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On April 4, 1994, the Supreme Court granted the government's writ of *certiorari* seeking review of the decision of the United States Court of Appeals for the Sixth Circuit in the major Medicare capital cost case of 1993, *Guernsey Memorial Hospital v. Secretary of Health and Human Services*.[1] This important case illustrates the tension that exists between Medicare and generally accepted accounting principles ("GAAP") when determining Medicare reimbursement for capital costs.[2] This article will use the *Guernsey* case as a vehicle for analyzing the interplay between Medicare and GAAP and will discuss other relevant recent judicial decisions.

I. The Interaction Between GAAP and Medicare

The Medicare provisions of the Social Security Act ("the Act")[3] entitle qualified providers to reimbursement for the reasonable cost of furnishing hospital services to Medicare benefi-

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1. 996 F.2d 830 (6th Cir. 1993), *cert. granted*, 114 S. Ct. 1395 (1994).

2. For cost-reporting periods beginning on or after October 1, 1983, Congress enacted a new system for reimbursing inpatient hospital operating costs under Medicare known as the "prospective payment system" or "PPS." *See* 42 U.S.C. § 1395ww(d) (1988 & Supp. III 1991); 42 C.F.R. § 412 (1992). The application of PPS to inpatient hospital capital-related costs is being phased in for cost-reporting periods beginning on or after October 1, 1991. 42 U.S.C. § 1395ww(g) (1988 & Supp. III 1991). *Guernsey* concerns capital-related costs claimed in the hospital's cost report for fiscal year 1985.

3. 42 U.S.C. § 1395-1395bbb (1988 & Supp. III 1991).

ciaries.[4] "Reasonable cost" is defined in 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."[5] Accordingly, Medicare will only reimburse providers for costs that were "actually incurred" and not the result of an inefficient service delivery system.

The statute further states that Medicare reimbursement for hospital costs "shall be determined in accordance with regulations [adopted by the Secretary of Health and Human Services] establishing the method or methods to be used, and the items to be included . . . ."[6] When adopting these regulations, the Act requires the Secretary to "consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) . . . ."[7] Some have argued that Congress intended this reference to "principles generally applied by national organizations" to force the Secretary to consider GAAP when formulating the regulations. However, the Secretary did not interpret the statute in this way, and, when first adopting the reasonable cost regulations in 1966, stated:

> In the framing of these proposed regulations for the determination of reasonable cost, it was the intent to give consideration to the principles generally applied by national organizations and established prepayment programs. Accordingly, in the development of the proposed principles of reimbursement there has been extensive consultation with representatives of the American Hospital Association and with many others including representatives of the American Nursing Home Association, the American Association of Hospital Accountants, the National Blue Cross Association, individual Blue Cross plans, the Health Insurance Association of America, and the private insurance field as well as State and Federal agencies which purchase hospital and institutional services.[8]

At the time that the reasonable cost regulations were being formulated, providers were concerned that they would be required to prepare one set of books for their general business and

4. 42 U.S.C. § 1395cc (1988 & Supp. III 1991).
5. 42 U.S.C. § 1395x(v)(1)(A) (1988).
6. *Id.*
7. *Id.*
8. 31 Fed. Reg. 7,864 (1966).

another for Medicare. To dispel this concern, the Secretary adopted two regulations,[9] which read in pertinent 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.*
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> The cost data must be based on an approved method of cost finding and on the accrual basis of accounting.
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> Under 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.[10]

Based on these rules, as a general matter hospitals must use accrual accounting to determine when a cost is "actually incurred" for Medicare purposes. Some accrual accounting principles are contained in a collection known as "generally accepted accounting principles," or "GAAP."[11] However, GAAP is not intended to address whether a cost is necessary "in the efficient delivery of needed health services."[12]

II. The Tensions Between GAAP and Medicare

Since the beginning of the Medicare program, providers have submitted cost reports as required by the foregoing regulations and have sought reimbursement for costs reported in accordance with GAAP. The Secretary generally paid these costs, except in two notable situations: first, when the Secretary

9. These regulations, 42 C.F.R. § 413.20(a) (1992) and § 413.24(a) & (b)(2) (1992), were originally codified at 42 C.F.R. § 405.406(a) (1967) and § 405.453(a) & (b)(2) (1967), respectively. They were moved to 42 C.F.R. Part 413 as part of a regulatory reorganization. 51 Fed. Reg. 34,790 (1986).

