SUPREME COURT OF THE UNITED STATES

No. 91–2079

GOOD SAMARITAN HOSPITAL, ET AL., PETITIONERS *v.* DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES

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

[June 7, 1993]

JUSTICE SOUTER, with whom JUSTICE STEVENS and JUSTICE SCALIA join, dissenting.

In the Court's view, the contrasting interpretations of clause (ii) proffered by the petitioners and the Secretary are in such equipoise that even slight deference to the Secretary is enough to tip the balance her way. As I read it, however, the language of clause (ii) plainly favors the petitioners.

The Court focuses on two portions of clause (ii). First, it says, the phrase "aggregate reimbursement produced by the methods of determining costs" may be understood, not only as the petitioners would read it, but as the Secretary does: "the total of the interim payments . . . derived from application of the methods [of determining costs] to rough, incomplete data." *Ante,* at 8. Second, the Court finds that "inadequate or excessive" may well mean, as the Secretary suggests, inadequate or excessive as measured against "the reasonable costs as determined by the [Secretary] applying the methods [of determining costs]." *Ibid.* I think the language of clause (ii) precludes these readings.

Clause (ii) identifies its subject, "aggregate reimbursement," as the figure "produced by the methods of determining costs." Thus, once we know what "the methods of determining costs" are, we should be able to discover the nature of the "aggregate reimbursement" that is "produced by" those methods. Section 1395x(v)(1)(A) makes it clear that "methods" refers to the regulations

implementing the statutory mandate to pay providers of services "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services." The first sentence of §1395x(v)(1)(A), which together with §1395hh authorizes the Secretary to issue such regulations, identifies them as "regulations establishing the . . . methods to be used . . . in determining . . . costs." And clause (i) of §1395x(v)(1)(A) uses the exact same phrase as clause (ii): the regulations shall take into account both direct and indirect costs, it says, so that "under the methods of determining costs," patients who are not Medicare beneficiaries will not subsidize beneficiaries, nor will beneficiaries subsidize nonbeneficiaries. Thus, "the methods of determining costs" are not procedures for estimating costs to make interim payments; rather, they are the means for figuring the actual "reasonable cost of . . . services."

The Secretary appears not to dispute this, but contends, in the Court's words, that the phrase "produced by the methods of determining costs" actually means "derived from application of the methods to rough, incomplete data." *Ante,* at 8. In other words, as the Government asserted at oral argument, "what you're really doing is taking estimated data but running them through the same methods that you're eventually going to run the final data through in order to get a result." Tr. of Oral Arg. 31–32. There is, however, an obvious difficulty with this proposed interpretation: the complete lack of any reference to "incomplete" or "estimated" data in clause (ii). Two less obvious difficulties are even more telling.

First, nothing in Title XVIII of the Social Security Act specifies that interim payments should be calculated by applying to estimated data the complete, detailed methodology for reaching a final reasonable cost figure; the Secretary's own regulations, indeed, suggest just the opposite. "The interim payment," states the relevant regulation, "may be related to the last year's average per diem, or to charges, or to any other ready basis of approximating costs." 42 CFR §413.60(a) (1992). And for purposes of devising preliminary estimates, this makes perfect sense; working through a permissible method for determining costs in all its detail may not improve the quality of an estimate if the raw figures used are mostly guesswork. But this divergence of methods for calculating interim payments and methods for determining reasonable cost casts doubt on the Secretary's proffered interpretation of "produced by the methods of determining costs." If interim, estimated payments may in fact be calculated without strict adherence to the methods of determining costs, it is hard to see why Congress would choose to identify a series of interim payments as "the aggregate reimbursement produced by the

methods of determining costs."

Second, the Secretary's interpretation assumes that "the methods of determining costs" are no more than a series of equations, which can be applied as readily to final, audited cost figures as to mere projections. But the statute suggests that the term "methods" is not to be understood so narrowly. In the words of the statute, for example, the regulations establishing the methods may not only "provide for determination of the costs of services on a per diem, per unit, per capita, or other basis"; they may also "provide for the use of estimates of costs of particular items or services." §1395x(v)(1)(A). Thus, as the statute conceives of them, the methods encompass not only a set of equations, but a set of determinations about whether to use actual costs or cost estimates for particular items or services. This set of determinations is relevant, of course, not to reckoning interim payments, but to calculating the final reimbursement due the provider of health services. Accordingly, a figure that is "produced by the methods of determining costs" should, absent some contrary indication, be the final figure.

