SUPREME COURT OF THE UNITED STATES

No. 93–1251

DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER *v.*
GUERNSEY MEMORIAL HOSPITAL

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

[March 6, 1995]

JUSTICE KENNEDY delivered the opinion of the Court.

In this case a health care provider challenges a Medicare reimbursement determination by the Secretary of Health and Human Services. What begins as a rather conventional accounting problem raises significant questions respecting the interpretation of the Secretary's regulations and her authority to resolve certain reimbursement issues by adjudication and interpretive rules, rather than by regulations that address all accounting questions in precise detail.

The particular dispute concerns whether the Medicare regulations require reimbursement according to generally accepted accounting principles (GAAP), and whether the reimbursement guideline the Secretary relied upon is invalid because she did not follow the notice-and-comment provisions of the Administrative Procedure Act in issuing it. We hold that the Secretary's regulations do not require reimbursement according to GAAP and that her guideline is a valid interpretive rule.

Respondent Guernsey Memorial Hospital issued bonds in 1972 and 1982 to fund capital improve-

ments. In 1985, the Hospital refinanced its bonded debt by issuing new bonds. Although the refinancing will result in an estimated $12 million saving in debt service costs, the transaction did result in an accounting loss, sometimes referred to as an advance refunding or defeasance loss, of $672,581. The Hospital determined that it was entitled to Medicare reimbursement for about $314,000 of the loss. The total allowable amount of the loss is not in issue, but its timing is. The Hospital contends it is entitled to full reimbursement in one year, the year of the refinancing; the Secretary contends the loss must be amortized over the life of the old bonds.

The Secretary's position is in accord with an informal Medicare reimbursement guideline. See U. S. Dept. of Health and Human Services, Medicare Provider Reimbursement Manual §233 (Mar. 1993) (PRM). PRM §233 does not purport to be a regulation and has not been adopted pursuant to the notice-and-comment procedures of the Administrative Procedure Act. The fiscal intermediary relied on §233 and determined that the loss had to be amortized. The Provider Reimbursement Review Board disagreed, see App. to Pet. for Cert. 54a, but the Administrator of the Health Care Financing Administration reversed the Board's decision, see *id.*, at 40a. In the District Court the Secretary's position was sustained, see *Guernsey Memorial Hospital* v. *Sullivan*, 796 F. Supp. 283 (SD Ohio 1992), but the Court of Appeals reversed, see *Guernsey Memorial Hospital* v. *Secretary of HHS*, 996 F. 2d 830 (CA6 1993). In agreement with the Hospital, the court interpreted the Secretary's own regulations to contain a "flat statement that generally accepted accounting principles `are followed'" in determining Medicare reimbursements. *Id.*, at 833 (quoting 42 CFR §413.20(a)). Although it was willing to accept the argument that PRM §233's treatment of advance refunding losses "squares with economic reality," 996 F. 2d, at 834, the Court of Appeals concluded that, because PRM §233 departed from GAAP, it "effects a substantive change in the regulations [and is] void by reason of the agency's failure to comply with the Administrative Procedure Act in adopting it." *Id.*, at 832. Once the court ruled that GAAP controlled the timing of the accrual, it followed that the Hospital, not the Secretary, was correct and that the entire loss should be recognized in the year of refinancing.

We granted certiorari, 511 U. S. ___ (1994), and now reverse.

Under the Medicare reimbursement scheme at issue here, participating hospitals furnish services to program beneficiaries and are reimbursed by the Secretary through fiscal intermediaries. See 42 U. S. C. §§1395g and 1395h (1988 and Supp. V). Hospitals are reimbursed for "reasonable costs," defined by the statute as "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services." §1395x(v)(1)(A). The Medicare statute authorizes the Secretary to promulgate regulations "establishing the method or methods to be used" for determining reasonable costs, directing her in the process to "consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing" reimbursement amounts. *Ibid.*

The Secretary has promulgated, and updated on an annual basis, regulations establishing the methods for determining reasonable cost reimbursement. See *Good Samaritan Hospital* v. *Shalala*, 508 U. S. ___, ___ (1993) (slip op., at 2). The relevant provisions can be found within 42 CFR pt. 413 (1993). Respondent contends that two of these regulations, §§413.20(a) and 413.24, mandate reimbursement according to GAAP, and the Secretary counters that neither does.