10. 42 C.F.R. §§ 413.20(a) & 413.24(a) & (b)(2) (1992) (emphasis added).

11. GAAP are found in the three official publications of the American Institute of Certified Public Accountants ("AICPA"): 1) Accounting Principles Board opinions, 2) Financial Accounting Standards Board statements, and 3) Accounting Research Bulletins. Guernsey Memorial Hosp. v. Secretary of Health and Human Serv., 996 F.2d 830, 832 n.1 (6th Cir. 1993). *See* Walter B. Meigs & Robert F. Meigs, Accounting: The Basis for Business Decisions 511-22 (7th ed. 1987) (explaining why GAAP is considered authoritative in the preparation of financial statements).

12. 42 U.S.C. § 1395x(v)(1)(A) (1988).

determined that reimbursement of a cost would violate the statute because the cost, although accrued under GAAP, had not been "actually incurred" by the hospital in that the hospital had not incurred a cash outlay in the year for which payment is sought;[13] and second, when the Secretary determined that reimbursement of a cost would be inconsistent with the statute because the cost, although incurred, was not a "reasonable cost"—in other words, not "necessary in the efficient delivery of needed health services."[14]

When faced with these situations, providers have taken the position that the Secretary is required by 42 C.F.R. §§ 413.20 and 413.24 to reimburse costs properly reported in accordance with accrual accounting principles (GAAP). It is the providers' view that the Secretary cannot refuse to reimburse these costs unless the Secretary has adopted a regulation providing for other treatment of the costs.[15] 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.[16] Disputes in this area, such as those in *Guernsey*, often arise when the Secretary's departure from

13. An example of this is sick-leave costs, which can be accrued for GAAP purposes in a particular cost year even if the leave is "carried over" by employees to the next year. Thus, the provider does not actually incur the cost until the sick leave is used or the employee receives payment for the leave in a different cost year. *See* HCFA, MEDICARE PROVIDER REIMBURSEMENT MANUAL § 2144.8 (1983) [hereinafter PRM] (discussing reimbursement methodology for sick-leave costs).

14. *See* 42 U.S.C. § 1395x(v)(1)(A) (1988). For example, the cost of a case of champagne may be properly recorded for GAAP purposes, but proper recording of this cost will not, by itself, make it payable as a "reasonable cost" related to patient care.

15. *See* Guernsey Memorial Hosp. v. Sullivan, 796 F. Supp. 283, 288 (S.D. Ohio 1992). The word "regulation," as it is used here, refers to a policy pronouncement adopted under the notice and comment provisions of the Administrative Procedure Act ("APA"). 5 U.S.C. §§ 701-706 (1988). Although the APA explicitly exempts benefit programs, like Medicare, from the APA notice and comment requirements (*see* Holy Cross Hosp.-Mission Hills v. Heckler, 749 F.2d 1340, 1346 (9th Cir. 1984)), the Secretary waived the exception to the APA in 1971. 36 Fed. Reg. 2,532 (1971). *See* National Medical Enters., Inc. v. Sullivan, 957 F.2d 664, 670 n.8 (9th Cir. 1992).

16. 41 Fed. Reg. 46,292 (Oct. 20, 1976); PRM at I. *See* HCA Health Servs. of Midwest, Inc. v. Bowen, 869 F.2d 1179 (9th Cir. 1989) (upholding Secretary's reliance on GAAP where no Medicare policy on point); *see also* Dominguez Valley Hosp. v. Shalala, Medicare and Medicaid Guide (CCH) ¶ 41.961 (D.C.C.D. Cal. 1993). A program announcement includes a regulation *or a manual provision.* Regulations are subject to the notice and comment requirements of the APA. Manual provisions are instructions to Medicare participants that are published by the Health Care Financing Administration ("HCFA"). The Provider Reimbursement Manual contains most of the manual provisions at issue in GAAP cases.

