OFFICIAL TRANSCRIPT

PROCEEDINGS BEFORE

THE SUPREME COURT

OF THE

UNITED STATES

CAPTION: THOMAS JEFFERSON UNIVERSITY, dba THOMAS JEFFERSON UNIVERSITY HOSPITAL Petitioner v. DONNA E. SHALALA, SECRETARY OF HEALTH & HUMAN SERVICES

CASE NO: 93-120

PLACE: Washington, D.C.

DATE: Monday, April 18, 1994

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IN THE SUPREME COURT OF THE UNITED STATES

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THOMAS JEFFERSON UNIVERSITY, :
dba THOMAS JEFFERSON :
UNIVERSITY HOSPITAL :
Petitioner :
v. : No. 93-120
DONNA E. SHALALA, SECRETARY :
OF HEALTH & HUMAN SERVICES :

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Washington, D.C.

Monday, April 18, 1994

The above-entitled matter came on for oral argument before the Supreme Court of the United States at 10:03 a.m.

APPEARANCES:

RONALD N. SUTTER, ESQ., Washington, D.C.; on behalf of the Petitioner.

AMY L. WAX, ESQ., Assistant to the Solicitor General, Department of Justice, Washington, D.C.; on behalf of the Respondent.

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P R O C E E D I N G S

(10:03 a.m.)

CHIEF JUSTICE REHNQUIST: We'll hear argument first this morning in Number 93-120, Thomas Jefferson University v. Donna E. Shalala. Mr. Sutter.

ORAL ARGUMENT OF RONALD N. SUTTER

ON BEHALF OF THE PETITIONER

MR. SUTTER: Thank you, Mr. Chief Justice, and may it please the Court:

At issue is whether certain costs incurred by petitioner -- by petitioner's related medical school in support of petitioner's graduate medical education program are allowable under Medicare.

There's no question that these costs, which are clerical and support costs in support of the program, would normally be allowable costs. The Government has conceded that. The question is, are they unallowable because the hospital did not claim these costs in prior years.

It is important to understand the implications of the Government's position.

QUESTION: Before you go any further, may I ask why you say that there is no doubt that they would normally be allowable costs?

MR. SUTTER: Because the --

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QUESTION: What -- perhaps under the regulation, as you interpret it, but what provision of the statute allows these costs to be charged -- to be reimbursed?

MR. SUTTER: The statute requires the reimbursement of reasonable cost --

QUESTION: Right.

MR. SUTTER: -- and it requires -- this will be found in the Ohio State amicus brief at pages 1 and 2. It requires the reimbursement of direct and indirect costs.

QUESTION: Costs of services provided to the patients, isn't that right?

MR. SUTTER: Costs that are necessary in the efficient delivery of needed health services. That would be the opening -- opening phrase, the first three or four lines of the provision.

QUESTION: Section 1395x(v) defines inpatient hospital services to include services -- services provided in a hospital by an intern or a resident in training.

MR. SUTTER: Right.

QUESTION: Or by a physician where the hospital has a teaching program approved as specified.

MR. SUTTER: Right.

QUESTION: But what you are trying to charge here, as I understand it, unless I mistake the case, are not services provided, but rather the costs of training

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these people.

MR. SUTTER: Well, it is the cost of services, too, Justice Scalia, because interns and residents are actually providing care in the hospital, and what we are talking about is the stipends that are paid to them, the compensation paid to the teaching physicians, and the related support costs, and --

QUESTION: Well, are they providing care -- I thought what you were talking about is, you know, we've all of us been sick in a hospital and the doctor comes in and he has three young doctors with him, you know, and they are all saying, oh, wow, ooh, and aah, but they are not providing any services. They are just learning from what the other doctor does. I thought that's what we're talking about here.

MR. SUTTER: Sometimes they provide services.

QUESTION: Well, sometimes, but in order to recover under the statute, you must provide services, as I see it.

MR. SUTTER: A lot of times they are providing services. They do come in and examine patients, and it's true they observe, but they're also providing services.

QUESTION: Whenever they are, it seems to me you're entitled to it under the statute.

QUESTION: Do you claim that you are entitled to

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it when they're not providing services, when they're just standing around looking?

