitures. However, the issue of forfeitable sick leave occurs only in the context of contributions to a deferred compensation fund. In a situation in which an employee has the right to demand cash at the end of the year for unused sick leave, the employee has earned a nonforfeitable right. In all other situations, sick pay can be claimed for Medicare payment only on a cash basis for the year in which the benefits are paid; therefore, the issue of accrual of forfeitable sick leave does not arise.

In proposing to incorporate Medicare's policy on sick leave costs (contained in section 2144.8 of the Provider Reimbursement Manual) into the regulations, we believe it was understood that sick pay costs can be claimed for payment only in the cost reporting period in which paid, unless the sick leave is funded in a deferred compensation plan or unless an employee has the nonforfeitable right to demand cash at the end of the year for unused sick leave. This policy has been included in section 2144.8 for many years. Nevertheless, we have revised the regulations by specifying under § 413.100(c)(2)(iii)(C) that sick pay costs can be claimed only on a cash basis if paid on any bases other than those in § 413.100(c)(2)(iii) (A) or (B) (that is, through a funded deferred compensation plan, or in situations in which the sick leave plan grants employees the nonforfeitable right to demand cash payment for unused sick leave at the end of each year).

Comment: One commenter stated that although timing differences will occur in any accrual method of accounting, in total, the program is not overpaying since any overestimate of expenses in one year is offset by reduction in accrued expenses in a subsequent period when the sick leave, vacation, and other types of leave are determined to be overaccrued.

Response: The purpose of the longstanding policy on liquidation of liabilities, which we proposed to incorporate in the regulations, is to

assure that a provider properly claims costs during each cost reporting period. Costs claimed during a period for which the related liability may never be liquidated result in overpayment of the costs in the year the costs are claimed. Reduction in accrued expenses in a subsequent period when sick leave is determined to be overaccrued results in Medicare's recognizing and paying for excessive costs up until the point when accrued expenses are reduced in the subsequent period.

However, in the case of vacation benefits, we are incorporating into the regulations the policy that is currently included in the Provider Reimbursement Manual regarding liquidation of the vacation accrual. In proposing to incorporate the requirements of section 2146, Medicare's policy on vacation costs, into the regulations, we believe it was understood that if payment is not made within the required time period or if benefits are forfeited by the employee, the adjustment to disallow the cost is made in the current period (that is, the latest year in which payment should have been made or the year in which the benefits are forfeited) rather than in the period in which the cost was accrued and claimed for Medicare payment. (However, an intermediary may choose to require adjustment in the period in which the cost was accrued and claimed for Medicare payment if the cost report for that period is open or can be reopened, and if the intermediary believes the adjustment is more appropriate in that period.) This policy has been included in section 2146.2 for many years. The new § 413.100(c)(2)(ii)(C) codifies this longstanding policy.

Comment: One commenter asserted that administrative costs associated with a funded deferred compensation plan (required when sick pay is not payable at year end) would prohibit the implementation of such plans in numerous facilities—effectively eliminating this form of ''short-term disability insurance.''

Response: If a provider is unable to afford the administrative costs associated with establishing a deferred compensation plan, the provider could simply claim its sick pay costs at the time when payment is made to the employee, in accordance with § 413.100(c)(2)(iii)(C). Of course, under this arrangement, the provider would not be permitted to claim accrued sick pay costs. However, under § 413.100(c)(2)(iii)(B), if a provider's sick leave plan grants employees the nonforfeitable right to demand cash payment for unused sick leave at the end of each year, sick pay is includable in allowable costs, without funding, in the cost reporting period in which it is earned.

H. Vacation Pay

Comment: One commenter stated that the consistency requirement for vacations is unclear and has no relationship to the probability or timing of payment, and requested that the term ''consistent'' be limited to the time frame for liquidation of the vacation liability and not be extended to the rate of accrual. The commenter believes that as vacation pay benefits are vested, the accrual should be recognized—consistency between classes of employees is irrelevant.