Section 413.20(a) provides as follows:

> "The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program. Standardized definitions, accounting, statistics, and reporting practices that are widely accepted in the hospital and related fields are followed. Changes in these practices and systems will not be required in order to determine costs payable under the

> principles of reimbursement. Essentially the methods of determining costs payable under Medicare involve making use of data available from the institution's basis accounts, as usually maintained, to arrive at equitable and proper payment for services to beneficiaries."

Assuming, *arguendo*, that the "[s]tandardized definitions, accounting, statistics, and reporting practices" referred to by the regulation refer to GAAP, that nevertheless is just the beginning, not the end, of the inquiry. The decisive question still remains: Who is it that "follow[s]" GAAP, and for what purposes? The Secretary's view is that §413.20(a) ensures the existence of adequate provider records but does not dictate her own reimbursement determinations. We are persuaded that the Secretary's reading is correct.

Section 413.20(a) sets forth its directives in an ordered progression. The first sentence directs that providers must maintain records that are sufficient for proper determination of costs. It does not say the records are conclusive of the entire reimbursement process. The second sentence makes it clear to providers that standardized accounting practices are followed. The third sentence reassures providers that changes in their recordkeeping practices and systems are not required in order to determine what costs the provider can recover when principles of reimbursement are applied to the provider's raw cost data. That sentence makes a distinction between recordkeeping practices and systems on one hand and principles of reimbursement on the other. The last sentence confirms the distinction, for it contemplates that a provider's basic financial information is organized according to GAAP as a beginning point from which the Secretary "arrive[s] at equitable and proper payment for services." This is far different from saying that GAAP is by definition an equitable and proper measure of reimbursement.

The essential distinction between recordkeeping requirements and reimbursement principles is confirmed by the organization of the regulations in 42 CFR pt. 413 (1993). Subpart A sets forth introductory principles. Subpart B, containing the regulation here in question, is entitled "Accounting Records and Reports." The logical conclusion is that the provisions in Subpart B concern recordkeeping requirements rather than reimbursement, and closer inspection reveals this to be the case. §413.20 is the first section in Subpart B, and is entitled "Financial data and reports." In addition to §413.20(a), the other paragraphs in §413.20 govern the "[f]requency of cost reports," "[r]ecordkeeping requirements for new providers," "[c]ontinuing provider recordkeeping requirements," and "[s]uspension of program payments to a provider . . . [who] does not maintain . . . adequate records." Not until the following Subparts are cost reimbursement matters considered. Subpart C is entitled "Limits on Cost Reimbursement," Subpart D "Apportionment [of allowable costs]," Subpart E "Payment to Providers," and Subparts F through H address reimbursement of particular cost categories. The logical sequence of a regulation or a Part of it can be significant in interpreting its meaning.

It is true, as the Court of Appeals said, that §413.20(a) "does not exist in a vacuum" but rather is a part of the overall Medicare reimbursement scheme. 996 F. 2d at 835. But it does not follow from the fact that a provider's cost accounting is the first step toward reimbursement that it is the only step. It is hardly surprising that the reimbursement process begins with certain recordkeeping requirements.

The regulations' description of the fiscal intermediary's role underscores this interpretation. The regulations direct the intermediary to consult and assist providers in interpreting and applying the principles of Medicare reimbursement to generate

claims for reimbursable costs, §413.20(b), suggesting that a provider's own determination of its claims involves more than handing over its existing cost reports. The regulations permit initial acceptance of reimbursable cost claims, unless there are obvious errors or inconsistencies, in order to expedite payment. §413.64(f)(2). When a subsequent, more thorough audit follows, it may establish that adjustments are necessary. *Ibid.;* see also §§421.100(a), (c). This sequence as well is consistent with the Secretary's view that a provider's cost accounting systems are only the first step in the ultimate determination of reimbursable costs.