MR. SUTTER: We claim that they are entitled to reimbursement for all the reasonable costs in connection with the training.

QUESTION: Well, that doesn't answer my question. I asked you if you claimed under a particular situation.

MR. SUTTER: Oh, sure. Yes.

QUESTION: So you do claim that they're -- you're entitled to recover for costs expended on them, even when they're not providing service?

MR. SUTTER: When they're learning?

QUESTION: Yes.

MR. SUTTER: Yes. But the entire program's a clinical program.

QUESTION: Well, I understand --

MR. SUTTER: This is not a classroom instruction.

QUESTION: Your basis for that, as I understand it, is a committee report which the Secretary has chosen to follow in his regulation.

Now, I have no problem with the Secretary's following a committee report in the regulation to be overly generous to hospitals, if he wishes, and nobody has

standing to challenge that, if he gives the hospital more money than they're entitled to, but you're coming in and saying that he must do it in the face of the statute, it seems to me.

MR. SUTTER: No, I don't think that's correct. The statute says --

QUESTION: Mr. Sutter, is your position essentially that the Secretary has interpreted a regulation one way and arbitrarily not applying that same way to you? I thought that was essentially your position.

MR. SUTTER: Certainly.

QUESTION: That because you're making this claim late, you're being treated differently?

MR. SUTTER: Certainly, yes.

QUESTION: And that your opening point was to the extent that these particular costs, as being properly reimbursable if you had made your claim on time --

MR. SUTTER: These --

QUESTION: -- are not contested by the Secretary?

MR. SUTTER: That is correct, Justice Ginsburg. These --

QUESTION: May I ask you a question about the continuing significance of this?

MR. SUTTER: Certainly.

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QUESTION: As I understand it, after 1986, this is no longer a problem because the system is different, is that so?

MR. SUTTER: That is correct. This was still under the reasonable cost system, and effective for years. Beginning on or after July 1, 1985, there is a new system in effect.

QUESTION: So the impact of the issue before us is for how many years?

MR. SUTTER: Well, it will have a carryover impact because this is the base year, and under the new system you look at the cost per resident trended forward, so the monetary impact for this year itself, for '85, would be roughly $600,000 to $700,000, but it would also have some carryover effect.

QUESTION: Is there a point where it will make no difference? That is, I'm trying to understand what time span we're dealing with, and I --

MR. SUTTER: Specifically we're dealing with 1985. That is the year under appeal.

QUESTION: But how long will this matter that you're complaining about have an impact on hospitals situated as you are?

MR. SUTTER: It could have an indefinite impact, until Congress changes the current law, which still looks

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back at a base year and trends it forward.

QUESTION: When you say it has a carryover effect, I take it what you mean is that if it's allowed for the base year, you go on charging the same amount every successive year adjusted for inflation so long as you do not pull back on the service?

MR. SUTTER: Well, actually, it's -- you get a base year amount per resident, and then you would multiply that by your current number of residents, so if the number of residents declines --

QUESTION: So it gives you a rate, in effect.

MR. SUTTER: It gives -- it's a rate.

QUESTION: Yes, okay.

MR. SUTTER: It's a rate per resident, that's correct.

To follow up, though, under the regulation, these are regarded as indirect costs under paragraph (g), and the Secretary has conceded in her petition, her cert petition, that these would normally be allowable costs.

QUESTION: Well, I don't know that we have authority to compel the Secretary to be consistent. I mean, consistency in a regulation is admirable, and legally necessary, but I'm not sure it's legally necessarily where to make him be consistent would make him contravene the words of the statute.

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MR. SUTTER: I don't think it contravenes the words of the statute. It says, in the efficient delivery of needed health services, and I don't think you're going to have good health services if you don't train your interns and residents.

QUESTION: It explicitly defines services to include the services provided by trainees, but not to include the training of the trainees. Now, if --

MR. SUTTER: But it does --

QUESTION: If the Secretary wants to be more generous in some instances to avoid controversy with a committee, that's fine.

MR. SUTTER: Well, Justice Scalia, Congress has never expressed any dissatisfaction with the inclusion of these costs. When the Secretary attempted to limit increases on them in 1985, the Congress did enact legislation to preclude that, which is 42 U.S.C. section 1395x(v)(1)(A).