Response: This rule codifies long-standing Medicare policy (section 2146 of the Provider Reimbursement Manual) regarding payment for vacation benefits. This policy recognizes the accrual of vacation benefits, and permits payment for the accrual in the cost reporting period in which the benefit is earned, if the provider's vacation policy regarding when the vacation must be taken—or when payment is made in lieu of the vacation—is consistent for all employees. If the policy regarding when vacation must be taken is not consistent among all employees, vacation must be taken or payment in lieu of vacation must be made within 2 years after the close of the cost reporting period in which the vacation was accrued in order for the accrual to be allowed in the year in which the vacation is earned.

We agree with the commenter that, for purposes of this Medicare vacation policy, a provider's vacation policy that is ''consistent among all employees'' addresses the provider's policy regarding the time frame in which vacation benefits must be used. The provider's policy may provide for different amounts of vacation accrual depending upon such factors as an employee's length of service, or whether the employee is managerial or nonmanagerial. We now believe our statement in the proposed rule that a provider's consistent policy is one in which no provision of the policy provides for different amounts of vacation benefits for certain positions and types of employees was an overextension of the language ''consistent among all employees''.

Medicare's vacation policy is intended to assure that a provider actually liquidates its accrued costs for vacation benefits. We believe the policy is clear and permits a high degree of flexibility for a provider. In situations in which a provider's vacation policy is not consistent for all employees regarding when vacation must be taken, Medicare's policy permits a reasonable time frame—2 years after the close of the cost reporting period in which the vacation was accrued—for liquidating vacation accruals in order for the accruals to be allowed in the year when the vacation is earned.

I. Deferred Compensation

Comment: One commenter expressed concern that the proposal would require hospitals to devote staff to track the payment of deferred compensation for 10, 20, or possibly more years in order to obtain payment.

Response: The proposed regulation did not change our current policy on deferred compensation, which has been in section 2140 of the Provider Reimbursement Manual for many years. If a provider's deferred compensation plan is funded in accordance with that policy, program payment has long been based on the current period contributions to the fund, provided liabilities related to the contributions are timely liquidated (usually within 1 year after the close of the current cost reporting period). Benefit payments from the deferred compensation fund, which can occur many years later, are part of the operation of the fund and do not affect program payments in the later periods when payments are actually made from the fund.

If a provider's deferred compensation is not funded in accordance with requirements in section 2140 of the Provider Reimbursement Manual, the manual instructions have long permitted program payment only during the period in which actual payment is made.

Therefore, these regulations require no more staff time to track deferred compensation payments than is used by providers under our current, longstanding policy.

Comment: One commenter asked that we add the word ''Plans'' to the title of § 413.24(c)(3)(vii) of the proposed rule, to read ''Deferred Compensation Plans'' and that we add a new paragraph (vii)(C), to read ''Deferred compensation plans under this section do not include accrued salaries and/or accrued bonuses that are allowable in the year earned, provided they are liquidated no later than the end of the provider's cost reporting period following the period in which the salary and bonuses were earned.''

Response: We believe it is clear that the salaries and bonuses referred to in the comment, which are earned currently and which are liquidated timely under this rule with no attempt to defer payment, are not treated as

deferred compensation. Therefore, we have not adopted the commenter's suggestion to address salaries and bonuses in the text of the regulation.

IV. Provisions of the Final Rule

This final rule generally confirms the provisions of the proposed rule, with the clarifying changes discussed above in the responses to comments. In addition, upon further consideration of the regulations text set forth in the proposed rule, we believe that one additional policy clarification is necessary.

Section 413.24(c)(2) of the proposed rule consisted of an example that indicated that the accrual of postretirement health benefits under Medicare cannot be recognized unless the liability for the benefits is liquidated timely. That example referred to Statement of Financial Accounting Standards (SFAS) No. 106 (December 1990), Employers' Accounting for Postretirement Benefits Other Than Pensions, without explicitly citing SFAS No. 106. SFAS No. 106, generally effective for fiscal years beginning after December 15, 1992, requires an employer to accrue the expected cost of providing postretirement benefits to employees (and the employees' beneficiaries and covered dependents) during the years the employees provide the necessary services. However, it does not provide for timely liquidation of the accruals in accordance with Medicare policy. Accordingly, the example clarified, consistent with Medicare policy, that the accrual of postretirement benefits (addressed in SFAS No. 106) cannot be recognized in allowable costs in the year of the accrual without timely liquidation of the related liability.