The Secretary's position that §413.20(a) does not bind her to reimburse according to GAAP is supported by the regulation's text and the overall structure of the regulations. It is a reasonable regulatory interpretation, and we must defer to it. *Thomas Jefferson Univ.* v. *Shalala,* 512 U. S. ___, ___ (1994) (slip op., at 7–8); see also *Martin* v. *Occupational Safety and Health Review Comm'n*, 499 U. S. 144, 151 (1991) ("Because applying an agency's regulation to complex or changing circumstances calls upon the agency's unique expertise and policymaking prerogatives, we presume that the power authoritatively to interpret its own regulations is a component of the agency's delegated lawmaking powers"); *Lyng* v. *Payne*, 476 U. S. 926, 939 (1986) ("agency's construction of its own regulations is entitled to substantial deference").

Respondent argues that, even if §413.20(a) does not mandate reimbursement according to GAAP, §413.24 does. This contention need not detain us long. Section 413.24 requires that a provider's cost data be based on the accrual basis of accounting, under which "revenue is reported in the period when 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."

§413.24(b)(2). But GAAP is not the only form of accrual accounting; in fact, both the GAAP approach and PRM §233 reflect different methods of accrual accounting. See Accounting Principles Board (APB) Opinion No. 26, ¶¶5–8, reprinted at App. 64–66 (describing alternative accrual methods of recognizing advance refunding losses, including the one adopted in PRM §233). Section 413.24 does not, simply by its accrual accounting requirement, bind the Secretary to make reimbursements according to GAAP.

The Secretary's reading of her regulations is consistent with the Medicare statute. Rather than requiring adherence to GAAP, the statute merely instructs the Secretary, in establishing the methods for determining reimbursable costs, to "consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment . . . to providers of services." 42 U. S. C. §1395x(v)(1)(A).

Nor is there any basis for suggesting that the Secretary has a statutory duty to promulgate regulations that, either by default rule or by specification, address every conceivable question in the process of determining equitable reimbursement. To the extent the Medicare statute's broad delegation of authority imposes a rulemaking obligation, see 42 U. S. C. §1395x(v)(1)(A), it is one the Secretary has without doubt discharged. See *Good Samaritan Hospital* v. *Shalala*, 508 U. S., at ___ and n. 13, ___ (slip op., at 15 and n. 13, 16). The Secretary has issued regulations to address a wide range of reimbursement questions. The regulations are comprehensive and intricate in detail, addressing matters such as limits on cost reimbursement, apportioning costs to Medicare services, and the specific treatment of numerous particular

costs. As of 1993, these regulations consumed some 620 pages of the Code of Federal Regulations.

As to particular reimbursement details not addressed by her regulations, the Secretary relies upon an elaborate adjudicative structure which includes the right to review by the Provider Reimbursement Review Board, and, in some instances, the Secretary, as well as judicial review in federal district court of final agency action. 42 U. S. C. §1395*oo*(f)(1); see *Bethesda Hospital Assn.* v. *Bowen,* 485 U. S. 399, 400–401 (1988). That her regulations do not resolve the specific timing question before us in a conclusive way, or "could use a more exact mode of calculating," does not, of course, render them invalid, for the "methods for the estimation of reasonable costs" required by the statute only need be "generalizations [that] necessarily will fail to yield exact numbers." *Good Samaritan*, *supra*, at ___ (slip op., at 15–16). The APA does not require that all the specific applications of a rule evolve by further, more precise rules rather than by adjudication. See *NLRB* v. *Bell Aerospace Co.*, 416 U. S. 267 (1974); *SEC* v. *Chenery Corp*., 332 U. S. 194 (1947). The Secretary's mode of determining benefits by both rulemaking and adjudication is, in our view, a proper exercise of her statutory mandate.