GAAP is embodied only in a manual provision and not in a regulation.

III. Court Decisions Relating to Medicare and GAAP

As stated above, Medicare will only reimburse those costs that the Secretary finds were related to patient care and actually incurred in the year for which reimbursement is sought.[17] Courts have generally agreed with the Secretary's position that the standards for determining whether a cost reported in accordance with GAAP meets the statutory requirement of being "necessary in the efficient delivery of needed health services"[18] should be upheld regardless of whether the standard is contained in a regulation or manual provision.[19] The Secretary has enjoyed success in these cases in part because the determination of whether a cost is related to patient care requires an interpretation of the statutory term "reasonable costs";[20] under *Chevron*

17. For a discussion of the application of this two-part test, see Charlotte Memorial Hosp. & Medical Ctr., Inc. v. Bowen, 860 F.2d 595 (4th Cir. 1988).

18. 42 U.S.C. § 1395x(v)(1)(A) (1988).

19. For examples of cases where the court upheld a *regulation* denying reimbursement for a cost reported in accordance with GAAP because the cost was not a "reasonable cost" under 42 U.S.C. § 1395x(v)(1)(A), see National Medical Enters., Inc. v. Sullivan, 957 F.2d 664 (9th Cir. 1992) (regulation establishing that goodwill was not related to patient care was reasonable, and conflict with GAAP was not an adequate basis for invalidating the regulation); Vallejo General Hosp. v. Bowen, 851 F.2d 229 (9th Cir. 1988) (GAAP did not apply to depreciation because there was a regulation on point); Providence Hosp. v. Shalala, 843 F. Supp. 650 (W.D. Wash. 1993) (when the Secretary refused to allow the use of a blended rate for all hospitals involved with a multi-hospital combined borrowing, requiring each hospital to determine its applicable interest rate in accordance with the regulations, court rejected the hospitals' reliance on GAAP, finding that the dispute involved a substantive Medicare issue rather than a pure accounting issue; therefore, providers could not rely on GAAP to establish the reasonableness of their costs).

For examples of cases where the court upheld a *manual provision* denying reimbursement for a cost reported in accordance with GAAP because the cost was not a "reasonable cost" under 42 U.S.C. § 1395x(v)(1)(A), see National Medical Enters., Inc. v. Sullivan, 916 F.2d 542 (9th Cir. 1990) (stock maintenance costs are not related to patient care; GAAP applies to record keeping); Sun Towers, Inc. v. Heckler, 725 F.2d 315 (5th Cir. 1984), *cert. denied*, 469 U.S. 823 (1984) (court rejected GAAP recognition of stock maintenance costs, deferring to the Secretary's manual provision that stated that these costs are not related to patient care); American Medical Int'l, Inc. v. Secretary of Health, Educ. & Welfare, 677 F.2d 118 (D.C. Cir. 1981) (because a manual provision applied to stock maintenance costs, GAAP did not apply); *contra* Villa View Community Hosp., Inc. v. Heckler, 720 F.2d 1086 (9th Cir. 1983) (Ninth Circuit relied on GAAP to justify Medicare payment holding that the Secretary's reliance on a regulation to deny payment for land use costs on the grounds that the costs were not related to patient care lacked a reasonable basis).

20. *See* 42 U.S.C. § 1395x(v)(1)(A) (1988).