QUESTION: Didn't you get in 1 year --

MR. SUTTER: I'm sorry, not --

QUESTION: You charged --

MR. SUTTER: Excuse me -- (Q). (Q).

QUESTION: You charged some indirect costs. The year before you had -- you went over all of your costs to see what you could allocate. You had -- didn't you have

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an adjustment for some indirect costs in '84, was it?

MR. SUTTER: The chronology is that in '74 for the first time the hospital began claiming the costs of the related medical school and claimed costs for physician compensation.

In '84, it began to claim some of the clerical costs, and then '85 claimed the remainder.

QUESTION: But you were allowed -- you were allowed the addition that you sought in '84.

MR. SUTTER: That is correct.

QUESTION: But in '85 you weren't.

MR. SUTTER: That is correct, Justice Ginsburg. That is correct, yes, but we really do have the situation here where, to give you a hypothetical of how it would operate, say in years 1 through 5, if a hospital had, say, claimed the physician compensation for a particular teacher in the GME program but that would have been allowed, but say in year 6 it failed to claim it, under the Secretary's position you would have the situation where for year 7 and thereafter, the Secretary would -- or the hospital would forever lose out.

And I think that's very hard to justify with the statute, which talks about reimbursing actual cost, excluding therefore only that part found to be unnecessary in the efficient delivery of needed health services, and

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if something is necessary in years 1 through 5, it should be necessary in year 7.

QUESTION: Well, do you say, Mr. Sutter, that you could prevail simply under the statute without regard to the regulation?

MR. SUTTER: We say both, but we do say --

QUESTION: Well, I --

MR. SUTTER: Yes. The answer to the question is yes, Mr. Chief Justice, we do say --

QUESTION: Does that mean that the Secretary could not, under a properly drawn regulation, deny these costs?

MR. SUTTER: That would be our contention, that they are part of the necessary delivery of needed health services, that's correct, and they have been from the beginning. They have been allowed from the beginning, and there are many university hospitals that for many years have been reimbursed for these costs, and most teaching hospitals do not have -- are not university hospitals, do not have related medical schools.

They incur these costs directly, and what we really have here is a distinction that is not based on medical necessity and is not based on benefit to the patient, and there is tremendous benefit to the patient in being in a teaching institution.

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If you have a serious medical condition, certainly I would want to go to a teaching facility. That is where the best care is given, and I think the training of these interns and residents is essential for continuing to have high quality care in the country.

Now, if I could look specifically at the regulations, the Secretary's position here conflict with both the medical education regulation itself and with the related organization regulation. The medical education regulation is quoted in relevant part at pages 9 through 11 of the AHA amicus brief. The Government has --

QUESTION: Is it quoted in your brief?

MR. SUTTER: Well, that is my brief.

QUESTION: Oh, I'm --

MR. SUTTER: The AHA AAMC amicus brief.

The Secretary has focused exclusively on paragraph (c), but it is very important to read the regulation in context. There are specific provisions, mandatory provisions in there, paragraphs (a), (b), and (g), and (a) says that providers are entitled to reimbursement of net costs as calculated in (g), and (g) describes the costs which are included and the revenues which must be offset.

In contrast, paragraph (c) is phrased in very general, descriptive, precatory language. It would seem

very strange as a general proposition to construe that language as imposing broad, draconian disallowances. It would seem particularly strange when (a) says that you -- you reimburse under (g), not (c), and (g) does not include a cross-reference to (c).

But let's look at (c). The Secretary has construed that as establishing two principles, the so-called redistribution principle and the so-called community support principle. The redistribution is based on the last sentence, and the community support on the prior sentence.

Let me begin with the redistribution. The last sentence refers to a redistribution of costs, but it does not define that term, and the Secretary has simply assumed that there has been a redistribution of costs here, but there has not. There has been a first-time claim, but the costs were not distributed in 1985 any differently than they were previously.

QUESTION: Well, were they being billed to the hospital by the school?