The Court asserts that a contrary indication may be found in the use of the adjective "aggregate" to modify "reimbursement." "`Aggregate,'" says the Court, "signifies `sum total' and its use therefore might suggest that Congress had in mind the outcome of adding up the interim payments." *Ante,* at 9, n. 9 (citation omitted). I find no such suggestion in the statute's use of that term, for "aggregate," unlike, say, "cumulative," carries no necessary connotation of addition over time. More importantly, there is a far better explanation for the use of the term "aggregate." A health care provider will, over the course of a fiscal year, provide many different kinds of services to Medicare beneficiaries. Part A Medicare benefits, for example, cover, among other things, "inpatient hospital services," see 42 CFR

§409.5 (1992), a term that encompasses everything from bed and board, nursing services, and use of hospital facilities to medical social services, drugs, biologicals, supplies, appliances and equipment, certain other diagnostic and therapeutic services, and medical or surgical services provided by certain interns or residents-in-training. §409.10(a). The statute plainly contemplates the use of different methods to determine the costs of these various services, see 42 U. S. C. §1395x(v)(1)(A) (stating that the regulations "may provide for using different methods in different circumstances"), and the Secretary has indeed provided for a number of different methods. For instance, under the Secretary's "[d]epartmental method" for apportioning costs, the provider's cost of "routine services" is apportioned between Medicare and non-Medicare patients on an average cost per diem basis, whereas the cost of "ancillary" services is apportioned on the basis of the ratio of Medicare beneficiary charges to total patient charges in each department. See 42 CFR §413.53(a)(1) (1992). The combined reimbursement for all of the different services performed by a health care provider, as calculated under all of the different methods allowed by the statute and specified in the regulations and other materials published by the Secretary, may aptly be labeled the "aggregate reimbursement."

As I thus read the statute, the term "aggregate" is important in making it clear not only that the "reimbursement" considered in clause (ii) is the total amount received by a provider for all of the services it has rendered to Medicare beneficiaries, but that the amount received should be considered only as a whole. This focus on the total amount received means that a provider who shows that a method results in a understating of the reasonable cost of a particular service will not necessarily be entitled to a "retroactive corrective adjustmen[t]" to recover that

particular cost, for the Government may be able to show that the same method, or another method used by the provider, has overstated other costs. (By the same token, of course, the Government will not always deserve an adjustment when it shows that a method has overstated a particular cost.) The text's direction to look only at the total reimbursement also means that the provider will not be entitled to the prospective application of a more accurate method of its own devising, an insight into the statute that is hardly new; as the Court acknowledges, see *ante*, at 11, we recognized in *Bowen* v. *Georgetown University Hospital*, 488 U. S. 204, 211 (1988) (emphasis in original), that "nothing in clause (ii) suggests that it permits changes in the *methods* used to compute costs; rather, it expressly contemplates corrective adjustments to the *aggregate amounts* of reimbursement produced pursuant to those methods."

This emphasis on the total, aggregate reimbursement received by the health-care provider makes sense in light of the broader goals of the Medicare program, addressing as it does Congress's concern that Medicare neither subsidize, nor be subsidized by, non-Medicare patients. See §1395x(v)(1)(A)(i). As long as the aggregate Medicare reimbursement to a health-care provider equals its total reasonable costs of providing services to Medicare beneficiaries, that goal has been attained; the details of the methods used do not matter. Thus, I can find no ambiguity in the phrase "aggregate reimbursement produced by the methods of determining costs"; it refers univocally to the total, final amount due to a provider for services rendered to Medicare beneficiaries under the regulations promulgated by the Secretary.

The Court also finds ambiguity in the direction stated in clause (ii) to provide for an adjustment if the reimbursement proves to be "inadequate or

excessive." While I agree with the Court that clause (ii) does not itself "at any point stat[e] the standard against which inadequacy or excessiveness is to be measured," *ante*, at 8, the absence of an explicit reference to a standard in clause (ii) does not keep us from looking for other textual clues about that standard. In this case, the strongest textual clue is found in the immediate neighbor of clause (ii), clause (i). Together, clauses (i) and (ii) form the fourth and last sentence of §1395x(v)(1)(A). Whereas the third sentence of §1395x(v)(1)(A) is permissive, the fourth sentence is mandatory; it concerns those things that the Secretary's regulations "shall" take into account or for which they "shall" provide. Clause (i) requires the regulations to take into account "both direct and indirect costs of providers of services" so that "the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs." §1395x(v)(1)(A)(i). The first of these two undesired results, it will be noted, would occur if the aggregate reimbursement to the provider were inadequate, in the sense of failing to cover all reasonable costs; the second, if that reimbursement were excessive.