U.S.A. v. Natural Resources Defense Council, Inc.,[21] courts must defer to the Secretary's reasonable interpretation of those statutes within the Secretary's authority.[22] Accordingly, courts will generally uphold a reasonable policy, regardless of whether that policy is embodied in a regulation or an interpretive rule.[23] Conversely, an unreasonable interpretation will not be redeemed by its form.[24]

Once the Secretary determines that a cost is related to patient care and is otherwise reimbursable under Medicare, the Secretary must next determine whether the cost was "actually incurred" in the cost year presented by the hospital or whether reimbursement would be more appropriate in some other cost year.[25] In general, the Secretary has determined that costs accrued under GAAP were "actually incurred." However, the Secretary occasionally has found that GAAP principles do not accurately reflect when a cost was incurred, and in those cases, the Secretary required other treatment of the costs.[26]

The Secretary has generally been successful in defending policies that defer reimbursement to providers because the cost was not actually incurred by the provider in the cost year for which payment is sought, regardless of whether the policy took the form of a regulation or simply a manual provision.[27] However, several courts have held that the Secretary must apply GAAP to determine when allowable costs have been incurred because, they held, deviations from GAAP that have been published only in manual form are not enforceable.[28] It was a challenge to a

21. 467 U.S. 837 (1984).

22. National Medical Enters., Inc. v. Sullivan, 957 F.2d at 669.

23. *See Chevron*, 467 U.S. at 844.

24. *See* Villa View Community Hosp. v. Heckler, 720 F.2d 1086 (9th Cir. 1983).

25. Providers seeking to apply GAAP must be prepared to show that GAAP accurately reflects the cost and that the cost at issue was related to patient care in the year it was accrued, as opposed to the cost of merely running a business. Villa View, 720 F.2d at n.18.

26. *See, e.g.*, Palms of Pasadena Hosp. v. Sullivan, 932 F.2d 982 (D.C. Cir. 1991).

27. *Id.* (regulation—court upheld a regulation that required providers to treat bad debts as if incurred on a cash basis); Methodist Hosp., Inc. v. United States, 626 F.2d 823 (Ct. Cl. 1980) (manual provision—court upheld the denial of reimbursement of accrued pension costs because they were not funded in the year at issue); Queen's Medical Ctr. v. Sullivan, 797 F. Supp. 821 (D. Haw. 1991) (manual provision—medical malpractice costs were not incurred until self-insurance trust fund was established).

28. Charlotte Memorial Hosp. & Medical Ctr. v. Bowen, 860 F.2d 595, 599 (4th Cir. 1988) (timing of deferred compensation—court decided that GAAP overrode manual provision because GAAP accurately reflected when the cost was incurred); National Medical Enters., Inc. v. Bowen, 851 F.2d 291 (9th Cir. 1988) (court refused

manual provision that was presented to the Sixth Circuit in *Guernsey*.

IV. ANALYSIS OF THE *GUERNSEY* DECISION

The *Guernsey* case provides a review of the Secretary's policy of reimbursing costs relating to the advance refunding of debt by a hospital.[29] The Secretary adopted manual provisions indicating the circumstances under which costs related to an advance-refunding transaction are "allowable" under Medicare.[30] The Secretary's policy is "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."[31] GAAP, on the other hand, recognizes costs relating to an advance-refunding transaction in the year of the transaction.[32]

Guernsey Memorial Hospital challenged the application of the Secretary's policy to its 1985 advance-refunding transaction.[33] The hospital argued that the Secretary was required to follow GAAP because the Secretary had not adopted a regulation providing for a different treatment of these transaction costs. In the hospital's view, *PRM* § 233 was insufficient to overcome the requirements of 42 C.F.R. §§ 413.20 and 413.24

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to apply manual provision that required return on equity to be paid in the year after it was incurred; finding no regulation on point, the court applied GAAP to allow current year reimbursement).

29. An "advance-refunding transaction" occurs when a hospital borrows money to pay off old debt prior to its maturity date. Proceeds from the new debt are deposited into an irrevocable trusteed escrow account and invested in United States government securities for the sole purpose of discharging the provider from any liability relating to the old debt. Although providers usually undertake advance refundings to benefit from lower interest rates, there are other purposes for advance refunding, such as obtaining release from restrictive covenants or improving cash flow and increasing borrowing capacity.