MR. SUTTER: No, they weren't, but that's not necessary under the related organization regulation. These --

QUESTION: Well, if it's -- if -- but -- it may not be necessary, but isn't it relevant, because if we

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don't look to the billing practice, then I'm not sure how the redistribution provision is ever going to be applied in any consistent fashion when related organizations are involved, because your argument in effect would be, because it's a related organization, it doesn't have to bill, and therefore nothing in effect is ever redistributed because we just looked to the total entity.

MR. SUTTER: That's not my argument. My argument is that you have a redistribution where you have a situation where a hospital begins billing for costs which in the past were incurred by an educational institution for that institution's own educational program. In other words, it begins billing for costs which in the past it could not have billed for.

QUESTION: So you say they can't bill for first-year medical education, for example. That would be a redistribution.

MR. SUTTER: Absolutely.

QUESTION: It would also be clearly forbidden by the statute.

Among the possible subjects of billing from the school to the hospital, as a practical matter, will there be any application of the redistribution limitation?

MR. SUTTER: There could be.

QUESTION: Can you give me an example?

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MR. SUTTER: Sure. If -- say there's a related medical school, and the -- and the -- sorry, not related medical school, a related nursing school, and the nursing school has for many years provided classroom instruction. It is part of the nursing school's program. They are not providing it as part of the hospital's program, and suddenly they decide ah, well, let's see if we can get the hospital to claim these costs. You couldn't do it, because that would be a redistribution.

QUESTION: Why? Isn't that a related institution, too?

MR. SUTTER: No, because the nursing school was not providing those services in the past as part of the hospital's educational program. See, in this case, this is the hospital's educational program. It has always been the hospital's educational program.

The related medical school has provided services in the past and in '85, but if you look at the related organization principle, it says the related organization is essentially the alter ego of the hospital.

You will find that in paragraph (c)(2), and the regulation is quoted on 6 through 8 of the Ohio State amicus brief appendix.

So essentially what you have here is you have the hospital -- these really would always be the

hospital's services. They were incurred by the medical school, but under the related organization they would always be regarded as the hospital services.

QUESTION: All right, as between simply the hospital and the medical school, those two related entities, assuming that we again are talking about a charge which is at least indirectly related to education, can there ever be a redistribution and hence an application of this limit?

MR. SUTTER: I think only if you had some activity that the medical school was conducting in the past that was its own program. I don't -- I would have a --

QUESTION: But if it was strictly -- I guess my problem I'm having is, if it were its own program in the sense that I think you're using that term, then it would not in fact be related to the teaching function of the hospital, so once we get within the sphere of what is related directly or indirectly to the hospital's teaching function, I think the implication of what you're saying is that the redistribution provision will never apply when we're doing cost accounting within a series of related entities.

MR. SUTTER: That's right if --

QUESTION: Okay.

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MR. SUTTER: -- if it is the program, and I think there are two policy issuances that are essentially on point there.

QUESTION: Well then in effect aren't you reading the redistribution sentence out of the regulation?

MR. SUTTER: I --

QUESTION: Because you're saying if it's covered by the statute and if you could claim it, you can claim it later.

MR. SUTTER: I'm not reading it out. I am reading it exactly as it is read in Provider Reimbursement Manual 404.2, which is at the Joint Appendix at pages 56 through 58, and as it is read in intermediary letter --

QUESTION: It would be so helpful if you would give an example --

MR. SUTTER: I will give you an example.

QUESTION: -- of something that fits within the statute as a legitimate cost, but couldn't be redistributed.

MR. SUTTER: Well, legitimate costs is nursing education. That's a legitimate cost. Other costs are in paragraph (e), and if you look at -- that's not quoted in my brief, but it is quoted in the Joint Appendix at pages 34 through 38. That is the original regulation, but in paragraph (e) there is a list of about 13 different

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activities.

All of those could be examples of something that's provided by a related organization as part of their own program which would be reimbursable under Medicare -- well, it wouldn't be reimbursable under Medicare if it wasn't provided by a provider, so if you had it in some other part, some other part of, say, the university, and suddenly you try to shift that and make it a provider program, you couldn't do it. Any of those examples --

QUESTION: Yes, but the illegitimate shift that you posit is illegitimate because it really is not related indirectly to the provision of medical education by the hospital.