We now believe that the original example is unnecessary in the final rule. Because payment for postretirement benefits is deferred, the benefits are deferred compensation. Therefore, Medicare policy on deferred compensation, funded and unfunded, applies to postretirement benefit deferred compensation plans as well as to other types of deferred compensation plans. The deferred compensation policy is found in section 2140 of the Provider Reimbursement Manual and also, with regard to liquidation of liabilities related to accrued deferred compensation costs, in § 413.100(c)(2)(vii) of this final rule. The deferred compensation policy sets forth the requirements to be met, including timely liquidation of liabilities, in order to receive Medicare payment for deferred compensation.

Under SFAS No. 106, a provider may have postretirement benefit obligations applicable to more than one year, for example, prior service costs, or a transition obligation (which, under SFAS No. 106, the provider may elect to accrue immediately or on a delayed basis). For purposes of Medicare payment, the deferred compensation policy provides, in Provider Reimbursement Manual section 2140.3.B.1 (by reference to section 2142.5, Pension Costs for Past and Current Service), that past service costs applicable to more than one cost reporting year must be amortized over a minimum of 10 years, even if the related liability for the accrual has been liquidated timely.

Therefore, in lieu of the example in proposed § 413.24(c)(2), we have clarified in § 413.100(c)(2)(vii)(C) of this final rule that postretirement benefit plans addressed in SFAS No. 106 are deferred compensation arrangements to which all the provisions of Medicare's deferred compensation policy apply.

We believe it should have been clear to readers of the proposed rule that Medicare's deferred compensation policy applies to all deferred compensation arrangements, including postretirement benefit plans. However, although the proposed rule addressed postretirement health benefits, clarifying that the accrual of such benefits cannot be recognized for Medicare payment in the year of the accrual without timely liquidation of the liability for the benefits, it did not emphasize the applicability of the deferred compensation policy in all respects to postretirement benefit plans.

Therefore, there could be situations in which a provider that has elected to accrue postretirement benefit past service costs over more than 10 years for accounting and reporting purposes (that is, for non-Medicare purposes) in conformity with SFAS No. 106, mistakenly believed it needed to use the same period for amortizing the costs for Medicare purposes. If, for Medicare purposes, the provider now wants to amortize the costs over fewer years, but not fewer than 10 years, it may request its intermediary, subject to the requirements in the regulations at § 405.1885, to make the change to applicable cost reporting periods in accordance with the longstanding policy in section 2140.3.B.1 of the Provider Reimbursement Manual. In all cases, Medicare payment is subject to the policy in this final rule and in Provider Reimbursement Manual section 2140.4 regarding timely liquidation of the associated accruals for the deferred compensation.

Correspondingly, if a provider has amortized the costs over fewer than 10 years for Medicare purposes without the express permission of its intermediary, the intermediary is required, subject to § 405.1885, to make necessary adjustments to conform the amortization to the policy in section 2140.3.B.1. of the Provider Reimbursement Manual. (We note that if a provider has been permitted by its intermediary to amortize such costs for Medicare purposes over fewer than 10 years, assuming timely liquidation of the associated accruals, the intermediary will not now make adjustments to reflect amortization over at least 10 years, nor is the provider required to make such a change.)

The other clarifying changes to the proposed rule that are set forth in this final rule, as discussed in our responses to public comments in Section IV of this final rule, are as follows:

