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## INTRODUCTION

Guernsey Memorial Hospital entered into an advance refunding transaction in 1985, which led it to the steps of the United States Supreme Court ten years later. The Secretary of Health and Human Services applied a policy to this transaction that conflicts with generally accepted accounting principles. Guernsey Memorial Hospital challenged the Secretary, and on March 6, 1995, the United States Supreme Court in a 5-4 decision reversed the Sixth Circuit[1] and ruled in favor of the Secretary.[2]

This case presented the Court with strikingly different visions of how the Medicare program should be operated. The hospital envisioned a program that would allow providers to know their Medicare reimbursement at the time they submit their cost reports, and that would require the Secretary to consider comments offered by providers on proposed policy changes. The Secretary's vision was a program that could change reimbursement policies, with providers being assured of an opportunity to comment only through their legal challenge of the application of the policies to them. The Supreme Court sided with the Secretary in a decision that reaffirms the Court's willingness to defer to the authority of the Secretary even at the risk of limiting pro-

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1. For an in-depth discussion of the decision of the Sixth Circuit, see Robert L. Roth, *Medicare and GAAP: Understanding the Decision of the Sixth Circuit in* Guernsey Memorial Hospital v. Secretary of Health and Human Services, 3 ANNALS HEALTH L. 29, 29-39 (1994).

2. Shalala v. Guernsey Memorial Hosp., 115 S. Ct. 1232 (1995).

vider input on reimbursement policy. This article analyzes the *Guernsey* decision and the anticipated effect it will have on future Medicare reimbursement decisions.

## I. BACKGROUND OF THE *GUERNSEY* CASE

*Guernsey* addresses Medicare reimbursement for costs relating to an advance refunding transaction. In an advance refunding transaction, a hospital borrows money to pay off old debt prior to its maturity date. The hospital then deposits the proceeds from the new debt into an irrevocable trusteed escrow account for the sole purpose of discharging the provider from any liability relating to the old debt. Advance refunding transactions can result in either a gain or loss to the hospital.

Rather than adopt a regulation detailing Medicare's reimbursement policy for advance refunding costs, the Secretary simply published in a manual provision her policy "to implicitly recognize any gain or loss incurred as the result of an advance refunding over the period from the date the refunding debt is issued to the date the holders of the refunded debt receive the principal payment, rather than immediately."[3] This policy conflicts with generally accepted accounting principles (GAAP),[4] which recognize costs relating to an advance refunding transaction in the year of the transaction.[5]

Because of this conflict with GAAP, Guernsey Memorial Hospital challenged the application of the Secretary's policy to its 1985 advance refunding transaction in federal district court. It argued that by adopting two regulations, the Secretary obligated herself to reimburse Medicare allowable costs in accordance with GAAP. The first regulation, 42 C.F.R. § 413.20, requires hospitals to use accounting and reporting practices that are widely accepted and followed, stating that these practices need not be changed to determine those costs that are payable

3. *See* HEALTH CARE FIN. ADMIN., MEDICARE PROVIDER REIMBURSEMENT MANUAL § 233 (1991) [hereinafter PRM].

4. "GAAP consists of the three official publications of the American Institute of Certified Public Accountants: Accounting Principles Board opinions, Financial Accounting Standards Board statements, and Accounting Research Bulletins." Guernsey Memorial Hosp. v. Secretary of Health & Human Servs., 996 F.2d 830, 832 n.1 (6th Cir. 1993), *rev'd*, 115 S. Ct. 1232 (1995). *See* WALTER B. MEIGS & ROBERT F. MEIGS, ACCOUNTING: THE BASIS FOR BUSINESS DECISIONS 511-22 (7th ed. 1987) (explaining why GAAP should be followed in financial statement preparation).