I mean, the reason -- if I understand it, the reason the attempt to shift the nursing cost fails is that the nursing cost has nothing to do -- that the cost of providing instruction in the nursing school is not indirectly related to the provision of the medical education which is subject to reimbursement under Medicare.

MR. SUTTER: That's not correct.

QUESTION: Then I don't understand the hypo, I guess.

MR. SUTTER: Nursing education is reimbursable under Medicare if it's provided by the provider, but you

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have situations, Justice Souter --

QUESTION: No, but in this case it's provided by a related entity, and it seems to me it's in the same boat as whatever education is provided by the medical school.

MR. SUTTER: Well, it depends who is the legal operator. If you have a separate nursing school --

QUESTION: But I thought you were telling us that if the entities are related, that distinction is one which does not matter.

MR. SUTTER: Under the related organization, the governing principle is (a), and that is, you have services furnished by the related organization for the provider on behalf of the provider. They are reimbursable to the provider. If your related organization is furnishing services on behalf of itself, that would not be reimbursable to the provider.

So if you had a separate nursing school --

QUESTION: Okay. Okay, I see what you --

MR. SUTTER: -- and it was a related organization's nursing school you couldn't shift that back.

You see, the example -- you do have --

QUESTION: In fact, you could only, as it were, as a matter of accounting you could only shift that to the medical school, and shifting it to the medical school

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doesn't get it to the provider, which is the hospital. Is that your argument?

MR. SUTTER: That's correct.

QUESTION: Yes, okay.

MR. SUTTER: Yes. Yes. We have a situation here where in '85 we are claiming costs that could have been claimed before and that weren't. We're not -- we don't have a situation where we're trying to claim in '85 costs that were not the hospital's before, weren't part of the hospital's program, and there you couldn't claim it, and I think there's a very good example in PRM section 404.2, which is on page 57 of the Joint Appendix, and there the concern is with redistribution when you're talking about a nonprovider-operated program, and you're talking about something like classroom instruction, and elsewhere they don't have a redistribution condition.

Also, specifically with --

QUESTION: May I ask you --

MR. SUTTER: Certainly.

QUESTION: Are you saying that the words "redistribution of costs" in the last sentence of the regulation really should be read to mean "redistribution of services or activities"? That's what you seem to be saying, if I understand you correctly.

MR. SUTTER: No. I think you need to trace

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before, before you get to the year, say in '85 here, and see, under Medicare, whose costs those properly would be viewed as.

The related organization principle would apply here not only to '85 but before. These costs were incurred by the medical school in '85 and before '85, but they would always be viewed as the provider's costs. That would be the rule under 413.17(a) and (c)(2). They would always be regarded as a provider's costs.

So I think you need to look at, under Medicare, whose costs would these be, and do you have a different situation in '85 than you had in '75?

QUESTION: But if I understand you correctly, your example of something that would fit within the regulation would have involved a reorganization of the provision of services and the activities. Am I wrong in that? Would the case -- would the regulation ever apply to a hospital which acted in precisely the same way over the years?

MR. SUTTER: Not as long as those are for costs that would consider to be customarily or traditionally carried on by the hospital, and on this point, intermediary letter 78-7 specifically applies to the related organization principle in the context of medical school and the hospital and says they are allowable under

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the related organization principle.

QUESTION: Mr. Sutter, if you could answer -- I don't want to take -- you have very little time left, but you raised section -- do I understand the effect of subsection (2), which is a definition of physicians' services, is to exclude for the future services provided by physicians who are employed in the educational institution, even if they are direct services provided to the patient?

MR. SUTTER: When you say subsection (2), I'm not sure --

QUESTION: (Q).

MR. SUTTER: Oh, (Q). 1395x --

QUESTION: That defines physicians' services and --

MR. SUTTER: No, no, 1395x(v)(1)(Q).

QUESTION: (v)(1)(Q).

MR. SUTTER: V as in very, (v)(1)(Q), and what that did is, it precluded the Secretary from doing anything that would reduce Medicare reimbursement for graduate medical education.

QUESTION: I had the wrong section. Thank you.