- In § 413.100(c)(2)(i) of this rule, we have clarified that short-term liabilities also include the current portion of long-term liabilities, such as the mortgage interest due to be paid in the current year.
- We have added new § 413.100(c)(2)(ii)(C) to address necessary adjustment to a provider's cost report if accruals for vacation pay and all-inclusive paid days off are not properly liquidated. The new material incorporates policy currently in section 2146.2 of the Provider Reimbursement Manual, which provides that the adjustment to disallow accrued cost generally is made in the current period if payment for the vacation or all-inclusive paid days off is not made in the required time period or if benefits are forfeited by the employee.
- In § 413.100(c)(2)(iii)(A) concerning sick pay, we have clarified that contributions to the deferred compensation plan must be reduced to reflect estimated forfeitures.
- In § 413.100(c)(2)(iii)(B), we have clarified that only if an employee has a *nonforfeitable* right to demand cash for unused sick leave at the end of each year can the sick pay be includable in allowable costs, without funding, in the cost reporting period in which it is earned. We believe that, typically, an employee's right to demand cash for unused sick leave is nonforfeitable. However, in a situation in which an employee has a right to demand cash but, later, for any reason may not be entitled to receive the cash (that is, the amount is forfeitable under certain conditions), a provider cannot accrue the sick leave benefit and make a current year claim for Medicare payment under § 413.100(c)(2)(iii)(B)

because that section applies only to situations in which an employee's right to demand cash is nonforfeitable. Rather, the provider can claim the cost only in the year when paid to the employee, unless it meets the provisions of § 413.100(c)(2)(iii)(A).

- We have added new § 413.100(c)(2)(iii)(C) to clarify in the regulations Medicare's policy in section 2144.8 of the Provider Reimbursement Manual, that sick pay paid can be claimed for Medicare payment only on a cash basis if paid on any basis other than those in § 413.100(c)(2)(iii) (A) or (B) (that is, through a funded deferred compensation plan, or in situations in which the sick leave plan grants employees the nonforfeitable right to demand cash payment for unused sick leave at the end of each year).
- In § 413.100(c)(2)(viii), we have removed the language included in the proposed rule that addressed the allowability in subsequent periods of self-insurance accruals liquidated after the time limit provided in that section. We did not address that issue for any of the other types of accrued costs addressed in the proposed rule and thus we do not believe it would be consistent to address that issue here. This issue is already addressed in implementing manual instructions.
- We have revised the wording of §§ 413.100(c)(2)(i), (c)(2)(iii), and (c)(2)(vii)) of this rule to clarify that a request for extension to the 1-year time limit for liquidating a liability must be made within the 1-year time period. We believe it was clear that a provider could not reasonably request an extension after having failed to liquidate within the 1-year period. The regulation now specifically addresses this point.

In the same sections of the rule, we have removed the language included in the proposed rule describing ''good cause'' for an extension. Such description is already covered in section 2305 of the Provider Reimbursement Manual.

Finally, as explained in section III of this final rule, we are moving the proposed provisions of § 413.24(b)(3) and (4), and § 413.24(c) into a new § 413.100, Special Treatment of Certain Accrued Costs. For the convenience of the reader, presented below is a crosswalk that shows the regulatory citations for the provisions of the proposed rule and for the corresponding provisions of this final rule.

Proposed	Final
§ 413.24(b)(2)	§ 413.24(b)(2) § 413.100(a)
§ 413.24(b)(3)	§ 413.100(b)(1)
§ 413.24(b)(4)	§ 413.100(b)(2)
§ 413.24(c)	§ 413.100(c)
§ 413.24(c)(1)	§ 413.100(c)(1)
§ 413.24(c)(2)	delete
§ 413.24(c)(3)	§ 413.100(c)(2)
§ 413.24(c)(3)(i)(A)(B)	§ 413.100(c)(2)(i)(A)(B)
§ 413.24(c)(3)(ii)(A)(B)(C)	§ 413.100(c)(2)(ii)(A)(B)(C)
§ 413.24(c)(3)(iii)(A)(B)(C)	§ 413.100(c)(2)(iii)(A)(B)(C)
§ 413.24(c)(3)(iv)	§ 413.100(c)(2)(iv)
§ 413.24(c)(3)(v)	§ 413.100(c)(2)(v)
§ 413.24(c)(3)(vi)	§ 413.100(c)(2)(vi)
§ 413.24(c)(3)(vii)(A)(B)	§ 413.100(c)(2)(vii)(A)(B)(C)
§ 413.24(c)(3)(viii)	§ 413.100(c)(2)(viii)

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, we consider all hospitals, long-term care facilities, and other providers to be small entities.

