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**THOMAS JEFFERSON UNIVERSITY v.
SHALALA: DOLLARS OR SENSE? THE
ILLOGICAL RESTRICTION OF MEDICARE'S
FUNDING OF GRADUATE
MEDICAL EDUCATION**

Contemporary medical education includes four years of medical school followed by at least three years of residency training.¹ The four years of medical school, referred to as undergraduate medical education,² consist of clinical clerkships as well as classroom instruction in the basic sciences.³ Upon completion of medical school and receipt of a medical degree, most physicians participate in residency training programs, referred to as graduate medical education ("GME").⁴ GME provides residents the opportunity to work with patients in a structured and supervised clinical education environment.⁵ While undergraduate medical education is mostly conducted in the classrooms of the medical school, residents are trained in the hospital setting.⁶ Accordingly, hospitals must hire qualified doctors in various specialties to supervise the program's residents.⁷ These

1. *Medical Education Funding by Medicare: Hearing Before the Subcomm. on Health of the Senate Comm. on Finance, 98th Cong., 2nd Sess. 6 (1984)* [hereinafter *Medical Education Funding*].

2. This is referred to as undergraduate medical education despite the fact that most medical students have graduated from an undergraduate institution. *Medical Education Passthrough: Hearing on S.1158 Before the Subcomm. on Health of the Senate Comm. on Finance, 99th Cong., 1st Sess. 8 (1985)* [hereinafter *Medical Education Passthrough*].

3. *Id.* at 8-9. Clinical education introduces medical students to the various specialties of clinical medicine. *Medical Education Funding, supra* note 1, at 6. Third year students are traditionally required to spend a specific amount of time in the areas of internal medicine, surgery, obstetrics/gynecology, psychiatry, and pediatrics. *Id.* Fourth year students take elective clerkships providing either additional expertise in the basic specialties or introductions into other specialties. *Id.*

4. *Medical Education Passthrough, supra* note 2, at 9. Currently, there are approximately 7,000 accredited GME programs. Carlos J.M. Martini, MD, MPH, MSc, *Graduate Medical Education in the Changing Environment of Medicine*, 268 *JAMA* 1097, 1097 (1992). These programs are located at more than 1,300 teaching hospitals and train more than 80,000 residents. Lelia B. Helms et al., *Litigation in Medical Education: Retrospect and Prospect*, 11 *J. CONTEMP. HEALTH L. & POL'Y* 317, 322 (1995).

5. *Medical Education Passthrough, supra* note 2, at 9.

6. *Medical Education Funding, supra* note 1, at 6.

7. *Ohio State Univ. v. Sullivan*, 777 F. Supp. 582, 587 (S.D. Ohio 1991), *aff'd*, 996 F.2d 122 (6th Cir. 1993), *cert. granted*, 114 S. Ct. 2731, *and vacated*, 114 S. Ct. 2731 (1994).

doctors require administrative and clerical staffs, office space, and supplies.⁸ The costs for each of these items, as well as compensation to the residents, comprise a portion of the cost of the educational activity.⁹ Such expenses, classified as traditional and customary costs incurred by a teaching hospital's GME program,¹⁰ are the type of costs Congress intended for Medicare to reimburse.¹¹

Medicare,¹² the federally funded health insurance program for the elderly and disabled, is the primary means through which the federal government finances GME.¹³ While Medicare has been instrumental in improving the status of our nation's health care,¹⁴ the program is severely

In addition to training physicians, hospitals offer educational programs for a broad array of health care specialties including nursing, occupational therapy, pharmacy, physical therapy, and x-ray technology. 42 C.F.R. § 413.85(e) (1994). A teaching hospital's customary or traditional role for these training programs will vary depending upon the kind of activity involved. *Ohio State Univ.*, 777 F. Supp. at 587.

8. *Ohio State Univ.*, 777 F. Supp. at 587; see also *Medical Education Passthrough*, supra note 2, at 4 (providing that direct GME expenses include "salaries and fringe benefits for residents, faculty, and support staff; the cost of conference and classroom space in the hospital; any costs of additional equipment and supplies; and allocated overhead costs").

9. *Ohio State Univ.*, 777 F. Supp. at 587.

10. *Id.*

11. See S. REP. NO. 404, 89th Cong., 1st Sess. 36 (1965), reprinted in 1965 U.S.C.A.N. 1943, 1977; H.R. REP. NO. 213, 89th Cong., 1st Sess. 32 (1965). At the 1965 legislative hearings, Congress instructed that until the community accepts its responsibility to pay GME costs, "part of the net cost of such activities (including stipends of trainees as well as compensation of teachers and other costs) should be considered as an element in the cost of patient care, to be borne to an appropriate extent by [Medicare]." S. REP. NO. 404; H.R. REP. NO. 213.

12. Title XVIII of the Social Security Act, Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 291, amended by 42 U.S.C. § 1395 (1988).

13. U.S. GENERAL ACCOUNTING OFFICE, MEDICARE: GRADUATE MEDICAL EDUCATION PAYMENT POLICY NEEDS TO BE REEXAMINED 1 (1994). In 1992, Medicare contributed \$5.2 billion to finance physician training and education. *Id.* Federal funding of clinical education is justified on the basis that clinical education is a public good; every graduate of medical school should be entitled to a residency position; the federal government should support academic medical institutions; and the federal government is responsible for the quantity, diversity, and geographic distribution of physicians. See *Fiscal Year 1990 Budget Issues Relating to Graduate Medical Education and its Support Under the Medicare Program: Hearing Before the Subcomm. on Health of the House Comm. on Ways & Means*, 101st Cong., 1st Sess. 50 (1989). But see Marc L. Rivo, MD, MPH et al., *Comparing Physician Workforce Reform Recommendations*, 270 JAMA 1083, 1083 (1993) (claiming that Medicare's GME funding policy has failed to provide a sufficient quantity and quality of physicians to meet our nation's health care needs).

14. Sr. Mary Jean Flaherty, S.C. & Sr. Rosemary Donley, S.C., *Health Care System Reform*, 10 J. CONTEMP. HEALTH L. & POL'Y 105, 109 (1994) (footnote omitted). Medicare has encouraged physicians to research and treat diseases which commonly afflict the elderly. *Id.* Since 1965, average life expectancy has increased by nearly three years, while

deficient with respect to its costs,¹⁵ particularly in the area of hospital expenditures.¹⁶ Hospitals providing services to Medicare beneficiaries ("Providers") are reimbursed by the Medicare program for the costs of traditional educational activities that enhance the quality of patient care.¹⁷ The program, however, will not pay for educational expenses "resulting from [a] redistribution of costs from educational institutions . . . to patient care institutions."¹⁸

The federal government and Providers disagree over the effect of this anti-redistribution principle on GME reimbursement.¹⁹ The Secretary of Health and Human Services ("Secretary"),²⁰ in an effort to limit Medicare expenditures,²¹ has construed the anti-redistribution regulation to bar reimbursement for all costs previously paid by a Provider's affiliated medical school.²² Providers argue, however, that because GME is essential to health care, the federal government should provide reimbursement

diseases such as heart disease, stroke, and diabetes have decreased by 30%. Eleanor D. Kinney, J.D., M.P.H., *The Medicare Appeals System for Coverage and Payment Disputes: Achieving Fairness in a Time of Constraint*, 1 ADMIN. L.J. AM. U. 1, 16 (1987) (footnote omitted). Medicare has also been successful in ensuring coverage for the elderly. At the time of its enactment, only 56% of the elderly had health insurance. *Id.* at 5 (footnote omitted). Today, more than 37 million people aged 65 and over are covered under the Medicare plan, Robin Toner & Robert Pear, *Medicare, Turning 30, Won't be What it Was*, N.Y. TIMES, July 23, 1995, at A1. This is the only age group in the United States with virtually universal coverage. *Id.*

15. In 1995, total Medicare expenditures are estimated to exceed \$153 billion, comprising over 10% of the federal budget. EXECUTIVE OFFICE OF THE PRESIDENT, OFFICE OF MANAGEMENT AND BUDGET, BUDGET OF THE UNITED STATES FISCAL YEAR 1995 at 235 (1994). Astonishingly, the Medicare budget, by itself, is more than half the entire defense budget. *Id.*

16. See Kinney, *supra* note 14, at 17 (footnotes omitted). Hospital services comprise 70% of all Medicare expenditures. *Id.* While Medicare expenditures were \$4.6 billion in 1967, *id.*, it is expected to be \$215 billion in 1999, EXECUTIVE OFFICE OF THE PRESIDENT, *supra* note 15, at 235.

17. 42 C.F.R. § 413.85(a)-(b) (1994).

18. 42 C.F.R. § 413.85(c) (1994).

19. See, e.g., *Thomas Jefferson Univ. v. Shalala*, 114 S. Ct. 2381, 2383-84 (1994); *Ohio State Univ. v. Secretary of United States Dep't of Health and Human Servs.*, 996 F.2d 122, 123 (6th Cir. 1993), *cert. granted*, 114 S. Ct. 2731, and *vacated*, 114 S. Ct. 2731 (1994).

20. The Secretary has the authority to prescribe Medicare regulations. 42 U.S.C. § 1395 hh(a)(1) (1988).

21. Robin Elizabeth Margolis, *HHS May Cut Medicare Payments to Teaching Hospitals*, 11 HEALTHSPAN 23, 23 (1994). Medicare currently pays teaching hospitals \$1.8 billion annually for the salaries and fringe benefits of interns and residents, faculty salaries, and overhead for teaching activities. Carol S. Weissert et al., *Education and the Health Professions: Explaining Policy Choices Among the States*, 19 J. HEALTH POL. POL'Y & L. 361, 364 (1994).