5. *See* ACCOUNTING PRINCIPLES BOARD OPINION No. 26 (1972).

under Medicare reimbursement principles.[6] The second regulation, 42 C.F.R. § 413.24, requires hospitals to base cost data on an approved method of cost finding and on the accrual basis of accounting; under the latter, revenue is received in the period earned and expenses are reported in the period incurred.[7]

If the Secretary wishes to depart from GAAP, the hospital argued, the Secretary must adopt a regulation doing so. In light of the fact that the Secretary's advance refunding policy both departed from GAAP and was not adopted as a regulation, the hospital asserted that the manual containing the policy was invalid and GAAP treatment was required.[8]

The Secretary responded that although providers are required to report their costs in accordance with GAAP under the regulations, the regulations do not require the Secretary to reimburse all costs in the year that they are reported.[9] According to the Secretary, providers can look to GAAP to determine whether a cost is reimbursable under Medicare only if there is no Medicare program pronouncement on point.[10] The Secretary also argued that GAAP treatment of an advance refunding transaction would be inconsistent with the economic reality of

6. Specifically, 42 C.F.R. § 413.20(a) (1995) (emphasis added) states in relevant part:

> 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 [Medicare] reimbursement.*

7. Specifically, 42 C.F.R. § 413.24(a) and (b)(2) (1995) state in relevant part:

> The cost data must be based on an approved method of cost finding and the accrual basis of accounting. . . . Under the accrual basis of accounting, revenue is received 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.

8. Guernsey Memorial Hosp. v. Sullivan, 796 F. Supp. 283, 288 (S.D. Ohio 1992), *rev'd in part, aff'd in part sub nom.* Guernsey Memorial Hosp. v. Secretary of Health and Human Servs., 996 F.2d 830 (6th Cir. 1993), *rev'd*, 115 S. Ct. 1232 (1995).

9. *Id.* at 289.

10. A program announcement includes a regulation or a manual provision. Regulations are subject to the notice and comment requirements of the Administrative Procedure Act (APA), 5 U.S.C. §§ 551-559 (1995). Manual provisions are instructions to Medicare participants that are published by the Health Care Financing Administration. The PRM contains most of the manual provisions at issue in GAAP cases. *See* PRM, *supra* note 3, at Forward ("For any cost situation that is not covered by the [PRM's] guidelines and policies, [GAAP] should be applied.").

the costs and would violate the statutory prohibition against cross-subsidization.[11]

## II. The Decisions of the Lower Courts

The district court applied the *Chevron* standard, which requires courts to defer to an agency's reasonable interpretation of those statutes within its authority, and upheld the Secretary's policy, finding that it was neither arbitrary nor capricious.[12] The two regulations, 42 C.F.R. §§ 413.20 and 413.24, required application of GAAP only for reporting purposes and not for determining Medicare reimbursement.[13] Therefore, the regulations adopted by the Secretary did not prohibit her from addressing the advance refunding policy in the form of a manual provision.[14]

The Sixth Circuit reversed, finding that 42 C.F.R. §§ 413.20 and 413.24 require application of GAAP and stating that were it not for section 233 of the manual, "any fair-minded person reading the regulations in the light of [GAAP] would have to conclude that Guernsey Hospital was entitled to reimbursement . . . in the year in which . . . the costs were deemed to have been incurred."[15] Accordingly, the court found manual section 233 an invalid substantive rule because (a) it conflicted with established regulations and (b) it was not adopted in accordance with the notice and comment requirements of the Administrative Procedure Act (APA).[16] However, the court noted that the Secre-

11. When adopting reasonable cost regulations, Congress requires the Secretary to assure that costs for Medicare patients "will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne" by other insurance programs. 42 U.S.C. § 1395x(v)(1)(A)(i) (1988).

12. Chevron U.S.A. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984). In light of *Chevron*, courts will generally uphold any policy of the Secretary that is found to be reasonable.

13. Guernsey, 796 F. Supp. at 290-91.

14. *Id.* at 291. However, the court noted that "the Secretary must have a permissible rationale for choosing to use some method other than GAAPs to determine when a particular allowable cost is reimbursable." *Id.* Otherwise, the Secretary's decision would be subject to reversal as arbitrary or capricious.