Also, section 1102(b) of the Act requires us to prepare a regulatory impact statement if a final rule may have a significant economic impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain rural counties adjacent to urban areas, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with fewer than 50 beds.

Our intention in this rule is not to signify a change in policy but, rather, to incorporate in regulations our longstanding 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 cost reporting period. Because this rule merely conforms regulations to present policies and practices, we have determined, and certified, that this rule will not have a significant effect on the operations of a substantial number of small entities or small rural hospitals. Therefore, we have not prepared a regulatory flexibility analysis or an analysis of the impact of this rule on small rural hospitals.

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

VI. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1980 (44 U.S.C. 3501 et seq.).

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 is revised to read as follows:

Authority: Secs. 1102, 1861(v)(1)(A), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395x(v)(1)(A), and 1395hh).

2. In § 413.1, the following changes are made:

a. The heading of paragraph (a) is revised to read as set forth below.

b. Paragraph (a)(2) is redesignated as paragraph (a)(3).

c. Paragraph (a)(1) is redesignated as paragraph (a)(2), and the heading ''General summary.'' is removed and the heading ''Scope.'' is added in its place.

d. A new paragraph (a)(1) is added to read as follows:

§ 413.1 Introduction.

(a) *Basis, scope, and applicability*—(1) *Statutory basis.* (i) *Basic provisions.* Section 1815 of the Act requires that the Secretary make interim payments to providers and periodically determine the amount that should be paid under Part A of the Medicare program to each provider of services for services it furnished. Section 1814(b) of the Act (for Part A) and section 1833(a) of the Act (for Part B) provide for payment on the basis of the lesser of a provider's reasonable costs or customary charges. Section 1861(v) of the Act defines ''reasonable cost.''

(ii) *Additional provisions.* Section 1814(j) of the Act provides for exceptions to the ''lower of cost or charges'' provisions. Section 1833 (a)(4) and (i)(3) of the Act provide for payment of a blended amount for certain surgical services furnished in a hospital's outpatient department. Section 1833(n) of the Act provides for payment of a blended amount for outpatient hospital diagnostic procedures such as radiology. Section 1834(c)(1)(C) of the Act establishes the method for determining Medicare payment for screening mammograms performed by hospitals. Section 1881 of the Act authorizes payment for services furnished to ESRD patients. Section 1883 of the Act provides for payment for post-hospital SNF care furnished by rural hospitals having swing-bed approval. Section 1886(h) of the Act provides for payment to a hospital for the services of interns and residents in approved teaching programs on the basis of a ''per resident amount.''

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Subpart B—Accounting Records and Reports

3. Section 413.24 is amended by revising paragraph (b)(2) to read as follows:

§ 413.24 Adequate cost data and cost finding.

* * * * *

(b) *Definitions*—

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(2) *Accrual basis of accounting.* As used in this part, the term *accrual basis of accounting* means that revenue is reported in the period in which it is earned, regardless of when it is collected; and an expense is reported in the period in which it is incurred, regardless of when it is paid. (See § 413.100 regarding limitations on allowable accrued costs in situations in which the related liabilities are not liquidated timely.)

* * * * *

Subpart F—Specific Categories of Costs

4. Section 413.100 is added to read as follows:

§ 413.100 Special treatment of certain accrued costs.

(a) *Principle.* As described in § 413.24(b)(2), under the accrual basis of accounting, revenue is reported in the period in which it is earned and expenses are reported in the period in which they are incurred. In the case of accrued costs described in this section, for Medicare payment purposes the costs are allowable in the year in which the costs are accrued and claimed for Medicare payment only under the conditions set forth in paragraph (c) of this section.

(b) *Definitions.* (1) *All-inclusive paid days off benefit.* An all-inclusive paid days off benefit replaces other vacation and sick pay plans. It is a formal plan under which, based on actual hours worked, all employees accrue vested leave or payment in lieu of vested leave for any combination of types of leave, such as illness, medical appointments, holidays, and vacations.