22. Margolis, *supra* note 21, at 23.

for all traditional GME activities, regardless of whether the activity had previously been borne by an educational institution.²³

This debate, as well as over \$150 million in GME reimbursements,²⁴ remained unsettled until the United States Supreme Court held in *Thomas Jefferson University v. Shalala*²⁵ that the anti-redistribution principle bars a Provider from receiving federal financing for any GME expense previously absorbed by its affiliated medical school.²⁶ In a five to four decision,²⁷ the Court held that the Secretary is entitled to broad deference when interpreting regulations concerning "a complex and highly technical regulatory program," such as Medicare.²⁸ Thus, the Court found that the Secretary's interpretation was both reasonable and "faithful to the regulations plain language."²⁹ According to the Court, the "anti-redistribution principle lays down a bright line [test] for distinguishing permissible from impermissible reimbursement: educational costs will not be reimbursed if they are the result of a 'redistribution of costs'" from an affiliated medical school to a Provider.³⁰

This Note first examines the manner in which Medicare reimburses Providers for GME expenses. Part II investigates a court's power to review the Secretary's interpretation of the anti-redistribution regulation. Part III analyzes the Supreme Court's holding in *Thomas Jefferson University v. Shalala* and its impact on similarly situated Providers. Finally, this Note concludes that the Secretary's interpretation is irrational in that

23. See *Ohio State Univ.*, 996 F.2d at 124; *Graduate Medical Education: Court Upholds HHS Interpretation of Rule for Indirect GME Reimbursement*, 3 HEALTH L. REP. (BNA) No. 26, at 894 (June 30, 1994) [hereinafter *GME: Court Upholds HHS Interpretation*] (stating the argument that the Secretary "wrongly interpreted the regulation to mean that if costs had not been claimed from the beginning of the [P]rovider's participation in Medicare, . . . any attempt later to identify the costs for Medicare reimbursement constituted a prohibited redistribution"). Those educational activities traditionally engaged in by Providers include clinical training of interns and residents. *Ohio State Univ. v. Sullivan*, 777 F. Supp. 582, 587 (S.D. Ohio 1991), *aff'd*, 966 F.2d 122 (6th Cir. 1993), *cert. granted*, 114 S. Ct. 2731, and *vacated*, 114 S. Ct. 2731 (1994).

24. Brief for Respondent at 10-12, *Thomas Jefferson Univ. v. Shalala*, 114 S. Ct. 2381 (1994) (No. 93-120) [hereinafter *Br. for Resp't*, Oct. 1993].

25. 114 S. Ct. 2381 (1994).

26. *Id.* at 2387.

27. This is the first time that the Supreme Court has split five to four on a decision involving Medicare. *GME: Court Upholds HHS Interpretation*, *supra* note 23, at 895.

28. *Thomas Jefferson Univ.*, 114 S. Ct. at 2387 (quoting *Pauley v. BethEnergy Mines, Inc.*, 501 U.S. 680, 697 (1991)).

29. *Id.* at 2389.

30. *Id.* (quoting 42 C.F.R. § 413.85(c) (1994)).

Providers furnishing similar benefits to their Medicare patients will receive disparate levels of reimbursement from the federal government.

I. THE MEDICARE PROGRAM

Congress enacted the federally funded Medicare program to ensure health insurance coverage for the elderly and disabled.³¹ Under the program, Medicare beneficiaries may receive treatment from any facility which participates as a "provider of [Medicare] services."³² Accordingly, Providers are directly reimbursed by the federal government for the costs incurred in treating their Medicare patients.³³

A. Administration of Medicare Reimbursement

Congress has delegated to the Secretary the authority to administer the Medicare reimbursement system and promulgate regulations necessary to govern payments to Providers.³⁴ In order for a Provider to receive federal funding, it must enter into a participation agreement with the Secretary to provide services to Medicare beneficiaries.³⁵ The Secretary then contracts with fiscal intermediaries³⁶ to assist with the reimbursement process.³⁷ At the end of the fiscal year, a Provider will file a detailed cost report with the intermediary indicating its total costs and how the costs are to be allocated.³⁸ The intermediary will analyze the cost report and prepare a written notice of program reimbursement identifying the total

31. Br. for Resp't, Oct. 1993, *supra* note 24, at 2 (citing 42 U.S.C. § 1395 (1988)). The Medicare program is divided into two parts. *Thomas Jefferson Univ. v. Sullivan*, [March-Sept. 1992 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 40,294, at 30,960 (E.D. Pa. May 1, 1992), *aff'd*, 993 F.2d 879 (3d Cir. 1993), *aff'd*, 114 S. Ct. 2381 (1994). Part A provides coverage for institutional providers such as hospitals. *Id.* (citing 42 U.S.C. § 1395c-d). Part B creates a voluntary program of "supplementary medical insurance" covering physicians' charges and other medical services. *Id.* (citing 42 U.S.C. § 1395k, l, x(s)).

32. *Thomas Jefferson Univ.*, [March-Sept. 1992 Transfer Binder] Medicare & Medicaid Guide (CCH) at 30,960 (citing 42 U.S.C. § 1395d, x(b) (1988)).

33. Brief for Petitioner at 3, *Thomas Jefferson Univ. v. Shalala*, 114 S. Ct. 2381 (1994) (No. 93-120) [hereinafter Br. for Pet'r, Feb. 1994].

34. 42 U.S.C. § 1395hh (1988).

35. 42 U.S.C. § 1395cc (1988). In particular, Providers must agree "not to charge . . . any individual . . . for items or services for which such individual is entitled to have payment made under [Medicare]." 42 U.S.C. § 1395cc(a)(1)(A).

36. In *Thomas Jefferson University v. Shalala*, Aetna Life Insurance Company served as the Secretary's fiscal intermediary. See *Thomas Jefferson Univ.*, [March-Sept. 1992 Transfer Binder] Medicare & Medicaid Guide (CCH) at 30,960.

37. *Id.* (citing 42 U.S.C. § 1395(h) (1988)).

38. 42 C.F.R. §§ 413.20(b), 413.24(f) (1994).

reimbursement due.³⁹ The notice will contain an explanation of the intermediary's decision and will advise the Provider of its right to appeal.⁴⁰

A Provider dissatisfied with the intermediary's decision may appeal by requesting a hearing before the Provider Reimbursement Review Board ("PRRB").⁴¹ The PRRB is a tribunal within the Department of Health and Human Services which maintains exclusive jurisdiction over Medicare reimbursement claims.⁴² Upon completion of the hearing,⁴³ the PRRB will issue a written decision based upon its findings from the record.⁴⁴ Any determination made by the PRRB is subject to review by the Secretary,⁴⁵ acting through the Health Care Financing Administration ("HCFA").⁴⁶ The HCFA may affirm, reverse, or modify the PRRB's decision.⁴⁷ If a Provider is still dissatisfied, it may seek judicial review by filing a civil action within sixty days after notification of the HCFA's decision.⁴⁸

B. General Cost Reimbursement Principles

Beginning in 1966, Medicare reimbursed Providers for all "reasonable costs" incurred in providing care to Medicare beneficiaries.⁴⁹ The "reasonable cost" reimbursement system was computed on the basis of "cost[s] actually incurred, excluding . . . any part of incurred cost[s] found to be unnecessary in the efficient delivery of needed health services."⁵⁰ Reasonable cost reimbursement, however, offered no incentive for Prov-

39. 42 C.F.R. § 405.1803 (1994).

40. *Id.*

41. *Thomas Jefferson Univ.*, [March-Sept. 1992 Transfer Binder] Medicare & Medicaid Guide (CCH) at 30,961 (citing 42 U.S.C. § 1395oo(a) (1988)); 42 C.F.R. § 405.1835 (1994).

42. *Id.* (citing 42 U.S.C. § 1395oo (1988)). The PRRB is selected by the Secretary and is comprised of five experts in the field of Medicare reimbursements. 42 U.S.C. § 1395oo(h). Two members of the PRRB must represent Providers and at least one member must be a certified public accountant. *Id.*

43. At the hearing, parties may present documented evidence, 42 C.F.R. § 405.1855 (1994), witnesses, 42 C.F.R. § 405.1859, and oral arguments and written briefs, 42 C.F.R. § 405.1861.

44. 42 C.F.R. § 405.1871 (1994).

45. 42 U.S.C. § 1395oo(f)(1) (1988).

46. *Thomas Jefferson Univ.*, [March-Sept. 1992 Transfer Binder] Medicare & Medicaid Guide (CCH) at 30,961; Kinney, *supra* note 14, at 8.

47. 42 C.F.R. § 405.1875(g) (1994).

48. 42 C.F.R. § 405.1877(a) (1994).

49. *Thomas Jefferson Univ.*, [March-Sept. 1992 Transfer Binder] Medicare & Medicaid Guide (CCH) at 30,960; 42 U.S.C. § 1395 x(v)(1)(A) (1988).

50. 42 U.S.C. § 1395x(v)(1)(A) (1988).

iders to be efficient in their delivery of patient care.⁵¹ Rather, it nurtured a situation in which rising costs would be met with increased levels of reimbursement.⁵²

Recognizing the need to control escalating Medicare expenditures,⁵³ Congress limited the rate at which Providers could increase their operating costs within the Tax Equity and Fiscal Responsibility Act of 1982 ("TEF-RA").⁵⁴ Providers with cost increases exceeding their "target amount" were to be penalized; those that did not surpass this amount were to receive a portion of the savings.⁵⁵

In 1983, Congress radically restructured Medicare reimbursement by establishing the Prospective Payment System ("PPS").⁵⁶ The PPS was enacted to enable the federal government to limit Medicare expenditures and offer Providers a financial incentive to deliver patient care efficiently.⁵⁷ Under the PPS, fixed rates are assigned to the different categories of Medicare services.⁵⁸ Payments are then made on the basis of these predetermined rates.⁵⁹ The PPS, however, allows for a pass-through pro-

51. *Thomas Jefferson Univ.*, [March-Sept. 1992 Transfer Binder] Medicare & Medicaid Guide (CCH) at 30,960.

