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 O'CONNOR, with whom JUSTICE SCALIA, JUSTICE SOUTER, and JUSTICE THOMAS join, dissenting.

Unlike the Court, I believe that general Medicare reporting and reimbursement regulations require provider costs to be treated according to "generally accepted accounting principles." As a result, I would hold that contrary guidelines issued by the Secretary of Health and Human Services in an informal policy manual and applied to determine the timing of reimbursement in this case are invalid for failure to comply with the notice and comment procedures established by the Administrative Procedure Act, 5 U. S. C. §553. Because the Court holds to the contrary, I respectfully dissent.

It is undisputed, as the Court notes, *ante*, at 2, that respondent, Guernsey Memorial Hospital (Hospital), is entitled to reimbursement for the reasonable advance refunding costs it incurred when it refinanced its capital improvement bonds in 1985. The only issue here is one of timing: whether reimbursement is to be made in a lump sum in the year of the refinancing, in accordance with generally accepted accounting principles (known in

the accounting world as GAAP), or in a series of payments over the remaining life of the original bonds, as the Secretary ultimately concluded after applying §233 of the Medicare Provider Reimbursement Manual (PRM). The Hospital challenged the Secretary's reimbursement decision under the Medicare Act, 42 U. S. C. §1395*oo*(f), which incorporates the Administrative Procedure Act, 5 U. S. C. §551 *et seq*. (1988 ed. and Supp. V), by reference. Under the governing standard, reviewing courts are to "hold unlawful and set aside" an agency action that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U. S. C. §706(2)(A). We must give substantial deference to an agency's interpretation of its own regulations, *Lyng* v. *Payne*, 476 U. S. 926, 939 (1986), but an agency's interpretation cannot be sustained if it is "`plainly erroneous or inconsistent with the regulation.'" *Stinson* v. *United States*, 508 U. S. ___, ___ (1993) (slip op., at 9) (quoting *Bowles* v. *Seminole Rock & Sand Co.*, 325 U. S. 410, 414 (1945)). In my view, that is the case here.

The Medicare Act requires that, for reimbursement purposes, the actual reasonable costs incurred by a provider "shall be determined in accordance with regulations establishing the method or methods to be used . . . in determining such costs." 42 U. S. C. §1395x(v)(1)(A). The Secretary's regulations similarly provide that the "[r]easonable cost of any services must be determined in accordance with regulations establishing the method or methods to be used, and the items to be included." 42 CFR §413.9(b)(1) (1993). The Secretary is not bound to adopt GAAP for reimbursement purposes; indeed, the statute only requires that, in promulgating the necessary regulations, "the Secretary shall 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 . . . ." *Ibid.* Neither the Hospital nor the Court of Appeals disputes that the Secretary has broad and flexible authority to prescribe standards for reimbursement. See *Good Samaritan Hospital* v. *Shalala*, 508 U. S. ___, ___, n. 13 (1993) (slip op., at 15, n. 13).

Nevertheless, the statute clearly contemplates that the Secretary will state the applicable reimbursement methods in regulations—including default rules that cover a range of situations unless and until specific regulations are promulgated to supplant them with respect to a particular type of cost. Indeed, despite the Court's suggestion to the contrary, *ante*, at 7, only by employing such default rules can the Secretary operate the sensible, comprehensive reimbursement scheme that Congress envisioned. Otherwise, without such background guidelines, providers would not have the benefit of regulations establishing the accounting principles upon which reimbursement decisions will be based, and administrators would be free to select, without having to comply with notice and comment procedures, whatever accounting rule may appear best in a particular context (so long as it meets minimum standards of rationality). In my view, the question becomes simply whether the Secretary has in fact adopted GAAP as the default rule for cost reimbursement accounting.