MR. SUTTER: Mr. Chief Justice, I will reserve my remaining time.

QUESTION: Very well, Mr. Sutter. Ms. Wax,

we'll hear from you.

ORAL ARGUMENT OF AMY L. WAX

ON BEHALF OF THE RESPONDENT

MS. WAX: Mr. Chief Justice and may it please the Court:

Although petitioner tries hard to complicate this case, at bottom its resolution requires answering two straightforward questions. The first is whether the Secretary's reimbursement rule for education costs as embodied in this regulation at issue is a legitimate exercise of the Secretary's authority to determine reasonable costs of medical care to patients that will be paid by the Medicare program.

The second issue is whether the Secretary's rule is an unreasonable construction of the terms of the regulation itself under this Court's deference rules in Chevron and Udall v. Tallman.

The United States submits that both of these questions must be resolved in favor of the Secretary. The Secretary's rule is a perfectly reasonable rule in light of the text and purpose of the Medicare Act.

QUESTION: May I ask you a couple of questions to be sure, because it does seem to get complicated.

Is he correct in telling us that if another institution were claiming precisely these same costs, and

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had claimed them for the last 10 years and been allowed in the past, that it would be allowed these costs?

MS. WAX: It would depend on whether that institution was an affiliated institution.

QUESTION: Say it's exactly like this in all -- it's exactly like this institution in all respects, except that it had always claimed the same costs.

MS. WAX: Oh, I see what you're saying. You're giving me a hypothetical --

QUESTION: Yes.

MS. WAX: -- of a different institution. Yes. The rule is that if -- when a cost is first incurred by an institution, if that institution comes to Medicare and says we don't have, obviously, an established source of funding since this is the first time that we've taken on these new responsibilities, we want you to help us pay for them, then yes, the community support and redistribution rule would allow Medicare to pay those costs.

If the institution didn't claim them, they found some other source of funding, then they lose that claim forever.

QUESTION: And if this institution had claimed these very costs 5 years earlier and done it each year, would it get them this year?

MS. WAX: Yes.

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The statute creates an insurance program to pay for medical services and medicare care provided directly to patients. Its purpose is not to promote and support medical education.

QUESTION: That's my problem. What provision do you rely upon to allow any of these educational costs to be given?

MS. WAX: We rely upon the definition, which is a very broad definition, of reasonable costs, or the phrase, reasonable costs of medical care to patients.

Now, the Secretary has made a judgment, and he could -- she could have made a different judgment.

QUESTION: That medical care includes medical education.

MS. WAX: That medical education --

QUESTION: Medical care to me includes medical education for somebody who never treats me?

MS. WAX: Well, let me put it this way. We have to distinguish between the services that interns and residents provide to patients, the actual care they give, okay.

Physicians' services are not reimbursed under Part A of Medicare, which is the subject of this case. They are reimbursed under Part B, and under Part B, there's no separate allocation for intern and resident

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services, but what there is is there's an allocation for the attending physician, the physician in charge.

Every time he sees the patient, every time he signs the chart, Medicare is charged. Folded within that charge is his supervisory tasks of the team of apprentices and assistants that help him. Those are Part B costs. So you're right, Justice Scalia, we are not charging Medicare -- Medicare is not being charged for the services that these trainees render.

This is something different. This is the enhanced quality of care in an institution that results from having an education or training program on the premises.

It's vague. It's a kind of secondary atmospheric effect.

QUESTION: It's like having an intern or a resident there during the night, when maybe simply a for-pay hospital wouldn't.

MS. WAX: Well, it's the effect of having a teaching program with the scholarly atmosphere, the extra scrutiny, the extra oversight. It's those sorts of benefits of having an education program on the premises, and not the direct services that the interns are providing, which is a Part B cost. That's how we conceptualize it.

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Now, the Secretary has made a judgment that it's a good thing overall to have a training program, although it's not essential. Petitioner is simply wrong that the presence of interns and residents is essential to the efficient delivery of medical care, because it isn't. 80 percent of hospitals have no interns and residents. They do a perfectly good job of taking care of patients.

QUESTION: But it seems to me, Ms. Wax, that Congress did advert to this airy benefit that you're referring to and didn't include it. I mean, it says -- it refers to interns or residents in training, but it refers to them only as inpatient hospital services.