52. *Id.*; see also H.R. REP. NO. 25, 98th Cong., 1st Sess. 132 (1983), reprinted in 1983 U.S.C.A.N. 219, 351 (providing that the Prospective Payment System was established to "reform the financial incentives hospitals face [and promote] efficiency in the provision of services by rewarding cost/effective hospital practices").

53. From 1967 to 1985, total Medicare expenditures increased from \$4.6 billion to \$62.9 billion. Kinney, *supra* note 14, at 17 (footnote omitted).

54. *Thomas Jefferson Univ.*, [March-Sept. 1992 Transfer Binder] Medicare & Medicaid Guide (CCH) at 30,960.

55. For example, hospitals with operating costs less than or equal to their "target amount" were reimbursed for those costs plus 50% of the difference between their "target amount" and their operating costs, or 5% of the "target amount," whichever is less. 42 U.S.C. § 1395ww(b)(1)(A) (1988). However, hospitals which exceeded their "target amount" were only reimbursed to the extent of their target rate plus 25% of the difference between this amount and their operating costs. 42 U.S.C. § 1395ww(b)(1)(B).

56. *Thomas Jefferson Univ.*, [March-Sept. 1992 Transfer Binder] Medicare & Medicaid Guide (CCH) at 30,960; 42 U.S.C. § 1395ww(d) (1988).

57. See *Thomas Jefferson Univ.*, [March-Sept. 1992 Transfer Binder] Medicare & Medicaid Guide (CCH) at 30,960.

58. See *id.* In contrast to the reasonable cost reimbursement system, the PPS reimburses hospitals a predetermined amount for the care of Medicare beneficiaries in each of the 490 valid diagnosis-related groups ("DRG's"). *Statement on the Importance of the Medicare Program to the Overall Financial Viability of Academic Medicare: Hearing Before the Subcomm. on Health of the House Comm. on Ways & Means, available in 1995 WL 43755 (F.D.C.H.) at *5 (February 6, 1995) [hereinafter Importance of the Medicare Program].*

59. *Importance of the Medicare Program, supra* note 58, at *5.

vision excluding direct GME expenses.⁶⁰ Thus, direct GME costs continued to be reimbursed under the old reasonable cost system.⁶¹

In 1986, Congress finally adopted a new payment methodology for GME expenses.⁶² As of July 1, 1985, the amount of costs a Provider incurred within its base year, a period ranging from fiscal year October 1, 1983, to September 30, 1984, influenced the reimbursement amount for all subsequent years.⁶³ Consequently, a number of Providers,⁶⁴ in an attempt to maximize future reimbursements, increased their expenses for this period by claiming costs previously paid by their affiliated medical school.⁶⁵ These increased costs form the basis of the dispute between the

60. See *Medical Education Funding*, *supra* note 1, at 88; H.R. REP. NO. 25, *supra* note 52, at 132, reprinted in 1983 U.S.C.C.A.N. at 359.

61. H.R. REP. NO. 25, *supra* note 52, at 132, reprinted in 1983 U.S.C.C.A.N. at 359. The Secretary justified the "direct medical education passthrough" provision in her 1982 report *Hospital Prospective Payment for Medicare*:

The Department believes that the *direct* costs of approved medical education should be excluded from the rate and be reimbursed as per the present [reasonable cost reimbursement] system. This approach will assure that the base rate is related to a patient care outcome and not significantly influenced by factors whose existence is really based on objectives quite apart from the care of particular patients in a particular hospital.

Medical Education Funding, *supra* note 1, at 88 (statement of the Association of American Medical Colleges).

62. Brief for Respondent at 5, *Thomas Jefferson Univ. v. Shalala*, 114 S. Ct. 2381 (1994) (No. 93-120) [hereinafter Br. for Resp't, March 1994].

63. *Id.* at 5-6 (citing Consolidated Omnibus Reconciliation Act (COBRA) of 1985, Pub. L. No. 99-272, § 9202(a), 100 Stat. 171 (1986) (codified at 42 U.S.C. § 1395ww(h) (1988); 42 C.F.R. § 413.86(e)(1)(i)(A) (1994)). "COBRA . . . distinguishes between 'direct graduate medical education costs,' which are reimbursed through the 'base year' methodology in 42 U.S.C. § 1395ww(h), and 'indirect costs' associated with post-graduate training programs, which are . . . reimbursed through the PPS system . . ." Br. for Resp't, March 1994, *supra* note 62, at 5 n.4 (quoting 42 U.S.C. § 1395ww(h), ww(d)(5)(B)). In distinguishing the two types of costs, the Conference Report on the COBRA stated:

The [M]edicare program provides reimbursement for both the direct and indirect costs of medical education incurred by teaching hospitals. The direct costs of approved medical education programs (such as salaries for residents and teachers and classroom costs) are excluded from the prospective payment system, and are reimbursed on a reasonable cost basis. The indirect costs are increased patient care costs associated with teaching programs due to such factors as increased diagnostic testing, increased numbers of procedures prescribed, higher staffing ratios, and a more severely ill patient population.

Id. (quoting H.R. CONF. REP. NO. 453, 99th Cong., 1st Sess. 455 (1985)).

64. Approximately 30 Providers attempted to increase their Medicare expenses during their base year and in subsequent years. See Br. for Resp't, Oct. 1993, *supra* note 24, at 10-11.

65. *Id.*; see, e.g., *Thomas Jefferson Univ. v. Shalala*, 114 S. Ct. 2381, 2385 (1994); *Ohio State Univ. v. Secretary, United States Dep't of Health and Human Servs.*, 996 F.2d 122, 124-25 (6th Cir. 1993), cert. granted, 114 S. Ct. 2731, and vacated, 114 S. Ct. 2731 (1994).

Secretary and Providers concerning the interpretation of the anti-redistribution regulation.⁶⁶

C. Regulations Governing GME Reimbursement

The regulations which govern the reimbursement of GME are set out in 42 C.F.R. section 413.85.⁶⁷ Section 413.85(a) codifies Congress' original intent to reimburse Providers for GME expenses by stating that "approved educational activities" are "allowable cost[s]" for which a Provider may receive reimbursement.⁶⁸ "Approved educational activities" are defined as "formally organized or planned programs of study usually engaged in by [P]roviders in order to enhance the quality of patient care."⁶⁹

Section 413.85(c), the anti-redistribution regulation, provides in full that:

Many [P]roviders engage in educational activities including training programs for . . . medical students, interns and residents These programs contribute to the quality of patient care within an institution and are necessary to meet the community's needs for medical . . . personnel. It is recognized that the costs of such educational activities should be borne by the community. However, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. Until communities undertake to bear these costs, the [Medicare] program will participate appropriately in the support of these educational activities. *Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by [P]roviders in conjunction with their operations, it is not intended that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units.*⁷⁰

66. See generally *Thomas Jefferson Univ.*, 114 S. Ct. at 2381 (considering whether section 413.85(c) prohibits reimbursement to Providers for otherwise reimbursable costs); *Ohio State Univ.*, 996 F.2d at 122 (determining whether the anti-redistribution regulation bars Providers from recovering increased Medicare expenses incurred during their base year).

67. Br. for Pet'r, Feb. 1994, *supra* note 33, at 5 (footnote omitted).

68. 42 C.F.R. § 413.85(a) (1994); see also S. REP. NO. 404, *supra* note 11, at 36, reprinted in 1965 U.S.C.C.A.N. at 1997 (providing that a portion of the cost of a Provider's GME program should be paid for by Medicare).

69. 42 C.F.R. § 413.85(b) (1994).

70. 42 C.F.R. § 413.85(c) (1994) (emphasis added).

In section 413.85(g), the Secretary has set out the formula for determining the reasonable costs of GME reimbursement.⁷¹ A Provider will be reimbursed the net cost of the approved educational activity minus the revenue it receives from tuition.⁷² In addition, under the related-organization principle, a Provider can recover the costs incurred by its affiliated medical school in connection with the Provider's GME program, as long as the Provider and medical school are related by common ownership.⁷³ This regulation has been construed by the Secretary to allow a Provider to recover expenses incurred directly by its affiliated medical school.⁷⁴

The regulations presented in section 413.85 have been part of the Medicare program since its inception.⁷⁵ Despite this fact, the Secretary never utilized the anti-redistribution regulation to deny any related-party reimbursement claim (e.g., hospital-affiliated medical school) until the mid-1980s.⁷⁶ Furthermore, a formal definition of "redistribution" was not promulgated by the Secretary until September 1992.⁷⁷ Hence, the proper interpretation of the anti-redistribution regulation can only be derived through "the relevant legislative history, the Secretary's own previous interpretations and practices, and the plain meaning of the regulation, read in context with the entire statutory and regulatory

71. 42 C.F.R. § 413.85(g) (1994).

72. *Id.* The net cost of an approved educational activity includes expenses such as trainee stipends, teachers' salaries, and other "direct and indirect costs." *Id.*

73. 42 C.F.R. § 413.17(a) (1994); *see infra* notes 206-13 and accompanying text.

74. Br. for Pet'r, Feb. 1994, *supra* note 33, at 6-7. For example, the Secretary has allowed Providers to include within its reimbursable costs such expenses as teaching faculty salaries, a medical library, physician office space, and clerical support. *Intermediary Letter*, No. 78-7 (Feb. 1978), *reprinted in* Petition for a Writ of Certiorari, Thomas Jefferson Univ. v. Shalala, 114 S. Ct. 2381 (1994) (No. 93-120) at 65a [hereinafter *Intermediary Letter*].