Like the Court, see *ante*, at 7, I do not think that 42 CFR §413.24 (1993), which provides that Medicare cost data "must be based on . . . the accrual basis of accounting," requires the use of GAAP. As the regulation itself explains, "[u]nder the accrual basis of accounting, 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). This definition of "accrual basis"

simply incorporates the dictionary understanding of the term, thereby distinguishing the method required of cost providers from "cash basis" accounting (under which revenue is reported only when it is actually received and expenses are reported only when they are actually paid). GAAP employs the generally accepted form of accrual basis accounting, but not the only possible form. In fact, both the applicable GAAP rule, established by Early Extinguishment of Debt, Accounting Principles Board Opinion No. 26 (1972), reprinted at App. 62, and PRM §233 appear to reflect accrual, as opposed to cash basis, accounting principles.

Although §413.24 simply opens the door for the Secretary to employ GAAP, 42 CFR §413.20 makes clear that she has, in fact, incorporated GAAP into the cost reimbursement process. That section provides that "[s]tandardized definitions, accounting, statistics, and reporting practices that are widely accepted in the hospital and related fields are followed." §413.20(a). As the Court of Appeals noted, "[i]t is undisputed, in the case at bar, that Guernsey Memorial Hospital keeps its books on the accrual basis of accounting and in accordance with generally accepted accounting principles." 996 F. 2d 830, 834 (CA6 1993). Similarly, related entities in the health care field employ GAAP as their standardized accounting practices. See American Institute of Certified Public Accountants, Audits of Providers of Health Care Services §3.01, p. 11 (1993) ("Financial statements of health care entities should be prepared in conformity with generally accepted accounting principles"); Brief for American Hospital Assn. et al. as *Amici Curiae* 7–8 ("Generally accepted accounting principles have always provided the standard definitions and accounting practices applied by non-government hospitals in maintaining their books and records"). Accordingly, the Secretary concedes that, under §413.20, the Hospital at the very least was

required to submit its request for Medicare reimbursement in accordance with GAAP. 796 F. Supp. 283, 288–289 (SD Ohio 1992); Tr. of Oral Arg. 8.

The remainder of §413.20 demonstrates, moreover, that the accounting practices commonly used in the health care field determine how costs will be reimbursed by Medicare, not just how they are to be reported. The first sentence of §413.20(a) begins with a statement that the provision explains what "[t]he principles of *cost reimbursement* require" (emphasis added). And the sentence emphasizing that standardized accounting and reporting practices "are followed" is itself accompanied by the promise that "[c]hanges in these practices and systems will not be required in order to determine costs payable [that is, reimbursable] under the principles of reimbursement." The language of the regulation, taken as a whole, indicates that the accounting system maintained by the provider ordinarily forms the basis for determining how Medicare costs will be reimbursed. I find it significant that the Secretary, through the HCFA Administrator, has changed her interpretation of this regulation, having previously concluded that this provision generally requires the costs of Medicare providers to be reimbursed according to GAAP when that construction was to her benefit. See *Dr. David M. Brotman Memorial Hospital* v. *Blue Cross Assn./Blue Cross of Southern California*, HCFA Admin. Decision, CCH Medicare and Medicaid Guide ¶ 30,922, p. 9839 (1980) (holding that, "[u]nder 42 CFR 405.406 [now codified as §413.20], the determination of costs payable under the program should follow standardized accounting practices" and applying the GAAP rule—that credit card costs should be treated as expenses in the period incurred—and not the PRM's contrary rule—that such costs should be considered reductions of revenue).

Following the Secretary's current position, the Court

concludes, *ante*, at 4, that §413.20 was intended to do no more than reassure Medicare providers that they would not be required fundamentally to alter their accounting practices for reporting purposes. Indeed, the Court maintains, the regulation simply ensures the existence of adequate provider financial records, maintained according to widely accepted accounting practices, that will enable the Secretary to calculate the costs payable under the Medicare program using some other system-wide method of determining costs, which method she does not, and need not, state in any regulations. For several reasons, I find the Court's interpretation of §413.20 untenable.