15. Guernsey, 996 F.2d 830, 834.

16. *Id. Accord* Mother Frances Hosp. of Tyler, Texas v. Shalala, 15 F.3d 423 (5th Cir. 1994); Graham Hosp. Ass'n v. Sullivan, 832 F. Supp. 1235 (C.D. Ill. 1993); Methodist-Evangelical Hosp. v. Shalala, Nos. 92-2887-LFO & 93-0470-LFO, 1993 U.S. Dist. LEXIS 18571 (D.D.C. Dec. 22, 1993); St. John Hosp. v. Shalala, Medicare & Medicaid Guide (CCH) ¶ 41,700 (E.D. Mich. Aug. 18, 1993); Mercy Hosp. v. Sullivan, No. 90-0024P, 1991 U.S. Dist. LEXIS 21139 (D. Me. Apr. 25, 1991); Baptist Hosp. E. v. Sullivan, 767 F. Supp. 139 (W.D. Ky. 1991).

tary's policy was not irrational and could have been promulgated as a valid regulation.[17]

## III. The Supreme Court's Decision

The Supreme Court reversed the Sixth Circuit and reinstated manual section 233. Writing for the majority, Justice Kennedy stated that the Secretary's position was "a reasonable regulatory interpretation," concluding that "we must defer to it."[18] Justice Kennedy analyzed 42 C.F.R. §§ 413.20 and 413.24 both individually and in the context of the Secretary's other reimbursement regulations. He stated that the "text" of 42 C.F.R. § 413.20(a) and the "overall structure" of the Secretary's regulations supported her position that the regulations do not "bind her to reimburse according to GAAP."[19] The Court also held that rule making would be required if, unlike here, a manual provision "adopted a new position inconsistent with any of the Secretary's existing regulations."[20]

Rather than simply stop here, the Court went beyond advance refunding to address the Secretary's entire Medicare reimbursement system, stating: "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 interpretation, rather than by regulations that address all accounting questions in precise detail."[21]

The Court found that the Secretary has no statutory duty to "address every conceivable question in the process of determining equitable reimbursement."[22] It continued: "To the extent the Medicare statute's broad delegation of authority imposes a rulemaking obligation, *see* 42 U.S.C. § 1395x(v)(1)(A),[23] it is

17. 996 F.2d at 834.

18. Shalala v. Guernsey Memorial Hosp., 115 S. Ct. 1232, 1236 (1995) (citing Thomas Jefferson Univ. Hosp. v. Shalala, 114 S. Ct. 2381 (1994)).

19. Specifically, he found that 42 C.F.R. § 413.20 requires providers to report costs in accordance with GAAP. The Secretary uses this data to determine the proper reimbursement levels under her authority to determine proper Medicare payments. With respect to § 413.24, Justice Kennedy simply found that GAAP is only one form of accrual accounting and the requirement of § 413.24 that providers use accrual accounting did not bind the Secretary to reimburse in accordance with GAAP. *Id.* at 1237.

20. *Id.* at 1233.

21. *Id.* at 1234.

22. *Id.* at 1237.

23. Under 42 U.S.C. § 1395x(v)(1)(A) (1988), Medicare reimbursement for hospital costs "shall be determined in accordance with regulations [adopted by the Secre-

one the Secretary has without doubt discharged" by adopting regulations that consume more than 600 pages of the Code of Federal Regulations.[24] Accordingly, rather than adopt regulations to address every reimbursement situation, the Secretary properly exercises her statutory mandate by relying "on 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."[25]

Although the Court conceded that payment for advance refunding costs was not addressed by the Secretary's regulations, it found that capital-related costs, which include costs relating to an advance refunding transaction, are addressed by the regulations; the only question not addressed in the regulations was whether the loss should be recognized "at once or spread over a period of years."[26] The Court found that this question was answered by the Secretary's interpretation (providing for payment over a period of years) characterizing manual section 233 as "a prototypical example of an interpretive rule"[27] because it is "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 . . . ."[28]

Dissenting Justice O'Connor, who was joined by Justices Scalia, Thomas, and Souter, found that the regulations "taken as a whole" require the Secretary to apply GAAP unless there is a regulation providing for other treatment.[29] Therefore, the dissenters would have held the informal policy included in manual section 233 invalid for failure to comply with the notice and comment rulemaking procedures of the APA.[30]

The dissenting justices agreed with the majority that the Medicare statute does not require the Secretary to follow GAAP in making reimbursement determinations.[31] Neverthe-

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tary of Health and Human Services] establishing the method or methods to be used, and the items to be included . . . ."