75. Br. for Pet'r, Feb. 1994, *supra* note 33, at 7.

76. *Id.* at 7-8; Thomas Jefferson Univ. v. Shalala, 114 S. Ct. 2381, 2390-91 (1994) (Thomas, J., dissenting).

77. Br. for Pet'r, Feb. 1994, *supra* note 33, at 8. The Secretary's definition of "redistribution," which came out approximately seven years after the dispute concerning the anti-redistribution clause originated, states:

Redistribution of costs is defined as an attempt by a [P]rovider to increase the amount, or to expand the types, of the costs of educational activities that are allowed for Medicare payment purposes by claiming costs that previously were not claimed by the [P]rovider and were considered costs of an educational institution. For example, costs for a school of nursing or allied health education that were incurred by an educational institution rather than the [P]rovider in its prospective payment or rate-of-increase limit base year cost report are not allowable costs in subsequent fiscal years.

57 Fed. Reg. 43,659, 43,672 (1992) (to be codified at 42 C.F.R. pt. 413) (proposed Sept. 22, 1992).

scheme."⁷⁸

II. JUDICIAL REVIEW OF THE SECRETARY'S INTERPRETATION

Section 706 of the Administrative Procedure Act authorizes a judicial court to set aside an agency's actions when they are found to be "arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law."⁷⁹ An action is considered to be arbitrary and capricious when the agency:

[R]elie[s] on factors which Congress has not intended it to consider, entirely fail[s] to consider an important aspect of the problem, offer[s] an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise.⁸⁰

Although a court is to conduct a careful inquiry into the facts, it is not empowered to substitute its wisdom for that of the agency.⁸¹ A court "must give substantial deference to an agency's interpretation of its own regulations."⁸² As long as there is a rational basis for the agency's decision, a reviewing court cannot overturn the action as arbitrary and capricious.⁸³ Thus, the court's task is not to choose which interpretation best serves the regulation's purpose.⁸⁴ Rather, an agency's interpretation is controlling unless "an alternative reading is compelled by the regulation's plain language or by other indications of the Secretary's intent."⁸⁵

A. *The Secretary's Interpretation Does Not Comport with the Regulation's Plain Language*

Prior to the Supreme Court's decision in *Thomas Jefferson University v. Shalala*, the federal courts of appeals were split as to the correct interpre-

78. Br. for Pet'r, Feb. 1994, *supra* note 33, at 8.

79. Administrative Procedure Act § 706(2) (A), 5 U.S.C. § 706(2)(A) (1988); *see, e.g.*, *Univ. of Cincinnati v. Bowen*, 875 F.2d 1207 (6th Cir. 1989) (holding that the Secretary's denial of Medicare reimbursements to a Provider was inconsistent with the regulation's intent, and therefore, not entitled to deference).

80. *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Ins. Co.*, 463 U.S. 29, 43 (1983).

81. JACOB A. STEIN ET AL., *ADMINISTRATIVE LAW* § 51.03, at 51-118 (1994) (footnote omitted).

82. *Thomas Jefferson Univ. v. Shalala*, 114 S. Ct. 2381, 2386 (1994) (citing *Martin v. Occupational Safety and Health Review Comm'n*, 499 U.S. 144, 150 (1991); *Lyng v. Payne*, 476 U.S. 926, 939 (1985); *Udall v. Tallman*, 380 U.S. 1, 16 (1965)).

83. STEIN ET AL., *supra* note 81, at 51-122 (footnote omitted).

84. *Thomas Jefferson Univ.*, 114 S. Ct. at 2386.

85. *Gardner v. Jenkins*, 485 U.S. 415, 430 (1988).

tation of the anti-redistribution regulation.⁸⁶ In *Ohio State University v. Secretary, United States Department of Health and Human Services*,⁸⁷ the United States Court of Appeals for the Sixth Circuit admitted that it must defer to the Secretary's finding as long as it is "reasonable, consistent, and persuasive."⁸⁸ Nevertheless, the court refused to accord such deference, finding the Secretary's interpretation in conflict with the regulation's plain meaning.⁸⁹

The *Ohio State University* court focused on the precise words of the regulation; namely, the program's intent to share in the support of "educational activities customarily or traditionally carried on by [P]roviders."⁹⁰ From this language, the court concluded that section 413.85(c) bars the redistribution of only certain kinds of costs; specifically, those costs related to non-traditional activities, such as classroom expenses.⁹¹ However, according to the court, if the costs incurred relate to the clinical training of physicians, and therefore involve patient care, reimbursement should never be denied.⁹²

B. Affording Deference to the Secretary's Interpretation

In *Thomas Jefferson University v. Shalala*,⁹³ a case virtually identical to *Ohio State University*, the United States Court of Appeals for the Third Circuit reached an entirely opposite conclusion.⁹⁴ Upon reviewing the

86. See *Thomas Jefferson Univ. v. Shalala*, 993 F.2d 879 (3d Cir. 1993), *aff'd*, 114 S. Ct. 2381 (1994); *Ohio State Univ. v. Secretary, United States Dep't of Health and Human Servs.*, 996 F.2d 122 (6th Cir. 1993), *cert. granted*, 114 S. Ct. 2731, and *vacated*, 114 S. Ct. 2731 (1994).

87. 996 F.2d 122 (1993).

88. *Id.* at 123-24 (citing *Whiteside v. Secretary of Health and Human Servs.*, 834 F.2d 1289, 1292 (6th Cir. 1987)).

89. *Id.* at 124.

90. *Id.* (citing 42 C.F.R. § 413.85(c) (1994)).

91. *Id.* The court distinguished between a Provider's GME program, which trains physicians by having them perform medical services, and a medical school's educational program which takes place in the classroom. *Id.*

92. *Id.* According to the appellate court, the underlying purpose of the anti-redistribution regulation is to "limit reimbursement to educational costs related to patient care and to deny reimbursement for educational costs unrelated to patient care." *Id.* (quoting *Ohio State Univ. v. Sullivan*, 777 F. Supp. 582, 587 (S.D. Ohio 1991), *aff'd*, 996 F.2d 122 (6th Cir. 1993), *cert. granted*, 114 S. Ct. 2731, and *vacated*, 114 S. Ct. 2731 (1994)).

93. *Thomas Jefferson Univ.*, 993 F.2d at 879.

94. *Id.* The appellate court affirmed the district court's decision without opinion. *Id.* Thus, the appellate court adopted the views of the lower court. See *Thomas Jefferson Univ. v. Sullivan*, [March-Sept. 1992 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 40,294 (E.D. Pa. May 1, 1992), *aff'd*, 993 F.2d 879 (3d Cir. 1993), *aff'd*, 114 S. Ct. 2381 (1994).

plain language of the anti-redistribution regulation, the court found the Secretary's interpretation reasonable, and therefore entitled to deference.⁹⁵ In reaching its conclusion, the court acknowledged the regulation's intent that Medicare subsidize traditional educational activities conducted by Providers.⁹⁶ Equally clear to the court, however, was the regulation's desire that Medicare not "participate in increased costs resulting from redistribution of costs from educational institutions . . . to patient care institutions."⁹⁷ Consequently, the Third Circuit held that the Secretary was correct in concluding that the regulation admits of only one construction:

[I]f the costs of activities customarily and traditionally carried on by [P]roviders . . . have been absorbed by an educational unit, such costs may not later be redistributed to a patient care unit. It is clear that what the regulation prohibits is the "redistribution of costs." Any other interpretation would clearly run afoul of the principle that a regulation will be construed to give effect to its plain meaning.⁹⁸

III. THE SUPREME COURT'S DECISION IN *THOMAS JEFFERSON UNIVERSITY V. SHALALA*

In *Thomas Jefferson University v. Shalala*,⁹⁹ the United States Supreme Court resolved the split among the circuits and affirmed the Secretary's interpretation of the anti-redistribution regulation.¹⁰⁰ The Court concluded that the Secretary's construction is not only plausible, but "it is the most sensible [reading] the language will bear."¹⁰¹ According to the Court, the meaning of section 413.85(c) is "straightforward."¹⁰² its first clause identifies the scope of reimbursable expenses (*i.e.*, traditional edu-

95. *Thomas Jefferson Univ.*, [March-Sept. 1992 Transfer Binder] Medicare & Medicaid Guide (CCH) at 30,966.

96. *Id.* at 30,963; S. REP. No. 404, *supra* note 11, at 36, *reprinted in* 1965 U.S.C.C.A.N. at 1977; *see also* St. John's Hickey Memorial Hosp. v. Califano, 599 F.2d 803, 808 (7th Cir. 1979) (finding Congress clearly expressed its intent that educational activities which enhance the quality of patient care should be supported by Medicare), *questioned on other grounds in*, Homemakers North Shore, Inc., v. Bowen, 832 F.2d 408, 413 (1987).

97. *Thomas Jefferson Univ.*, [March-Sept. 1992 Transfer Binder] Medicare & Medicaid Guide (CCH) at 30,966 (emphasis omitted) (citing 42 C.F.R. § 413.85(c) (1994)).

98. *Id.* at 30,966. According to the court, the regulation does not distinguish between academic and clinical training of physicians for the purposes of determining reimbursable expenses. *Id.* at 30,964.

99. 114 S. Ct. 2381 (1994).

100. *Id.* at 2384.

101. *Id.* at 2387.