Initially, the Court's view is belied by the text and structure of the regulations. As the Court of Appeals noted, "the sentence in . . . §413.20(a) that says standardized reporting practices `are followed' does not exist in a vacuum." 996 F. 2d, at 835. The Provider Reimbursement Review Board has explained that "the purpose of cost reporting is to enable a hospital's costs to be known so that its reimbursement can be calculated. For that reason, there must be some consistency between the fundamental principles of cost reporting and those principles used for cost reimbursement." *Fort Worth Osteopathic Medical Center* v. *Blue Cross and Blue Shield Ass'n/Blue Cross and Blue Shield of Texas*, CCH Medicare and Medicaid Guide ¶40,413, p. 31,848 (1991). The text of §413.20 itself establishes this link between cost reporting and cost reimbursement by explaining that a provider hospital generally need not modify its accounting and reporting practices in order to determine what costs Medicare will reimburse. That is, "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." §413.20(a). By linking the reimburse-

ment process to the provider's existing financial records, the regulation contemplates that both the agency and the provider will be able to determine what costs are reimbursable. It would make little sense to tie cost reporting to cost reimbursement in this manner while simultaneously mandating different accounting systems for each.

In addition, as the Court aptly puts it, "[t]he logical sequence of a regulation . . . can be significant in interpreting its meaning." *Ante*, at 5. Consideration of how a provider's claim for reimbursement is processed undermines the Court's interpretation of §413.20(a). The Court suggests that the fiscal intermediaries who make the initial reimbursement decisions take a hospital's cost report as raw data and apply a separate set of accounting principles to determine the proper amount of reimbursement. In certain situations, namely where the regulations provide for specific departures from GAAP, this is undoubtedly the case. But the description of the intermediary's role in the regulations contemplates reliance on the GAAP-based cost report *as determining reimbursable costs* in considering the ordinary claim. See, *e.g.*, §413.60(b) (providing that, "[a]t the end of the [reporting] period, the actual apportionment, *based on the cost finding and apportionment methods selected by the provider, determines* the Medicare reimbursement for the actual services provided to beneficiaries during the period" (emphasis added)); §413.64(f)(2) ("In order to reimburse the provider as quickly as possible, an initial retroactive adjustment will be made as soon as the cost report is received. For this purpose, *the costs will be accepted as reported, unless there are obvious errors or inconsistencies, subject to later audit*. When an audit is made and the final liability of the program is determined, a final adjustment will be made" (emphasis added)). The fiscal intermediary, then, is essentially instructed to check the hospital's

cost report for accuracy, reasonableness, and presumably compliance with the regulations. But that task seems to operate within the framework of the hospital's normal accounting procedure—*i.e.*, GAAP—and not some alternative, uncodified set of accounting principles employed by the Secretary. See generally 42 CFR §§421.1–421.128 (1993).

I take seriously our obligation to defer to an agency's reasonable interpretation of its own regulations, particularly "when, as here, the regulation concerns `a complex and highly technical regulatory program,' in which the identification and classification of relevant `criteria necessarily require significant expertise and entail the exercise of judgment grounded in policy concerns.'" *Thomas Jefferson Univ.* v. *Shalala*, 512 U. S. ___, ___ (1994) (slip op., at 8) (quoting *Pauley* v. *BethEnergy Mines, Inc.*, 501 U. S. 680, 697 (1991)). In this case, however, the Secretary advances a view of the regulations that would force us to conclude that she has not fulfilled her statutory duty to promulgate regulations determining the methods by which reasonable Medicare costs are to be calculated. If §413.20 does not incorporate GAAP as the basic method for determining cost reimbursement in the absence of a more specific regulation, then there is *no* regulation that specifies an overall methodology to be applied in the cost determination process. Given that the regulatory scheme could not operate without such a background method, and given that the statute requires the Secretary to make reimbursement decisions "in accordance with regulations establishing the method or methods to be used," 42 U. S. C. §1395x(v)(1)(A), I find the Secretary's interpretation to be unreasonable and unworthy of deference.