Advance-refunding transactions can result in either a gain or a loss. For example, if the new debt (refunding debt) has a lower interest rate than the old debt (refunded debt), the provider must borrow more principal on the new debt to generate sufficient investment income to satisfy the debt service obligations of the old debt. Under GAAP, the increase in principal is treated as a loss in the year of the transaction. On the other hand, if the new debt has a higher interest rate than the old debt, the provider can borrow less principal and still generate sufficient investment income to satisfy the debt service obligations of the old debt. Under GAAP, the decrease in principal is treated as a gain in the year of the transaction.

30. *See* PRM, *supra* note 13, at § 233 (1991).

31. *Id.*

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

33. Guernsey Memorial Hosp. v. Sullivan, 792 F. Supp. 283 (S.D. Ohio 1992).

for a hospital to use accrual accounting. The Secretary responded that although 42 C.F.R. § 413.20 requires providers to report their costs in accordance with GAAP, it does not require the Secretary to reimburse all costs in the year that they are reported.[34] The Secretary then argued that GAAP treatment of an advance-refunding transaction would be inconsistent with the economic reality of the costs and would violate a statutory prohibition against cross-subsidization.[35]

The district court applied the *Chevron* standard[36] and upheld the Secretary's policy finding that it was neither arbitrary nor capricious. The district court's decision was based on its finding that 42 C.F.R. §§ 413.20 and 413.24 require application of GAAP only for reporting purposes and not for purposes of determining Medicare reimbursement. Thus, the Secretary was free to address the advance-refunding policy in the form of a manual provision because there was no regulation limiting her authority.[37]

The Sixth Circuit reversed, finding that 42 C.F.R. §§ 413.20 and 413.24 require application of GAAP. The court determined that were it not for *PRM* § 233, "any fair-minded person reading the regulation in light of [GAAP] would have to conclude that Guernsey Hospital was entitled to reimbursement" under GAAP.[38] The court found *PRM* § 233 to be an invalid substantive rule because it conflicted with established regulations and was not adopted in accordance with the notice and comment requirements of the APA. However, the court noted that the Sec-

34. *Id.* at 289.

35. 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). In its petition for certiorari, the government asserted that by reimbursing all costs in one year, the costs would be inappropriately attributed to patients who will only be gaining part of the benefit of the transaction, thereby causing Medicare to bear costs for non-Medicare patients in the year of the advance-refunding transaction. *See* 42 C.F.R. §§ 413.5 and 9. The government further argued that the economic reality is that the savings (or loss) from an advance-refunding transaction relate to costs over a period of years. Guernsey, No. 93-1251, *petition for cert.*, at 20-21 (filed Feb. 1, 1994) (*available in* Westlaw, at 1994 WL 198819).

36. Chevron U.S.A. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984).

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

38. Guernsey Memorial Hosp. v. Secretary of Health & Human Servs., 996 F.2d 830, 834 (6th Cir. 1993).

retary's "policy was not irrational and could have been promulgated as a valid regulation."[39]

The United States then petitioned the Supreme Court to review the decision of the Sixth Circuit. On April 4, 1994, the Supreme Court granted the government's petition.[40] The two questions presented are 1) whether the Secretary's regulations require the use of GAAP and 2) if GAAP is not required, whether *PRM* § 233 is an invalid substantive rule.[41]

V. Other Recent GAAP Cases

As a general matter, providers have not been successful in extending GAAP to other reimbursement areas recently, except in the area of capital leases. In *Ornda Healthcorp v. Shalala*,[42] plaintiff management company, which operated a hospital under a capital lease, relied on GAAP to claim capital costs (depreciation and interest) as "leasehold costs" in excess of its lease payment amount. The Secretary denied payment on the amount exceeding lease payment in accordance with 42 C.F.R. § 413.130(b), which precludes payment of capital costs unless the lease qualifies as a "virtual purchase" under the regulations, a standard that is more restrictive than the GAAP capital lease standard. The court rejected the Secretary's interpretation, holding that 42 C.F.R. § 413.130(b) does not address the issue of leasehold costs. It held that in the absence of a regulation explicitly on point, GAAP must be applied, citing *Guernsey* with approval.[43]