102. *Id.*

ational activities); while its second clause provides that the costs of such activities will not be reimbursed if they result from a shift of costs from an educational to a patient care facility.¹⁰³

A. Case History

Thomas Jefferson University Hospital ("Hospital") is a 700 bed teaching hospital which operates a Medicare-approved GME program.¹⁰⁴ Although the GME program takes place in the Hospital, it is conducted by members of the University's College of Medicine ("Medical School").¹⁰⁵ The Hospital and the Medical School are commonly owned by the University, and thus, are "related organizations" within the Medicare regulations.¹⁰⁶

Although the Hospital has provided services to Medicare beneficiaries since the program's inception, it did not seek reimbursement for any GME costs until 1974.¹⁰⁷ From 1974 to 1983, however, the Hospital claimed and received reimbursement for three salary-related GME costs: (1) salaries paid directly by the Hospital to the faculty of the Medical School for services provided to the Hospital's Medicare patients; (2) salaries paid directly to residents; and (3) funds transferred internally from the Hospital to the Medical School compensating the Medical School's faculty for the training of the Hospital's residents.¹⁰⁸

In 1985, in an attempt to refine its cost-finding techniques, the Hospital hired a national accounting firm to identify all GME related expenses for which it may have been eligible for repayment.¹⁰⁹ The accounting firm concluded that during fiscal year 1985, the Hospital had incurred GME program costs totalling more than \$8.8 million.¹¹⁰ This figure included nearly \$2.9 million in expenses directly incurred by the Medical School

103. *Id.*

104. *Id.* at 2385.

105. Br. for Resp't, Oct. 1993, *supra* note 24, at 4.

106. *Thomas Jefferson Univ.*, 114 S. Ct. at 2385 (citing 42 C.F.R. § 413.17(a) (1994)); see also *infra* notes 206-13 and accompanying text (explaining the related-organization regulation's impact on the meaning of the anti-redistribution principle). Under the related-organization regulation, a Provider is entitled to repayment for the costs incurred by its affiliated medical school. 42 C.F.R. § 413.17(a).

107. *Thomas Jefferson Univ.*, 114 S. Ct. at 2385.

108. *Id.*

109. *Id.*

110. *Id.* The GME costs amounted to approximately \$6.6 million while administrative costs amounted to nearly \$2.2 million. *Thomas Jefferson Univ. v. Sullivan*, [March-Sept. 1992 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 40,294, at 30,962 (E.D. Pa. May 1, 1992), *aff'd*, 993 F.2d 872 (3d Cir. 1993), *aff'd*, 114 S. Ct. 2381 (1994).

which had not previously been claimed by the Hospital.¹¹¹ Significantly, the Hospital's fiscal year 1985¹¹² coincided with the new base year reimbursement methodology established in 1986.¹¹³ Thus, the amount reimbursed to the Hospital during this period would influence its level of reimbursement for all subsequent years.¹¹⁴

Acting under the accounting firm's guidance, the Hospital submitted its claim to the fiscal intermediary seeking reimbursement for the entire \$8.8 million.¹¹⁵ The intermediary, however, denied the Hospital's claim and allowed repayment for only those costs that had been reimbursed in prior years.¹¹⁶ The intermediary concluded that the increased costs proposed by the Hospital constituted an improper attempt to shift costs from the Medical School in violation of the anti-redistribution regulation.¹¹⁷

On November 17, 1989, the PRRB reversed the decision of the intermediary and allowed reimbursement for the full \$8.8 million.¹¹⁸ The PRRB noted that although the term "redistribution" is not defined by the regulations, its use within section 413.85(c) is prefaced by a clause which states that the Medicare program will share in the support of traditional educational activities.¹¹⁹ Based on this language, the PRRB concurred with the "[Hospital's] interpretation that the focus of the regulation with respect to redistribution is on educational 'activities,' and not the 'cost' associated with the activity."¹²⁰ Accordingly, the PRRB concluded that the Hospital's claim for additional support for its GME program did not constitute a redistribution of costs from the Medical School to the

111. *Thomas Jefferson Univ.*, 114 S. Ct. at 2385.

112. The Hospital's fiscal year 1985 extended from July 1, 1984, to June 30, 1985. Br. for Resp't, March 1994, *supra* note 62, at 5-6.

113. *Thomas Jefferson Univ.*, 114 S. Ct. at 2385; *see also supra* notes 62-66 and accompanying text.

114. Br. for Resp't, Oct. 1993, *supra* note 24, at 6; *Thomas Jefferson Univ.*, 114 S. Ct. at 2385.

115. *Thomas Jefferson Univ.*, 114 S. Ct. at 2385.

116. Br. for Resp't, Oct. 1993, *supra* note 24, at 5.

117. *Thomas Jefferson Univ. v. Sullivan*, [March-Sept. 1992 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 40,294, at 30,962 (E.D. Pa. May 1, 1992), *aff'd*, 993 F.2d 879 (3d Cir. 1993), *aff'd*, 114 S. Ct. 2381 (1994).

118. *Thomas Jefferson Univ. v. Aetna Life Ins. Co.*, [1989-90 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 38,276, at 21,536 (Nov. 17, 1989), *modified*, [Oct.-Sept. 1989-90 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 38,353 (Jan. 18, 1990), *aff'd*, [March-Sept. 1992 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 40,294 (E.D. Pa. May 1, 1992), *aff'd*, 993 F.2d 879 (3d Cir. 1993), *aff'd*, 114 S. Ct. 2381 (1994).

119. *Id.* at 21,543.

120. *Id.* (quoting 42 C.F.R. § 413.85(c) (1994)).

Hospital.¹²¹

On January 18, 1990, the Secretary, acting through the HCFA, modified the PRRB's decision.¹²² The Secretary observed that under the pass-through provision of the PPS,¹²³ Providers "were attempting to claim [GME] costs not previously the responsibility of the Provider or reimbursed by Medicare."¹²⁴ According to the Secretary, this practice constituted an improper shift of costs from a medical school to a Provider's GME program.¹²⁵ Moreover, the Secretary turned to the community support language of section 413.85(c) as a means of denying repayment to the Hospital.¹²⁶ The Secretary reasoned that the Hospital's failure to claim these costs in previous years indicated community support for these activities.¹²⁷ According to the Secretary, "[t]he Medicare [program] was enacted to provide a hospital insurance and basic protection against the costs of hospital care for the aged, and not intended to subsidize medical education programs already supported by the community."¹²⁸ Therefore, the Secretary stated that:

To allow the community to withdraw that support and pass these costs to the Medicare program would result in a redistribution of costs in violation of 42 C.F.R. 413.85(c). It would [also] be the precise activity Congress intended to prevent. To allow it would

121. *Id.* According to the PRRB, the additional costs claimed by the Hospital were attributable to a refinement of cost-finding techniques and were not a prohibited redistribution. *Id.*

122. *Thomas Jefferson Univ. v. Aetna Life Ins. Co.*, [Oct.-Sept. 1989-90 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 38,353 (Jan. 18, 1990), *aff'd*, [March-Sept. 1992 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 40,294 (E.D. Pa. May 1, 1992), *aff'd*, 993 F.2d 879 (3d Cir. 1993), *aff'd*, 114 S. Ct. 2381 (1994).

123. See *supra* notes 56-61 and accompanying text (providing an explanation of the pass-through provision).

124. *Thomas Jefferson Univ.*, [Oct.-Sept. 1989-90 Transfer Binder] Medicare & Medicaid Guide (CCH) at 22,022 (footnote omitted).

125. *Id.*

126. *Id.* at 22,023. Specifically, the community support language of section 413.85(c) states that:

[T]he costs of . . . educational activities should be borne by the community. However, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. Until communities undertake to bear these costs, the [Medicare] program will participate appropriately in the support of these [educational] activities.

42 C.F.R. § 413.85(c) (1994).

127. *Thomas Jefferson Univ.*, [Oct.-Sept. 1989-90 Transfer Binder] Medicare & Medicaid Guide (CCH) at 22,023.

128. *Id.* Congress intended that until communities provide support for GME expenses, Medicare should assist in the financing of GME as part of its commitment to patient care. *Id.*

encourage the community to abdicate its commitment to education to an insurance program intended to provide care for the elderly.¹²⁹

The district court affirmed the Secretary's decision.¹³⁰ Applying a plain meaning approach, the court held that in order to qualify for reimbursement four conditions must be met.¹³¹ First, the costs must be incurred in connection with the clinical training of residents.¹³² Second, the program must enhance the quality of patient care within the hospital.¹³³ Third, the educational costs must not have previously been paid for by the community.¹³⁴ Finally, the costs must not have been shifted from a medical school to a hospital.¹³⁵ The court held that the Hospital had violated both the community support and anti-redistribution conditions.¹³⁶

In addressing the community support issue, the court deferred to the HCFA's decision that the increased costs claimed by the Hospital had previously been paid by the community.¹³⁷ The court also rejected the Hospital's argument that a Provider may look to Medicare for increased support when its community support decreases.¹³⁸ According to the court, the regulation's plain language and the statute's legislative history "express [Congress'] intent that the costs of medical educational programs should be borne by the community,"¹³⁹ and that Medicare would "participate . . . in the support of these activities" only "until . . . communities undertake to bear these costs."¹⁴⁰ Furthermore, the court looked

129. *Id.*

130. *Thomas Jefferson Univ. v. Sullivan*, [March-Sept. 1992 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 40,294, at 30,967 (E.D. Pa. May 1, 1992), *aff'd*, 993 F.2d 879 (3d Cir. 1993), *aff'd*, 114 S. Ct. 2381 (1994).

131. *Id.* at 30,964.

132. *Id.*

133. *Id.*

134. *Id.*

135. *Id.*

136. *Id.* at 30,967.

137. *Id.* at 30,965. According to the HCFA, community support consists of "any source of funding other than the Medicare program," *id.* at 30,964, including "tuition and fees, Federal appropriations, Federal grants and contracts, private gifts, grants and contracts, endowment income, investment income and other income," *id.* at 30,965 (quoting *Univ. of Minn. Hosps. & Clinics v. Blue Cross & Blue Shield Assoc.*, [Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 39,420, at 26,828 (May 29, 1991)). The Secretary based her definition of community support on "commonsense as well as the principles of cost reimbursement promulgated by the American Hospital Association." *Id.* at 30,964.