Unlike the Court, therefore, I would hold that §413.20 requires the costs incurred by Medicare providers to be reimbursed according to GAAP in the

absence of a specific regulation providing otherwise. The remainder of my decision flows from this conclusion. PRM §233, which departs from the GAAP rule concerning advance refunding losses, does not have the force of a regulation because it was promulgated without notice and comment as required by the Administrative Procedure Act, 5 U. S. C. §553. And, contrary to the Secretary's argument, PRM §233 cannot be a valid "interpretation" of the Medicare regulations because it is clearly at odds with the meaning of §413.20 itself. Thus, I would conclude that the Secretary's refusal, premised upon an application of PRM §233, to reimburse the Hospital's bond defeasement costs in accordance with GAAP was invalid.

The remaining arguments advanced by the Court in support of the Secretary's position do not alter my view of the regulatory scheme. The Court suggests that a contrary decision, by requiring the Secretary to comply with the notice and comment provisions of the Administrative Procedure Act in promulgating reimbursement regulations, would impose an insurmountable burden on the Secretary's administration of the Medicare program. I disagree. Congress obviously thought that the Secretary could manage that task when it required that she act by regulation. Moreover, despite the Court's suggestion, *ante*, at 7, nothing in my position requires the agency to adopt substantive rules addressing every detailed and minute reimbursement issue that might arise. An agency certainly cannot foresee every factual scenario with which it may be presented in administering its programs; to fill in the gaps, it must rely on adjudication of particular cases and other forms of agency action, such as the promulgation of interpretive rules and policy statements, that give effect to the statutory principles and the background

methods embodied in the regulations. Far from being foreclosed from case-by-case adjudication, the Secretary is simply obligated, in making those reimbursement decisions, to abide by whatever ground rules she establishes by regulation. Under the Court's reading of the regulations, the Secretary in this case did not apply any accounting principle found in the regulations to the specific facts at issue —and indeed could not have done so because no such principles are stated outside the detailed provisions governing particular reimbursement decisions. I believe that the Medicare Act's command that reimbursement requests by providers be evaluated "in accordance with regulations establishing the method or methods to be used" precludes this result.

Moreover, I find it significant that the bond defeasement situation at issue here *was* foreseen. If the Secretary had the opportunity to include a section on advance refunding costs in the PRM, then she could have promulgated a regulation to that effect in compliance with the Administrative Procedure Act, thereby giving the public a valuable opportunity to comment on the regulation's wisdom and those adversely affected the chance to challenge the ultimate rule in court. An agency is bound by the regulations it promulgates and may not attempt to circumvent the amendment process through substantive changes recorded in an informal policy manual that are unsupported by the language of the regulation. Here, Congress expressed a clear policy in the Medicare Act that the reimbursement principles selected by the Secretary—whatever they may be—must be adopted subject to the procedural protections of the Administrative Procedure Act. I would require the Secretary to comply with that statutory mandate.

The PRM, of course, remains an important part of the Medicare reimbursement process, explaining in

detail what the regulations lay out in general and providing those who must prepare and process claims with the agency's statements of policy concerning how those regulations should be applied in particular contexts. One role for the Manual, therefore, is to assist the Secretary in her daunting task of overseeing the thousands of Medicare reimbursement decisions made each year. As the Foreword to the PRM explains, "[t]he procedures and methods set forth in this manual have been devised to accommodate program needs and the administrative needs of providers and their intermediaries and will assure that the reasonable cost regulations are uniformly applied nationally without regard to where covered services are furnished." Indeed, large portions of the PRM are devoted to detailed examples, including step-by-step calculations, of how certain rules should be applied to particular facts. The Manual also provides a forum for the promulgation of interpretive rules and general statements of policy, types of agency action that describe what the agency believes the statute and existing regulations require but that do not alter the substantive obligations created thereby. Such interpretive rules are exempt from the notice and comment provisions of the Administrative Procedure Act, see 5 U. S. C. §553(b)(A), but they must *explain* existing law and not *contradict* what the regulations require.

