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