138. *Id.* at 30,965.

139. *Id.*

140. *Id.* (quoting 42 C.F.R. § 413.85(c) (1994)). Thus, the court concluded that

to the restructuring of the Medicare reimbursement system in 1983¹⁴¹ as proof of Congress' desire to limit "the spiraling costs of the Medicare program to prevent exhaustion of the fund and achiev[e] a level of budget neutrality."¹⁴² Consequently, the court concluded that to allow the shifting of costs traditionally paid for by another source to the Medicare program would clearly oppose the congressional intent.¹⁴³

With respect to the redistribution issue, the court rejected the Hospital's argument "that the [anti-]redistribution principle operates to prohibit only the impermissible shifting of 'activities' . . . and does not apply to the shifting of 'costs.'"¹⁴⁴ Rather, the court agreed with the Secretary that if "the costs . . . [had] been absorbed by an educational unit, such costs may not later be redistributed to a patient care unit."¹⁴⁵ Thus, despite the Hospital's contention that their increased claim "represented a refinement of its cost-finding techniques rather than a redistribution of costs," the court agreed with the Secretary's conclusion that "the increased claim for reimbursement represent[ed] an impermissible redistribution of costs."¹⁴⁶

The Hospital appealed the district court's decision to the United States Court of Appeals for the Third Circuit.¹⁴⁷ The appellate court affirmed the district court's decision without opinion.¹⁴⁸ The United States Supreme Court affirmed the appellate court's decision.¹⁴⁹ Justice Ken-

"[n]othing in the regulation suggests . . . that a [P]rovider may seek to compensate for a decline in community support by escalating costs claimed from the Medicare program." *Id.*

141. See *supra* notes 56-61 and accompanying text.

142. *Thomas Jefferson Univ.*, [March-Sept. 1992 Transfer Binder] Medicare & Medicaid Guide (CCH) at 30,965; H.R. REP. NO. 25, *supra* note 52, at 132, *reprinted in* 1983 U.S.C.C.A.N. at 351.

143. *Thomas Jefferson Univ.*, [March-Sept. 1992 Transfer Binder] Medicare & Medicaid Guide (CCH) at 30,965.

144. *Id.* at 30,966 (quoting 42 C.F.R. § 413.85(c) (1994)).

145. *Id.* (quoting 42 C.F.R. § 413.85(c) (1994)).

146. *Id.* But see *Thomas Jefferson Univ. v. Aetna Life Ins. Co.*, [1989-90 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 38,276, at 21,543 (Nov. 17, 1989) (holding that a failure to identify costs in the past should not "prohibit the correction of this [cost accounting] error"), *modified*, [Oct.-Sept. 1989 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 38,353 (Jan. 18, 1990), *aff'd*, [March-Sept. 1992 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 40,294 (E.D. Pa. May 1, 1992), *aff'd*, 993 F.2d 879 (3d Cir. 1993), *aff'd*, 114 S. Ct. 2381 (1994).

147. *Thomas Jefferson Univ. v. Shalala*, 993 F.2d 879, 879 (3d Cir. 1993), *aff'd*, 114 S. Ct. 2381 (1994).

148. *Id.*

149. *Thomas Jefferson Univ. v. Shalala*, 114 S. Ct. 2381, 2389 (1994).

ned, writing for the majority of five justices,¹⁵⁰ held that because the Secretary's interpretation was consistent with the anti-redistribution regulation's plain language, deference should be afforded and reimbursement should be denied.¹⁵¹ The Court, however, did not rule on the Secretary's construction of the community support principle because, according to the Court, the anti-redistribution clause alone was sufficient to deny reimbursement.¹⁵²

In a dissenting opinion, Justice Thomas¹⁵³ focused on the words of section 413.85(c) which state that the "intent of the [Medicare] program is to share in the support of educational activities customarily or traditionally carried on by [P]roviders."¹⁵⁴ The test for reimbursement, according to the dissent, is not whether a particular hospital "has traditionally claimed and been allowed" repayment for a specific category of reimbursable costs,¹⁵⁵ but "whether the educational activities for which reimbursement is sought are of a type 'customarily or traditionally' engaged in by [P]roviders."¹⁵⁶ If the answer to the question is no, then it would be a prohibited redistribution.¹⁵⁷ However, if the costs involve educational activities traditionally engaged in by Providers, and thus enhance the quality of patient care, no redistribution occurs when these costs are reimbursed.¹⁵⁸

B. The Majority's Approach: Strict Compliance with Administrative Law Principles

In obeying the arbitrary and capricious standard and exercising a deferential approach, the Court refused to contemplate which interpretation of the anti-redistribution clause best serves the regulation's purpose.¹⁵⁹ Rather, the Court simply focused on whether an "alternative reading of the [anti-redistribution] principle is compelled by the regulation's plain language or by other indications of the Secretary's intent at the time of

150. Justice Kennedy was joined by Chief Justice Rehnquist, and Justices Blackmun, Scalia, and Souter. *Id.* at 2383.

151. *Id.* at 2389.

152. *Id.* at 2387.

153. Justice Thomas was joined by Justices Stevens, O'Connor, and Ginsberg. *Id.* at 2389 (Thomas, J., dissenting).

154. *Id.* at 2394; 42 C.F.R. § 413.85(c) (1994).

155. *Thomas Jefferson Univ.*, 114 S. Ct. at 2394 (citation omitted).

156. *Id.* (quoting 42 C.F.R. § 413.85(c) (1994)).

157. *Id.*

158. *Id.*

159. *Id.* at 2386.

the regulation's promulgation."¹⁶⁰

The Hospital, anticipating the Court's position, presented three arguments¹⁶¹ as to why a deferential stance was inappropriate:¹⁶² (1) the Secretary's interpretation of the regulation is contrary to its plain meaning;¹⁶³ (2) the Secretary's construction violated her own internal policies;¹⁶⁴ and (3) the Secretary's current adaptation of the anti-redistribution principle contradicts previous applications of the regulation by the Department of Health and Human Services ("Department").¹⁶⁵

1. *The Secretary's Interpretation Is Inconsistent with Its Plain Meaning*

In its first argument, the Hospital asserted that the plain meaning of the regulation is to prohibit the reimbursement of costs for nontraditional GME activities (e.g., classroom training), but to allow reimbursement for costs of activities traditionally engaged in by Providers (e.g., clinical training).¹⁶⁶ According to the Hospital, the regulation's prohibition against the shifting of costs is prefaced by a sentence that begins, "the intent of the program is to share in the support of educational activities customarily or traditionally carried on by [P]roviders."¹⁶⁷ Because the Hospital had operated its GME program well before the inception of Medicare,¹⁶⁸ it contended that it was entitled to recover the "direct and indirect costs

160. *Id.* at 2386-87 (quoting *Gardebring v. Jenkins*, 485 U.S. 415, 430 (1988)).

161. An additional argument was presented by the Hospital based on the aspirational language of section 413.85(c). *See id.* at 2389; *infra* note 203.

162. *Thomas Jefferson Univ.*, 114 S. Ct. at 2387.

163. *Id.* at 2388; Br. for Pet'r, Feb. 1994, *supra* note 33, at 20; *infra* notes 166-72 and accompanying text.

164. *Thomas Jefferson Univ.*, 114 S. Ct. at 2388; Br. for Pet'r, Feb. 1994, *supra* note 33, at 21; *infra* notes 173-82 and accompanying text.

165. *Thomas Jefferson Univ.*, 114 S. Ct. at 2391; Br. for Pet'r, Feb. 1994, *supra* note 33, at 21; *infra* notes 183-88 and accompanying text.

166. *Thomas Jefferson Univ.*, 114 S. Ct. at 2388; Br. for Pet'r, Feb. 1994, *supra* note 33, at 20. In other words, the Hospital asserted the position followed by the United States Court of Appeals for the Sixth Circuit in *Ohio State University* and contended that the "redistribution that is prohibited is the redistribution of activities, not the redistribution of costs." *Id.*; *see also* *Ohio State Univ. v. Sullivan*, 777 F. Supp. 582, 587 (S.D. Ohio 1991), *aff'd*, 996 F.2d 112 (6th Cir. 1993), *cert. granted*, 114 S. Ct. 2731, and *vacated*, 114 S. Ct. 2731 (1994) (holding that the "underlying purpose of the [anti-]redistribution principle is to limit reimbursement to educational costs related to patient care"); *supra* notes 87-92 and accompanying text (discussing the *Ohio State University* decision).

167. Br. for Pet'r, Feb. 1994, *supra* note 33, at 20 (quoting 42 C.F.R. § 413.85(c) (1994) (emphasis omitted)).

168. *Id.* at 20-21 (citation omitted).

related to [these] educational activities."¹⁶⁹

The Court, however, rejected the Hospital's argument, finding it inconsistent with the plain language of the regulation.¹⁷⁰ In addition, the Court stated that even if it was consistent, administrative law principles would require that the Secretary's interpretation be given controlling weight.¹⁷¹ The inquiry, according to the Court, is whether or not the Secretary's interpretation is reasonable, not whether a better interpretation is offered by the Hospital.¹⁷²

2. *The Secretary's Interpretation Contradicts Internal Policies*

In its second argument, the Hospital attempted to overcome the deferential tactics of the Court by alleging that the Secretary's interpretation was inconsistent with her internal policies.¹⁷³ As proof of the Secretary's inconsistency, the Hospital offered internal operating guidelines issued by the HCFA to instruct Providers how to claim costs for the purposes of reimbursement.¹⁷⁴ Even though the memorandum detailed numerous categories and amounts of GME expenses incurred by a medical school which may be reimbursable to a Provider, it did not mention the anti-redistribution limitation.¹⁷⁵ Thus, according to the Hospital:

If the Secretary's current interpretation of the regulation is correct, [the guideline] should have instructed intermediaries that any related-party GME costs not previously claimed represented a prohibited redistribution. It did not. It is remarkable that neither the concept of redistribution nor the relevant regulatory section is cited in the Secretary's internal guidelines for the proper treatment of GME costs by teaching hospitals. This absence is persuasive evidence that the Secretary's interpretation of section 413.85(c) is *not* a long-standing or consistent policy, but rather a recently-discovered tool for denying legitimate

169. *Id.* at 20 (quoting *Ohio State Univ.*, 777 F. Supp. at 587).