We also believe it was proper for the Secretary to issue a guideline or interpretive rule in determining that defeasance losses should be amortized. PRM §233 is the means to ensure that capital-related costs allowable under the regulations are reimbursed in a manner consistent with the statute's mandate that the program bear neither more nor less than its fair share of costs. 42 U. S. C. §1395x(v)(1)(A)(i) ("[T]he necessary costs of efficiently delivering covered services to individuals covered by [Medicare] will not

be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by [Medicare]"). The Secretary has promulgated regulations authorizing reimbursement of capital-related costs such as respondent's that are "appropriate and helpful in . . . maintaining the operation of patient care facilities," 42 CFR §413.9(b)(2) (1993); see generally §§413.130–413.157, including "[n]ecessary and proper interest" and other costs associated with capital indebtedness, §413.153(a)(1); see also §§413.130(a)(7) and (g). The only question unaddressed by the otherwise comprehensive regulations on this particular subject is whether the loss should be recognized at once or spread over a period of years. It is at this step that PRM §233 directs amortization.

Although one-time recognition in the initial year might be the better approach where the question is how best to portray a loss so that investors can appreciate in full a company's financial position, see APB Opinion 26, ¶¶4–5, reprinted at App. 64, the Secretary has determined in PRM §233 that amortization is appropriate to ensure that Medicare only reimburse its fair share. The Secretary must calculate how much of a provider's total allowable costs are attributable to Medicare services, see 42 CFR §§413.5(a), 413.9(a) and (c)(3) (1993), which entails calculating what proportion of the provider's services were delivered to Medicare patients, §§413.50 and 413.53. This ratio is referred to as the provider's "Medicare utilization." App. to Pet. for Cert. 49a. In allocating a provider's total allowable costs to Medicare, the Secretary must guard against various contingencies. The percentage of a hospital's patients covered by Medicare may change from year to year; or the provider may drop from the Medicare program altogether. Either will cause the hospital's Medicare utilization to fluctuate. Given the undoubted fact that Medicare utilization will not be an annual

constant, the Secretary must strive to assure that costs associated with patient services provided over time be spread, to avoid distortions in reimbursement. As the provider's yearly Medicare utilization becomes ascertainable, the Secretary is able to allocate costs with accuracy and the program can bear its proportionate share. Proper reimbursement requires proper timing. Should the Secretary reimburse in one year costs in fact attributable to a span of years, the reimbursement will be determined by the provider's Medicare utilization for that one year, not for later years. This leads to distortion. If the provider's utilization rate changes or if the provider drops from the program altogether the Secretary will have reimbursed up front an amount other than that attributable to Medicare services. The result would be cross-subsidization, *id.,* at 50a, which the Act forbids. 42 U. S. C. §1395x(v)(1)(A)(i).

That PRM §233 implements the statutory ban on cross-subsidization in a reasonable way is illustrated by the Administrator's application of §233 to the facts of this case. The Administrator found that respondent's loss "did not relate exclusively to patient care services rendered in the year of the loss . . . . [but were] more closely related to [patient care services in] the years over which the original bond term extended." App. to Pet. for Cert. 49a. Because the loss was associated with patient services over a period of time, the Administrator concluded that amortization was required to avoid the statutory ban on cross-subsidization:

> "The statutory prohibition against cross-subsidization [citing the provision codified at 42 U. S. C. §1395x(v)(1)(A)], requires that costs recognized in one year, but attributable to health services rendered over a number of years, be amortized and reimbursed during those years when Medicare beneficiaries use those services." *Id.,* at 50a (footnote omitted).

> "By amortizing the loss to match it to Medicare utilization over the years to which it relates, the program is protected from any drop in Medicare utilization, and the provider is likewise assured that it will be adequately reimbursed if Medicare utilization increases. Further, the program is protected from making a payment attributable to future years and then having the provider drop out of the Program before services are rendered to Medicare beneficiaries in those future years." *Id.,* at 49a (footnote omitted).