24. 115 S. Ct. at 1237. The Secretary's regulations cover many topics, including Medicare and Medicaid eligibility, general program administration, and survey and certification; only a small percentage of the regulations relate to reimbursement.

25. *Id.*

26. *Id.* at 1238.

27. *Id.* at 1239.

28. *Id.*

29. *Id.* at 1242 (O'Connor, J., dissenting).

30. *Id.* at 1240.

31. *Id.*

less, they read the statute to require the Secretary to state applicable reimbursement methods in regulations "including default rules that cover a range of situations unless and until specific regulations are promulgated to supplant them . . . ."[32] Without these rules, "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 . . . ."[33]

Although the dissenters agreed that 42 C.F.R. § 413.24 does not require the use of GAAP, they found that 42 C.F.R. § 413.20 "makes clear that [the Secretary] has, in fact, incorporated GAAP into the cost reimbursement process."[34] They found "untenable" the majority's view that requires hospitals to report costs using "widely accepted accounting practices" but that allows the Secretary to determine payable costs using some other method that "she does not, and need not, state in any regulations."[35] Justice O'Connor continued: "By linking the reimbursement 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."[36]

Justice O'Connor explained that Medicare regulations could not be expected to address every reimbursement situation and, therefore, Congress "clearly contemplate[d]" that the Secretary would include in her regulations "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."[37] She continued: "[O]nly by employing such default rules can the Secretary operate the sensible, comprehensive reimbursement scheme that Congress envisioned."[38] The dissenters concluded that "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

32. *Id.* at 1241.

33. *Id.*

34. *Id.* Like the majority, the dissenters parsed § 413.20, but the dissenters came to a different conclusion. The dissenters seem to have been persuaded, at least in part, by their finding that the Secretary had previously argued in favor of the application of GAAP when the result was to her benefit. *Id.* at 1242 (citing Brotman Memorial Hosp. v. Blue Cross Ass'n/Blue Cross of S. Cal., 1980 Medicare & Medicaid Guide (CCH) ¶ 30,922 (Dec. 8, 1980)).

35. *Id.*

36. *Id.* (emphasis added).

37. *Id.* at 1241.

38. *Id.*

the methods by which reasonable Medicare costs are to be calculated."[39]

## IV. Analysis of the Decision on the Supreme Court

In *Guernsey*, the Supreme Court was presented with sharply contrasting views of how the Medicare program should be operated. Of the two visions, there is no question that the view of the dissenters is more simple and mindful of the importance of provider input in shaping Medicare policy. The dissenters believed that current authority requires Medicare reimbursement determinations to be made in accordance with GAAP, unless the Secretary has provided for different treatment in a specific regulation. While the Secretary retains complete discretion to depart from GAAP whenever she feels it does not achieve programmatic goals, providers must be given the opportunity to comment on these departures before they properly may be put in place.

This is in stark contrast to the vision of the majority, which believed that hospitals should report cost data under GAAP but the Secretary could run the cost data through some secret formula to determine the Medicare reimbursement. Using this system, the Secretary can establish policies without necessarily receiving any input from providers. Providers wishing to provide their views to the Secretary under this system are forced to do so by challenging reimbursement policies through expensive and time-consuming litigation.

This position is unfortunate because it encourages the Secretary to establish policies without seeking insight from the experience of the thousands of providers affected by the policies. Rather than adopt the cooperative system described in the dissent, the Supreme Court opted for the current, more confrontational system. In light of the Court's clear message that it will, in fact *must*, defer to any "reasonable" interpretation of the Secretary, providers face significant obstacles in trying to have their voices heard after the *Guernsey* decision.

39. *Id.* at 1243. The dissenters were not particularly sympathetic to the Secretary, perhaps because they found that the advance refunding issue was "foreseen" and "[i]f 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 [APA]." *Id.* at 1244.

## CONCLUSION

The *Guernsey* case is the third consecutive Medicare case in the last two years in which the Supreme Court has sided with the government, after a string of government losses in the late 1980's. Of the three, *Guernsey* reaches the farthest and will undoubtedly be often quoted by the government in reimbursement cases for the foreseeable future. The Supreme Court seems willing to grant deference to the Secretary even at the risk of stifling healthy and necessary debate of Medicare reimbursement policy.