170. *Thomas Jefferson Univ.*, 114 S. Ct. at 2388.

171. *Id.* (citing *Bowles v. Seminole Rock & Sand Co.*, 325 U.S. 410, 414 (1945)).

172. *Id.* Here, the Court viewed the Secretary's construction as reasonable because nothing in the language of the regulation indicates that the "redistribution of costs" only applies to certain activities, such as classroom instruction. *Id.* Rather, according to the Court, the regulation clearly indicates that any shifting of costs is prohibited. *Id.*

173. *Id.* at 2388; Br. for Pet'r, Feb. 1994, *supra* note 33, at 21.

174. *Thomas Jefferson Univ.*, 114 S. Ct. at 2388 (citation omitted); Br. for Pet'r, Feb. 1994, *supra* note 33, at 22; *Intermediary Letter*, *supra* note 74, at 64a-66a.

175. *Thomas Jefferson Univ.*, 114 S. Ct. at 2388; Br. for Pet'r, Feb. 1994, *supra* note 33, at 22; *Intermediary Letter*, *supra* note 74, at 64a-66a.

reimbursement claims.¹⁷⁶

The Court, however, rejected this argument.¹⁷⁷ Although the Court admitted that an interpretation by the Secretary which conflicts with a prior interpretation is “‘entitled to considerably less deference’ than a consistently held view,”¹⁷⁸ it failed to perceive the Hospital’s evidence as persuasive.¹⁷⁹ The Court stated that the Secretary’s omission of the anti-redistribution principle in the guidelines did not create a contrary policy because the letter did not purport to be a complete list of all the possible conditions that might be placed on the repayment of costs.¹⁸⁰ Rather, the letter specifically stated that it was only trying to review “a number of situations.”¹⁸¹ Thus, according to the Court, “[i]t is not surprising, then that the letter did not address the anti-redistribution principle, and the mere failure to address it hardly establishes an inconsistent policy on the part of the Secretary.”¹⁸²

3. *The Secretary’s Interpretation Is Inconsistent with Previous Applications of the Regulation*

In its final argument, the Hospital contended that the Secretary’s interpretation of section 413.85(c) is inconsistent with previous applications of the regulation.¹⁸³ According to the Hospital, if the Secretary’s construction of the anti-redistribution regulation is correct, then the initial reimbursement to the Hospital in 1974 was actually a prohibited “redistribution.”¹⁸⁴ This argument was based on the fact that even though the Hospital had not historically claimed such costs, the Department did not deny the Hospital’s claim in 1974, nor did the Department ever assert that any teaching hospital claiming GME costs for the first

176. Br. for Pet’r, Feb. 1994, *supra* note 33, at 22.

177. *Thomas Jefferson Univ.*, 114 S. Ct. at 2388.

178. *Id.* (citing *I.N.S. v. Cardoza-Fonseca*, 480 U.S. 421, 446 n.30 (1987) (quoting *Watt v. Alaska*, 451 U.S. 259, 273 (1981))).

179. *Id.*

180. *Id.*

181. *Id.* (quoting *Intermediary Letter*, *supra* note 74, at 64a). Specifically, the letter was only trying to review “situations rais[ing] questions about the reasonableness of [medical school faculty] costs as allowable hospital costs and the appropriateness of the bases used in allocating them to the hospital.” *Id.* (quoting *Intermediary Letter*, *supra* note 74, at 64a).

182. *Id.* (footnote omitted).

183. Br. for Pet’r, Feb. 1994, *supra* note 33, at 21.

184. *Id.* at 21-22 (quoting 42 C.F.R. § 413.85(c) (1994)). The Hospital did not receive any GME reimbursement from 1966 to 1973. *Thomas Jefferson Univ.*, 114 S. Ct. at 2391 (Thomas, J., dissenting). Despite this fact, the Hospital was granted reimbursement for the first time in 1974. *Id.*

time, or simply claiming increased costs, was engaged in a prohibited "redistribution."¹⁸⁵

The Court admitted that the Secretary's current construction may have been inconsistent with previous applications of the regulation.¹⁸⁶ Nevertheless, the Court held that the Secretary's current interpretation was valid.¹⁸⁷ According to the Court, "[t]he Secretary is not estopped for changing a view she believes to have been grounded upon a mistaken legal interpretation," and "where the agency's interpretation . . . is at least as plausible as competing ones, there is little, if any, reason not to defer to its construction."¹⁸⁸

C. *The Secretary's Interpretation Creates Irrational Disparities Among Similarly Situated Providers*

The United States Supreme Court, by rigidly complying with administrative law principles, failed to consider the logical ramifications of the Secretary's construction. The interpretation offered by the Secretary creates disparities among similarly situated Providers.¹⁸⁹ For instance, suppose, as the Hospital argued, Providers A, B, and C all had affiliated medical schools incurring \$1 million in GME expenses in Year X.¹⁹⁰ Prior to year X, Provider A had correctly claimed all of the GME-related expenses paid by its affiliated medical school; Provider B had claimed only fifty percent of the medical school's expenses; and Provider C had claimed none of the medical school's expenses.¹⁹¹ According to the Sec-

185. Br. for Pet'r, Feb. 1994, *supra* note 33, at 21 (quoting 42 C.F.R. § 413.85(c) (1994)). The costs recovered by the Hospital in 1974 were historically borne to a large extent by the Medical School. *Thomas Jefferson Univ.*, 114 S. Ct. at 2391 (Thomas, J., dissenting); see also *Thomas Jefferson Univ. v. Aetna Life Ins. Co.*, [Oct.-Sept. 1989-90 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 38,353 (Jan. 18, 1990), *aff'd*, [March-Sept. 1992 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 40,294 (E.D. Pa. May 1, 1992), *aff'd*, 993 F.2d 879 (3d Cir. 1993), *aff'd*, 114 S. Ct. 2381 (1994) (recognizing that tuition and educational grants to the Medical School funded the Hospital's pre-1974 GME activities). However, based upon the Secretary's current construction of the anti-redistribution regulation, the Hospital should not have received any financing because it had not received such reimbursements since the inception of the Medicare program. *Thomas Jefferson Univ.*, 114 S. Ct. at 2391 (Thomas, J., dissenting).

186. *Thomas Jefferson Univ.*, 114 S. Ct. at 2389.

187. *Id.*

188. *Id.* (quoting *Good Samaritan Hosp. v. Shalala*, 113 S. Ct. 2151, 2161 (1993)).

189. Brief for American Hospital Association and Association of American Medical Colleges as Amici Curiae in Support of Petitioner at 22, *Thomas Jefferson Univ. v. Shalala*, 114 S. Ct. 2381 (1994) (No. 93-120) [hereinafter Brief for AMA].

190. *Id.*

191. *Id.*

retary, "past practice would be binding."¹⁹² Provider A would be reimbursed \$1 million; Provider B would only recover \$500,000; and Provider C would receive nothing.¹⁹³ Thus, despite the fact that Provider C's patients received identical treatment as Provider A's patients, "[Provider] C would have to suffer in Year X and for all other years because in prior years it had waived its Medicare entitlement."¹⁹⁴

The interpretation offered by the Secretary creates enormous disadvantages among Providers offering the same benefits to the Medicare patients they serve.¹⁹⁵ It also produces an annual benefit for the federal government based on a Provider's waiver in an earlier year.¹⁹⁶ The Medicare statute does not support the creation of such irrational disparities.¹⁹⁷ According to the Medicare statute, "reasonable costs" are "the costs actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services."¹⁹⁸ Certainly, as suggested by the Hospital, the failure of Provider C to seek reimbursement for a GME-related expense in an earlier year does not render the cost "unnecessary in the efficient delivery of needed health services."¹⁹⁹ "If the cost is necessary in [Provider] A's 'efficient delivery of needed health services,' logically it must also be 'necessary' in [Provider] C's—whether or not [Provider] C waived its Medicare claim in prior years."²⁰⁰

Furthermore, based on the Secretary's construction, a Provider must forfeit its right to recover otherwise allowable costs simply because it failed to seek reimbursement in an earlier year.²⁰¹ This theory is irra-

192. *Id.*

193. *Id.*

194. *Id.*

195. *Id.*; *Thomas Jefferson Univ. v. Shalala*, 114 S. Ct. 2381, 2395 (Thomas, J., dissenting) (1994). As articulated by Justice Thomas, the Secretary's construction "arbitrarily subjects similarly situated Medicare [P]roviders, with identical levels of [GME reimbursement], to disparate reimbursement, simply because one [P]rovider may have foregone reimbursement to which it was plainly entitled." *Id.* It is arbitrary on the part of the Secretary to deny reimbursement to a hospital for an expense for which it was lawfully entitled reimbursement simply because the hospital's accounting procedures failed to recognize all of the costs for which it could be reimbursed. *Id.*

196. Brief for AMA, *supra* note 189, at 22.

197. *Id.*

198. *Id.* (quoting 42 U.S.C. § 1395x(v)(1)(A) (1988)).

199. *Id.* (quoting 42 U.S.C. § 1395x(v)(1)(A) (1988)).