Two other capital lease cases contradict the *Ornda* decision. First, in *Methodist Hospital of Lexington, Inc. v. Sullivan*,[44] the court found that the Secretary was justified in refusing to treat a capital lease under GAAP as a virtual purchase pursuant to Medicare regulations. According to the court, GAAP applies only if there are no program guidelines; it "cannot be used to

39. *Id.* at 834-35. For a brief summary of case law regarding the reimbursement of a loss on defeasance, see Methodist-Evangelical Hosp., Inc. v. Shalala, Medicare & Medicaid Guide (CCH) ¶ 42,017, at 38,788-89 (D.D.C. Dec. 22, 1993) (noting that out of one circuit court and at least five district courts considering the issue, only one district court has sustained the Secretary's ruling on amortization). Since the *Methodist* opinion, the Fifth Circuit reversed the one district court sustaining the Secretary. Mother Frances Hosp. v. Shalala, 15 F.3d 423 (5th Cir. 1994).

40. 62 U.S.L.W. 3653 (Apr. 5, 1994).

41. *Id.*

42. Medicare & Medicaid Guide (CCH) ¶ 41,975 (E.D. Ark. Oct. 5, 1993).

43. *Id.* at 38,533.

44. No. 91-2684-HB (W.D. Tenn. Oct. 21, 1992).

override basic program requirements."[45] In *Pickens County Hospital Association v. Sullivan*,[46] the court upheld the Secretary's finding that a long-term capital lease did not constitute a disposal on sale entitling the provider to claim a loss on disposal under a regulation, 42 C.F.R. § 413.134(a). Because the Secretary's action was found to have been based on a regulation, the court refused to consider plaintiff's argument that the transaction was a sale under GAAP.[47]

While it may be too early to tell whether the Ornda case is an aberration or an indication of things to come, one thing is clear—providers in Medicare reimbursement disputes are now regularly asking courts to consider GAAP.

Conclusion

The government has made two major efforts to address the tension between Medicare and GAAP. First, on October 9, 1991, the Secretary issued a Notice of Proposed Rulemaking entitled *Clarification of Medicare's Accrual Basis of Accounting Policy*.[48] The purpose of this proposed rule is to codify some situations where Medicare policy departs from GAAP. These situations include vacation pay, short-term liabilities, FICA taxes, sick pay, and deferred compensation costs. Given the decisions in *Guernsey* and *Mother Frances*,[49] the situations presented in the proposed rule are potentially unenforceable in the Fifth and Sixth Circuits until promulgated. However, there are other situations where Medicare policy conflicts with GAAP that are not addressed in the proposed regulation, such as advance refunding and capital lease costs.

Second, the government sought and was granted Supreme Court review of *Guernsey*. In its petition, the Secretary acknowledged that "[t]here is not yet a conflict among the courts of appeals regarding application of GAAP in the precise context of advance refunding transactions . . . ."[50] However, the Secretary's petition makes the point that a split among the circuits does exist with regard to the application of the Secretary's general Medicare reimbursement regulations, 42 C.F.R. §§ 413.20

45. *Id* at 11.
46. Medicare & Medicaid Guide (CCH) ¶ 41,598 (N.D. Ala. June 22, 1993).
47. *Id.* at 36,702-03.
48. 56 Fed. Reg. 50,834 (1991).
49. 15 F.3d 423 (5th Cir. 1994); *see supra* note 39.
50. Guernsey, *petition for cert.*, at 14 n.9.

and 413.24, and the use of GAAP to determine allowable costs.[51] The Supreme Court has said that it will address the question of whether "general Medicare record-keeping and reporting regulations require that provider costs be reimbursed according to 'generally accepted accounting principles,' despite contrary administrative rules issued by the secretary of health and human services . . . ."[52] We should be given the answer in about one year.

51. *Id.* at 11 (citing a split between the decisions of the Fourth, Sixth, and Ninth Circuits and the decisions of the Fifth and District of Columbia Circuits, as well as the Court of Claims).

52. 62 U.S.L.W. 3653.