Clause (ii) does not contain as exhaustive a description of its goal as clause (i); it simply requires the regulations to provide for suitable corrective adjustments where the methods of determining costs produce a reimbursement that "proves to be either inadequate or excessive." §1395x(v)(1)(A)(ii). Reading the two clauses together, however, I think it most reasonable to take clause (ii)'s "inadequate or excessive" as shorthand for the two consequences that were just described in the same order, but more fully, in clause (i). This construction has the further virtue, of course, of support in my reading of the

phrase "aggregate reimbursement produced by the methods of determining costs." For if that phrase, as I contend, refers to the amount ultimately due the provider as calculated under the Secretary's regulations (that is, according to the Secretary's "methods"), then the standard against which that amount is measured as "inadequate or excessive" must refer to some other figure (that is, a figure produced by some different method); no amount can be "inadequate or excessive" in relation to itself. Thus, in context, the phrase "inadequate or excessive" is not equivocal.

Broadening the context to all of Title XVIII only confirms the view that clause (ii) requires regulations providing for case-by-case exceptions to the methods for determining costs. Section 1395x(v)(1)(A), where clause (ii) is located, is a definitional, rather than an operative, provision; §1395x(v) defines "[r]easonable costs." The chief operative provision to which §1395x(v) relates is §1395f(b), which is titled "Amount paid to provider of services"; §1395f(b)(1) provides that under the Medicare program, providers of services are generally to be paid "the lesser of (A) the reasonable cost of such services, as determined under section 1395x(v) of this title . . . or (B) the customary charges with respect to such services." "Payments to providers of services" are covered under another section, 1395g. That section requires the Secretary "periodically [to] determine the amount which should be paid . . . to each provider of services," and requires "the provider of services [to] be paid, at such time or times as the Secretary believes appropriate (but not less often than monthly) . . . the amounts so determined, with necessary adjustments on account of previously made overpayments or underpayments." §1395g(a). As the Court notes, *ante*, at 8, the petitioners argue that this section's provision for "necessary adjustments on account of previously made overpayments or

underpayments" provides for the very book-balancing operation that the Secretary advances as the function of clause (ii), and thus renders clause (ii), as interpreted by the Secretary, entirely superfluous. The Court nonetheless appears to accept the Secretary's explanation that §1395g deals with periodic adjustments to be made during the course of the fiscal year, whereas clause (ii) is directed at year-end adjustments. *Ante,* at 8. Two circumstances keep me from doing the same.

First, nothing in the language of §1395g excludes "year-end adjustments" from its purview, or draws any distinction at all between periodic and year-end adjustments. All payments to providers for services to Medicare beneficiaries are made under the authority of §1395g, since it is the only section in Title XVIII of the Social Security Act to deal with that subject; and §1395g thus authorizes all payments to be "adjust[ed] on account of previously made overpayments or underpayments." It is doubtless this breadth which leads the Secretary to concede that had clause (ii) never been enacted, "the authority for some similar year-end mechanism might have been inferred under the Act as a whole, including 42 U. S. C. 1395g." Brief for Respondent 27, n. 16.

Second, the Secretary's proposed distinction between year-end and periodic adjustments fails to explain why Title XVIII would describe year-end, but not periodic, adjustments as "retroactive." The Secretary interprets "retroactive," as it appears in clause (ii), to mean only relating to a period for which some payment has already been made, thus rejecting the more common, stricter legal sense of the word, which implies the upsetting of some prior settled expectation or transaction. In this weak sense employed by the Secretary, however, the adjustments authorized by §1395g are just as "retroactive" as those authorized under the Secretary's

interpretation of clause (ii); they too relate to "previously made overpayments or underpayments." This leaves the Secretary with no way to explain why Congress, in passing the Social Security Amendments of 1965 (which established the Medicare program, and contained both passages, see 79 Stat. 297, 323), chose to distinguish §1395g "adjustments" from §1395x(v)(1)(A)(ii) "retroactive corrective adjustments."

For all of these reasons, I believe the text of the statute unambiguously requires the promulgation of regulations allowing providers (and the Secretary) to seek adjustments on the grounds that, as calculated under the methods of determining costs, the total reimbursement for a fiscal period is lower than (or higher than) the actual reasonable cost of providing services to Medicare beneficiaries. I respectfully dissent from the Court's opposite conclusion.