200. *Id.* at 22-23 (quoting 42 U.S.C. § 1395x(v)(1)(A) (1988)).

201. According to the Secretary's Brief, the issue presented in *Thomas Jefferson University* is: "Whether the Secretary reasonably determined that 42 C.F.R. 413.85(c) bars a hospital providing Medicare services from obtaining reimbursement of *otherwise reimburs-*

tional because it conditions the federal funding of GME on the past practices of a Provider. This would be akin to the Internal Revenue Service denying "a deduction for interest on a home mortgage because a taxpayer failed to claim the deduction in prior years."²⁰² Consequently, rather than rectifying the Hospital's earlier failure to seek recovery for its allowable costs, the Secretary has exacerbated the problem by allowing inequitable levels of reimbursements among Providers furnishing the same degree of benefits to the patients that they serve.

D. Justice Thomas' Dissent: Examine the Context in which the Regulation Appears

Justice Thomas turned to the Medicare regulations as a whole to support his conclusion that all costs incurred with respect to traditional educational activities are properly reimbursable under the Medicare program.²⁰³ In the dissent's view, the proper construction of the anti-redistribution principle could only be determined by analyzing the entire

able GME program costs that previously were absorbed by its affiliated medical school." Br. for Resp't, Oct. 1993, *supra* note 24, at I (emphasis added). It cannot be disputed that the activities for which the Hospital sought reimbursement were otherwise reimbursable expenses. See *Thomas Jefferson Univ. v. Shalala*, 114 S. Ct. 2381, 2395 (1994) (Thomas, J., dissenting) (stating that the activities for which the Hospital sought reimbursement were the type customarily carried on by teaching hospitals); see also *Ohio State Univ. v. Sullivan*, 777 F. Supp. 582, 587 (S.D. Ohio 1991), *aff'd*, 996 F.2d 122 (6th Cir. 1993), *cert. granted*, 114 S. Ct. 2731 (1994), and *vacated*, 114 S. Ct. 2731 (1994) (providing that customary GME-related expenses include salaries of physicians, salaries of clerical and administrative staffs, and the cost of office space and supplies); *Medical Education Passthrough*, *supra* note 2, at 4 (stating that Medicare has traditionally reimbursed Providers for the salaries of residents, faculty, and support personnel, and the cost of classroom space, equipment, and supplies). Nevertheless, the Secretary denied the Hospital's claim. *Thomas Jefferson Univ.*, 114 S. Ct. at 2383.

202. Brief for AMA, *supra* note 189, at 25-26; *GME: Court Upholds HHS Interpretation*, *supra* note 23, at 895. Furthermore:

If past practice is the criterion, it logically follows that a hospital which has mistakenly received GME reimbursement for unallowable costs in the past should continue to be reimbursed for those costs. The Secretary would undoubtedly object to making such payments, and she would, of course, be right. But it makes no more sense to deny allowable costs because a hospital waived its lawful entitlement in prior years than to reimburse unallowable costs because a hospital was mistakenly reimbursed in prior years. Mistakes should be corrected, not perpetuated.

Brief for AMA, *supra* note 189, at 26.

203. *Thomas Jefferson Univ. v. Shalala*, 114 S. Ct. 2381, 2395 (Thomas, J., dissenting) (1994). The dissent also pointed to the fact that section 413.85(c) speaks in vague aspirational terms, *id.* at 2390, such as the "intent of the Medicare program," 42 C.F.R. § 413.85(c) (1994) (emphasis added). Thus, according to the dissent, the "Secretary [should not be able] to transform . . . what self-evidently are mere generalized expressions

regulation together with the related-organization principle.²⁰⁴ Consequently, the dissent concluded that “[section] 413.85(c)’s anti-redistribution principle simultaneously expresses an intent to fund educational activities customarily conducted by teaching hospitals and disallows reimbursement for costs incurred by their affiliated educational units in conducting educational programs not customarily or traditionally engaged in by such hospitals.”²⁰⁵

1. *The Failure to Consider the Related-Organization Principle Distorts Section 413.85(c)’s True Meaning*

Under the related-organization regulation, a Provider will be reimbursed for the “costs applicable to services, facilities, and supplies furnished to the [P]rovider by organizations related to the [P]rovider by common ownership or control.”²⁰⁶ Furthermore, items obtained by a Provider from an organization that “is owned or controlled by the owner(s) of the [P]rovider, [are treated as if] . . . the items are obtained from [the Provider] itself.”²⁰⁷ Together, these two provisions stand for the proposition that “transactions between [teaching hospitals and their affiliated medical schools] . . . are not arm’s length transactions, but rather transfers between entities which are essentially alter egos.”²⁰⁸

of intent into substantive rules of reimbursability.” *Thomas Jefferson Univ.*, 114 S. Ct. at 2390 (Thomas, J., dissenting) (citation omitted).

204. *Thomas Jefferson Univ.*, 114 S. Ct. at 2394 (Thomas, J., dissenting).

205. *Id.* Thus, because the activities for which the Hospital sought reimbursement were clearly customary educational activities, the dissent would have held that the anti-redistribution regulation provides no basis for denying the Hospital’s requested reimbursement. *Id.* at 2395.

206. 42 C.F.R. § 413.17(a) (1994). Specifically, section 413.17(a) provides that:
 Except as provided in paragraph (d) of this section, *costs applicable to services, facilities, and supplies furnished to the [P]rovider by organizations related to the [P]rovider by common ownership or control are includable in the allowable cost of the [P]rovider at the cost to the related organization.* However, such costs must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.

42 C.F.R. § 413.17(a) (emphasis added).

207. 42 C.F.R. § 413.17(c)(2) (1994). Specifically, section 413.17(c)(2) provides that:
 If the [P]rovider obtains items of services, facilities, or supplies from an organization, even though it is a separate legal entity, and the organization is owned or controlled by the owner(s) of the [P]rovider, *in effect the items are obtained from itself Therefore, reimbursable cost should include the costs for these items at the cost to the supplying organization.*

42 C.F.R. § 413.17(c)(2) (emphasis added).

208. Reply Brief for Petitioner at 15, *Thomas Jefferson Univ. v. Shalala*, 114 S. Ct. 2381 (1994) (No. 93-120) (citing 42 C.F.R. § 413.17(c)(2) (1994)).

As alter egos, it would be illogical, as the Secretary's construction would have it,²⁰⁹ to construe the shifting of costs from an affiliated medical school to a teaching hospital as a prohibited redistribution.²¹⁰ There can be no shifting of costs when, in reality, only one organization exists.²¹¹ Consequently, the Secretary erred in analyzing the term "'redistribution' wholly divorced from the context in which it appears."²¹² By rigidly defining the anti-redistribution regulation, the Secretary failed to consider the plain meaning of the related-organization principle. This failure exemplifies the shortcomings of the Secretary's construction: rather than adopting an interpretation that takes into account the entire Medicare scheme, the Secretary's narrow interpretation is a distortion of the anti-redistribution regulation's true meaning.²¹³

IV. CONCLUSION

The importance of GME in enhancing the quality of patient care has been recognized since the beginning of the Medicare program. Despite this fact, the Court, in *Thomas Jefferson University*, deferred to the Secretary's interpretation of the anti-redistribution regulation and restricted a Provider's ability to receive reimbursement for any cost previously paid

209. The Secretary asserts that section 413.85(c) is more specific than the related-organization principle, and therefore, should control. *Thomas Jefferson Univ. v. Shalala*, [March-Sept. 1992 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 40,294, at 30,966 (E.D. Pa. May 1, 1992), *aff'd*, 993 F.2d 879 (3d Cir. 1993), *aff'd*, 114 S. Ct. 2381 (1994). However, given section 413.85(c)'s precatory language, this can be disputed. See *Thomas Jefferson Univ.*, 114 S. Ct. at 2395 (Thomas, J., dissenting); *supra* note 203. While the anti-redistribution regulation speaks in terms of the Medicare program's "intent", 42 C.F.R. § 413.85(c), the related-organization principle expressly states that "costs applicable to services . . . furnished to the [P]rovider by [related] organizations . . . are includable in the allowable cost of the [P]rovider," 42 C.F.R. § 413.17(a) (1994) (emphasis added).

210. Reply Brief for Petitioner, *supra* note 208, at 15.

211. See Brief of Amici Curiae States of Ohio, Arkansas, Delaware, Louisiana, Minnesota, New Hampshire, New York, Pennsylvania, Utah and Virginia in Support of Petitioner at 20, *Thomas Jefferson Univ. v. Shalala*, 114 S. Ct. 2381 (1994) (No. 93-120).

212. *Thomas Jefferson Univ.*, 114 S. Ct. at 2394 (Thomas, J., dissenting) (quoting 42 C.F.R. § 413.85(c) (1994)). According to the majority, the anti-redistribution regulation can be broken down into two clauses with the second clause "impos[ing] the relevant restriction on cost redistribution." *Id.* at 2387. However, as the Hospital argued and the dissent concurred, the proper interpretation of section 413.85(c) can only be derived by reading the entire regulatory framework together with the related-organization principle. *Id.* at 2394.

213. *Id.* at 2394 (Thomas, J., dissenting). According to the dissent, the Secretary's construction of the anti-redistribution regulation "is premised on a distortion of the text of the regulation enunciating [it], . . . and it is the text . . . which must be given controlling effect." *Id.* (citation omitted).

for by its affiliated medical school. While an isolated reading of the words of the anti-redistribution regulation may lend support to the Secretary's interpretation, a careful analysis of the Medicare regulations as a whole proves that her construction is a distortion. In citing to administrative law principles, the Court failed to recognize the impracticalities of the Secretary's interpretation. Instead, the Court has adhered to a definition that creates enormous disadvantages among Providers offering the same degree of benefit to the Medicare patients they serve.

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