MS. WAX: Right. Well, it is true that Congress did refer to them in the definitional section. The way Medicare actually works that is that we fold them into the Part B charges.

To the extent that that definition implies that there ought to be some sort of reimbursement for intern and resident costs as hospital services, which is a matter of classification, we do provide some, because the Secretary has a rule that under certain circumstances she will pay some share of the costs of maintaining these programs. Not under all circumstances.

If there's private support that's sufficient, and there's a track record of private support, the

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Secretary is not going to come in and supplant that support or compensate for its withdrawal, and the question in this case is, is that an abuse of the Secretary's discretion, or is that a reasonable, legitimate rule that accomplishes a number of legitimate purposes in supporting an educational program?

QUESTION: For how many years has that been the Secretary's interpretation -- it includes these training courses?

MS. WAX: Well, the regulation has been on the books since 1966, Your Honor.

QUESTION: And at what point did the regulation start to get interpreted the way it is now? That is, you can't be a Johnny-come-lately. If you didn't ask for it when you first began providing the training, you can't ask for it later.

MS. WAX: Well, Your Honor, it's difficult to answer that question for the following reason. When a hospital or provider incurs costs, it goes to the intermediary, which is an insurance carrier that contracts with the Secretary, and it submits a cost report. It makes a request for reimbursement, and the intermediary is the first entity that interprets and applies the Secretary's regulations.

Now, as long as the intermediary is allowing

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costs, and the provider is happy, we assume that the intermediary has been applying those regulations correctly since they were implemented, and the Secretary isn't going to know about any problems unless there's been a denial of costs and the provider appeals and is dissatisfied.

QUESTION: Is that what happened in 1984 in this case? Because it is an anomaly that they woke up to one cost in '84 and they were allowed reimbursement, and then in '85 when they wanted more, they weren't.

MS. WAX: Well, that seems to be what happened in '84. What happened in '84 is that the intermediary in this case was kind of caught off guard.

We're not saying there are never any mistakes made by intermediaries. We acknowledge that the intermediary made a mistake in 1984 in this case and we didn't catch it until this litigation came before the Administrator and allowed the costs.

QUESTION: Although the PRR, or whatever it is, thought that the Administrator was wrong in this case.

MS. WAX: Right. That's right, but then when it appealed to the Administrator, the Administrator said no, intermediary, you should not have allowed these costs, but it's too late, because the reopening period has lapsed, so we have to -- I mean, there is closure for some of these cost reports, and there was closure for the '84 cost

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report.

But the point is, Justice Ginsburg, that we're assuming that everything was cooking along from 1966 until '84, and that this regulation was pretty much being complied with by the medical schools and the intermediaries, and then all of a sudden in 1985, everything changed.

First of all, the prospective payment system was put in place, which put a very severe limit on the reimbursing available for ordinary medical services, and this created tremendous financial pressure on the hospitals and on the medical schools to find alternative sources of funding.

But medical education was still being reimbursed on a reasonable cost basis up through the base year in 1985, so there was -- and other sources of funding were drying up, costs were rising. Basically the costs and the sources of funding were on a collision course with each other, so medical schools started to bring in accounting firms to audit their books and try and ferret out new costs that could be shifted to Medicare under the rubric of education costs. Now, this is precisely what Congress didn't want to have happen.

QUESTION: Well, is the Johnny-come-lately rule an attempt, at least in part, to apply the redistribution

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rule?

MS. WAX: It is -- it is -- let me put it this way. The redistribution rule is a Johnny-come-lately rule, so to speak. It's a use-it-or-lose-it rule, but it specifically applies to related educational entities.

This regulation really has two parts. It has a broader community support principle which would apply not just to medical schools but actually to the provider itself.

QUESTION: Well, may I interrupt you with one question. With respect to related entities, why didn't you -- why isn't the only consistent position, or why wouldn't the only consistent position have been to apply the Johnny-come-lately rule in effect at year 1, and at day 1, and say that if, in your internal accounting as between these related entities, the school had not been billing the hospital, you may not start billing the hospital, i.e. with implications for Medicare, now.