As an application of the statutory ban on cross-subsidization and the regulatory requirement that only the actual cost of services rendered to beneficiaries during a given year be reimbursed, 42 U. S. C. §1395x(v)(1)(A)(i); 42 CFR §413.9 (1993), PRM §233 is a prototypical example of an interpretive rule "`issued by an agency to advise the public of the agency's construction of the statutes and rules which it administers.'" *Chrysler Corp.* v. *Brown*, 441 U. S. 281, 302, n. 31 (1979) (quoting the Attorney General's Manual on the Administrative Procedure Act 30, n. 3 (1947)). Interpretive rules do not require notice-and-comment, although, as the Secretary recognizes, see Foreword to the PRM, they also do not have the force and effect of law and are not accorded that weight in the adjudicatory process, *ibid.*

We can agree that APA rulemaking would still be required if PRM §233 adopted a new position inconsistent with any of the Secretary's existing regulations. As set forth in Part II, however, her regulations do not require reimbursement according to GAAP. PRM §233 does not, as the Court of Appeals concluded it does, "effect[] a substantive change in the regulations." 996 F. 2d, at 832.

There is much irony in the suggestion, made in support of the Hospital's interpretation of the statute

and regulations, that the Secretary has bound herself to delegate the determination of any matter not specifically addressed by the regulations to the conventions of financial accounting that comprise GAAP. The Secretary in effect would be imposing upon herself a duty to go through the time-consuming rulemaking process whenever she disagrees with any announcements or changes in GAAP and wishes to depart from them. Examining the nature and objectives of GAAP illustrates the unlikelihood that the Secretary would choose that course.

Contrary to the Secretary's mandate to match reimbursement with Medicare services, which requires her to determine with some certainty just when and on whose account costs are incurred, GAAP "do[es] not necessarily parallel economic reality." R. Kay & D. Searfoss, Handbook of Accounting and Auditing, ch. 5, p. 7 (2d ed. 1989). Financial accounting is not a science. It addresses many questions as to which the answers are uncertain, and is a "process [that] involves continuous judgments and estimates." *Id.*, at ch. 5, pp. 7–8. In guiding these judgments and estimates, "financial accounting has as its foundation the principle of conservatism, with its corollary that `possible errors in measurement [should] be in the direction of understatement rather than overstatement of net income and net assets.'" *Thor Power Tool Co.* v. *Commissioner*, 439 U. S. 522, 542 (1979) (citation omitted). This orientation may be consistent with the objective of informing investors, but it ill-serves the needs of Medicare reimbursement and its mandate to avoid cross-subsidization. Cf. *id.*, at 543 ("[T]he accountant's conservatism cannot bind the Commissioner [of the IRS] in his efforts to collect taxes").

GAAP is not the lucid or encyclopedic set of pre-existing rules that the dissent might perceive it to be. Far from a single-source accounting rulebook, GAAP

"encompasses the conventions, rules, and procedures that define accepted accounting practice at a particular point in time." Kay & Searfoss, at ch. 5, p. 7 (1994 Update). GAAP changes and, even at any one point, is often indeterminate. "[T]he determination that a particular accounting principle is generally accepted may be difficult because no single source exists for all principles." *Ibid.* There are 19 different GAAP sources, any number of which might present conflicting treatments of a particular accounting question. *Id.*, at ch. 5, pp. 6–7. When such conflicts arise, the accountant is directed to consult an elaborate hierarchy of GAAP sources to determine which treatment to follow. *Ibid.* We think it is a rather extraordinary proposition that the Secretary has consigned herself to this process in addressing the timing of Medicare reimbursement.

The framework followed in this case is a sensible structure for the complex Medicare reimbursement process. The Secretary has promulgated regulations setting forth the basic principles and methods of reimbursement, and has issued interpretive rules such as PRM §233 that advise providers how she will apply the Medicare statute and regulations in adjudicating particular reimbursement claims. Because the Secretary's regulations do not bind her to make Medicare reimbursements in accordance with GAAP, her determination in PRM §233 to depart from GAAP by requiring bond defeasance losses to be amortized does not amount to a substantive change to the regulations. It is a valid interpretive rule, and it was reasonable for the Secretary to follow that policy here to deny respondent's claim for full reimbursement of its defeasance loss in 1985.

The judgment of the Court of Appeals is reversed.

It is so ordered.