(2) *Self-insurance.* Self-insurance is a means by which a provider independently or as part of a group undertakes the risk of protecting itself against anticipated liabilities by providing funds in an amount equal to anticipated liabilities, rather than by purchasing insurance coverage.

(c) *Recognition of accrued costs.*—(1) *General.* Although Medicare recognizes, in the year of accrual, the accrual of costs for which a provider has not actually expended funds during the current cost reporting period, for purposes of payment Medicare does not recognize the accrual of costs unless the related liabilities are liquidated timely.

(2) *Requirements for liquidation of liabilities.* For accrued costs to be recognized for Medicare payment in the year of the accrual, the requirements set forth below must be met with respect to the liquidation of related liabilities. If liquidation does not meet these requirements, the cost is disallowed, generally in the year of accrual, except as specified in paragraph (c)(2)(ii) of this section.

(i) *A short-term liability.*

(A) Except as provided in paragraph (c)(2)(i)(B) of this section, a short-term liability, including the current portion of a long-term liability (for example, mortgage interest payments due to be paid in the current year), must be liquidated within 1 year after the end of the cost reporting period in which the liability is incurred.

(B) If, within the 1-year time limit, the provider furnishes to the intermediary sufficient written justification (based upon documented evidence) for nonpayment of the liability , the intermediary may grant an extension for good cause. The extension may not exceed 3 years beyond the end of the cost reporting year in which the liability was incurred.

(ii) *Vacation pay and all-inclusive paid days off.*

(A) If the provider's vacation policy, or its policy for all-inclusive paid days off, is consistent for all employees, liquidation of the liability must be made within the period provided for by that policy.

(B) If the provider's vacation policy, or its policy for all-inclusive paid days off, is not consistent for all employees, liquidation of the liability must be made within 2 years after the close of the cost reporting period in which the liability is accrued.

(C) If payment is not made within the required time period or if benefits are forfeited by the employee, an adjustment to disallow the accrued cost is made in the current period (that is, the latest year in which payment should have been made or the year in which the benefits are forfeited) rather than in the period in which the cost was accrued and claimed for Medicare payment. However, an intermediary may choose to require the adjustment in the period in which the cost was accrued and claimed for Medicare payment if the cost report for that period is open or can be reopened as provided in § 405.1885 of this chapter, and if the intermediary believes the adjustment is more appropriate in that period.

(iii) *Sick pay.*

(A) If sick leave is vested and funded in a deferred compensation plan, liabilities related to the contributions to the fund must be liquidated, generally within 1 year after the end of the cost reporting period in which the liability is incurred. If, within the 1-year time limit, the provider furnishes to the intermediary sufficient written justification (based upon documented evidence) for nonpayment of the liability, the intermediary may grant an extension for good cause. The extension may not exceed 3 years beyond the end

of the cost reporting year in which the liability was incurred. Contributions to the deferred compensation plan must be reduced to reflect estimated forfeitures. Actual forfeitures above or below estimated forfeitures must be used to adjust annual contributions to the fund.

(B) If the sick leave plan grants employees the nonforfeitable right to demand cash payment for unused sick leave at the end of each year, sick pay is includable in allowable costs, without funding, in the cost reporting period in which it is earned.

(C) Sick pay paid on any basis other than that specified in paragraphs (c)(2)(iii) (A) or (B) of this section can be claimed for Medicare payment only on a cash basis for the year in which the benefits are paid.

(iv) *Compensation of owners.* Accrued liability related to compensation of owners other than sole proprietors and partners must be liquidated within 75 days after the close of the cost reporting period in which the liability occurs.

(v) *Nonpaid workers.* Obligations incurred under a legally-enforceable agreement to remunerate an organization of nonpaid workers must be discharged no later than the end of the provider's cost reporting period following the period in which the services were furnished.

(vi) *FICA and other payroll taxes.* The provider's share of FICA and other payroll taxes that the provider becomes obligated to remit to governmental agencies is included in allowable costs only during the cost reporting period in which payment (upon which the tax is based) is actually made to the employee. For example, no legal obligation exists for a provider-employer to pay FICA taxes until the employee is paid and the specific amount of liability known.