As a result, the policy considerations upon which the Court focuses, see *ante*, at 9–12, are largely beside the point. Like the Court of Appeals, I do not doubt that the amortization approach embodied in PRM §233 "squares with economic reality," 996 F. 2d, at 834, and would likely be upheld as a rational regulation were it properly promulgated. Nor do I doubt that amortization of advance refunding costs may have certain advantages for Medicare reimbursement purposes. It is certainly true that the Act prohibits the Medicare program from bearing more or

less than its proper share of hospital costs, 42 U. S. C. §1395x(v)(1)(A)(i), but immediate recognition of advance refunding losses does not violate this principle. While the Court, like the Secretary, assumes that advance refunding costs are properly attributed to health care services rendered over a number of years, it does not point to any evidence in the record substantiating that proposition. In fact, what testimony there is supports the view that it is appropriate to recognize advance refunding losses in the year of the transaction because the provider no longer carries the costs of the refunded debt on its books thereafter; the losses in question simply represent a one-time recognition of the difference between the net carrying costs of the old bonds and the price necessary to reacquire them. See, *e.g.*, App. 14–15, 22. While reasonable people may debate the merits of the two options, the point is that both appear in the end to represent economically reasonable and permissible methods of determining what costs are properly reimbursable and when. Given that neither approach is commanded by the statute, the cross-subsidization argument should not alter our reading of §413.20.

Finally, the Secretary argues that she was given a "broad and flexible mandate" to prescribe standards for Medicare reimbursement, and that, as a result, "it is exceedingly unlikely that the Secretary would have intended, in general regulations promulgated as part of the initial implementation of the Medicare Act, to abdicate to the accounting profession (or to anyone else) ultimate responsibility for making particular cost reimbursement determinations." Brief for Petitioner 19. She points out that the purpose of Medicare reimbursement, to provide payment of the necessary costs of efficient delivery of covered services to Medicare beneficiaries, may not be identical to the objective of financial accounting, which is "to provide useful information to management, shareholders,

creditors, and others properly interested" and "has as its foundation the principle of [financial] conservatism." *Thor Power Tool Co.* v. *Commissioner*, 439 U. S. 522, 542 (1979) (rejecting taxpayer's assertion that an accounting principle that conforms to GAAP must be presumed to be permissible for tax purposes). The Court makes this argument as well. See *ante*, at 12–13.

Reading the regulations to employ GAAP, even though it is possible that the relevant reimbursement standard will change over time as the position of the accounting profession evolves, does not imply an abdication of statutory authority but a necessary invocation of an established body of accounting principles to apply where specific regulations have not provided otherwise. The Secretary is, of course, not bound by GAAP in such a situation and, indeed, has promulgated reimbursement *regulations* that depart from the GAAP default rule in specific situations. Compare, *e.g.*, §413.134(f)(2) (limited recognition of gain or loss on involuntary conversion of depreciable asset) with R. Kay & D. Searfoss, Handbook of Accounting and Auditing, ch. 15, p. 14 (2d ed. 1989 and 1994 Update) (gains or losses are recognized under GAAP in the period of disposal of a depreciable asset, even if reinvested in a similar asset). The Secretary would also be free to devise a reimbursement scheme that does not involve GAAP as a background principle at all if she believes, as the Court argues, that use of GAAP binds her to a cost allocation methodology ill-suited to Medicare reimbursement, see *ante*, at 13. Our task is simply to review the regulations the Secretary has in fact adopted, and I conclude that the Secretary has incorporated GAAP as the reimbursement default rule.

Contrary to the Court's conclusion, I do not believe

that the Administrator's reimbursement decision can be defended as a rational application of the statute and the existing regulations. The Hospital sought reimbursement for its advance refunding costs in accordance with GAAP and in compliance with the Secretary's published regulations. The Administrator applied PRM §233, which calls for a departure from GAAP in this instance, to deny the Hospital's request; that decision contradicted the agency's own regulations and therefore resulted in a reimbursement decision that was "not in accordance with law" within the meaning of the Administrative Procedure Act, 5 U. S. C. §706(2)(A). I agree with the court below that "[t]he `nexus' that exists in the regulations between cost reporting and cost reimbursement is too strong . . . to be broken by a rule not adopted in accordance with the rulemaking requirements of the Administrative Procedure Act." 996 F. 2d, at 836. Because the Court holds otherwise, I respectfully dissent.