(vii) *Deferred compensation.*

(A) Reasonable provider payments made under unfunded deferred compensation plans are included in allowable costs only during the cost reporting period in which actual payment is made to the participating employee.

(B) Accrued liability related to contributions to a funded deferred compensation plan must be liquidated within 1 year after the end of the cost reporting period in which the liability is incurred. An extension, not to exceed 3 years beyond the end of the cost reporting year in which the liability was incurred, may be granted by the intermediary for good cause if the provider, within the 1-year time limit, furnishes to the intermediary sufficient written justification for non-payment of the liability.

(C) Postretirement benefit plans (including those addressed in Statement of Financial Accounting Standards No. 106 (December 1990)) are deferred compensation arrangements and thus are subject to the provisions of this section regarding deferred compensation and to applicable program instructions for determining Medicare payment for deferred compensation.

(viii) *Self-insurance.* Accrued liability related to contributions to a self-insurance program that are systematically made to a funding agency and that cover malpractice and comprehensive general liability, unemployment compensation, workers' compensation insurance losses, or employee health benefits, must be liquidated within 75 days after the close of the cost reporting period.

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

Dated: April 20, 1995.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

[FR Doc. 95–15341 Filed 6–26–95; 8:45 am]

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42 CFR Part 413

[BPD–794–F]

RIN 0938–AG55

Medicare Program; Date for Filing Medicare Cost Reports

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

ACTION: Final rule.

SUMMARY: This final rule extends the time frame providers have to file cost reports from no later than 3 months after the close of the period covered by the report to no later than 5 months after the close of that period. This change is necessary to ensure that providers have an adequate amount of time to file complete and accurate cost reports. We are also defining what HCFA considers to be an ''acceptable'' cost report submission.

EFFECTIVE DATE: These regulations are effective June 27, 1995. Thus, for cost reporting periods ending before June 27, 1995, cost reports continue to be due no later than 3 months following the close of the cost reporting period. For cost reporting periods ending on or after June 27, 1995, cost reports are due no later than 5 months following the close of the cost reporting period.

FOR FURTHER INFORMATION CONTACT: Katie Walker (410) 966–7278.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1815(a) of the Social Security Act (the Act) requires that each provider participating in the Medicare program submit information (as requested by the Secretary) in order to determine the amount of payment due to the provider for services furnished under the Medicare program. Implementing regulations at 42 CFR 413.24(f) require that participating providers submit cost reports that generally cover a consecutive 12-month period of the provider's operations. Section 102 of the Provider Reimbursement Manual, Part II (PRM-II), states that a provider may select any annual period for Medicare cost reporting purposes regardless of the reporting period it uses for other purposes. Once a provider has informed the Health Care Financing Administration (HCFA) of its selection, HCFA requires it to report annually thereafter for periods ending on the same date unless that provider's intermediary approves a change in the provider's reporting period. The intermediary makes interim payments to the provider during the provider's cost reporting year. Based on the annual cost report, a retroactive adjustment is made after the end of the provider's cost reporting year to bring the interim payments made during the period into agreement with the reimbursable amount payable to the provider. Section 413.24(f)(2)(i) specifies that cost reports are due on or before the last day of the third month following the close of the period covered by the report. Section 413.24(f)(2)(ii) states that the intermediary may grant a 30-day extension of the due date, for good cause, after first obtaining the approval of HCFA. Section 104.A.2 of the PRM requires that in order to obtain an extension, the provider must submit a written request and obtain written approval from its intermediary before the cost report due date.

A provider that voluntarily or involuntarily terminates its participation in the Medicare program, or experiences a change of ownership, must file a cost report no later than 45 days following the effective date of the termination of the provider agreement or the change of ownership, as required by § 413.24(f)(2)(iii). HCFA will not grant an extension of the cost report due date in either of these situations.

To ensure timely receipt of the cost reports, section 2231.1 of the Medicare Intermediary Manual, Part 2, requires that the intermediary send a ''reminder'' letter to the provider at the end of the second month following the end of the