Conversely, if you didn't take that position, why is there ever going to be a rational cutoff?

MS. WAX: Well, if you're asking me why that position wasn't taken initially for this medical school, that we didn't allow a shift in costs --

QUESTION: Well, I think I'm really asking why shouldn't it have been taken?

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If a Johnny-come-lately rule is appropriate, it seems to me it should have been appropriate at day 1, and if it was not appropriate, and in any case was not applied at day 1, what is the justification, short of a new act of Congress, for applying it later on?

MS. WAX: Well, first of all, it was applied from day 1 for the particular costs being claimed that are the subject of this case, okay -- it is.

QUESTION: Had the costs -- had the costs that you admit are allowable been the subject of some kind of billing or accounting notation, at least, as between the school and the hospital, prior to Medicare?

MS. WAX: Okay -- well, the costs that we say are allowable and that were found to be allowable were costs that provider had been claiming all along, even though they were incurred by the medical school.

QUESTION: But not all along. Wasn't -- isn't it true that it was -- they didn't start until late? They didn't start until '74.

MS. WAX: Okay, that --

QUESTION: They didn't start when Medicare first came in.

MS. WAX: That's a different issue, and there the question is, was what happened in 1974, was it consistent with this antiredistribution and community

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support principle? In other words, in 1973 --

QUESTION: Well, let's just stick to redistribution for a moment.

MS. WAX: Redistribution --

QUESTION: Why, if -- why wasn't it inconsistent with redistribution the first year they claimed it in '74?

MS. WAX: Because we don't know, because we don't have it in the record, what exactly the costs were that they were claiming in '74, and let me give you an example.

QUESTION: Well, let's assume they were all of the costs that were being claimed prior to '85. I mean, just assume that for the sake of argument. If those were the costs they were claiming, and they had not claimed them prior to '74, why didn't that constitute an attempted redistribution in '74?

MS. WAX: We don't know whether they claimed them prior to '74. I mean, we don't know whether they incurred them prior to '74. That's the answer.

QUESTION: If they incurred them prior to '74, and had not claimed them before '74, would it have been an attempted redistribution within the meaning of (c)?

MS. WAX: Yes, if they had been costs of the medical school. They might have been costs of the provider. We don't know what the allocation was between

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the medical school and the provider.

QUESTION: So your argument is that you can't tax the -- that the other side cannot tax the Government with inconsistency because at least so far as this record is concerned, neither it nor the Government knows what was happening before '74, and the only thing that you know for sure is what is happening as to 1985.

MS. WAX: That's essentially our answer, Your Honor. I mean, the fact is --

QUESTION: But why isn't your answer the same as the one you gave me with respect to '84, and that is, the initial -- what --

MS. WAX: Intermediary.

QUESTION: The intermediary let it through, so it never came to your attention.

MS. WAX: That could be the answer, too, for all we know.

I mean, we assume that -- we want to assume, and we do as a general matter assume that the intermediary has applied the regulation correctly, and we assume that the providers and the medical schools can read the regulation, too, but the fact is that whether this was a mistake, or whether it was a matter of new costs, you have to realize that the amount expended by an institution on programs doesn't stay constant from year to year.

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A tremendous expansion and upgrading of these programs was taking place from the mid-1960's all the way through the nineties. There was a huge burgeoning of new programs, new expenditures on old programs, and for all we know between '73 and '74, Thomas Jefferson could have doubled the number of residents, tripled the number of faculty, increased its resident salaries -- all of these things were happening at the time in schools all across the country.

QUESTION: May I ask another sort of elementary question, I suppose.

You talk about both the antidistribution principle and the community support principle, and I must confess to some difficulty knowing exactly what is and is not community support, but put that to one side.

Are these independent -- is each an independently sufficient reason for your prevailing, or do they rely on one another?

MS. WAX: They are each independently sufficient, Your Honor, so that this Court could agree with us, and we think they should, on our reading of the very explicit language of the redistribution clause.

QUESTION: You mean the last sentence of the regulation.

MS. WAX: Right, the last sentence of the

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regulation, which says --

QUESTION: The first part of the regulation isn't at all that clear, though.

MS. WAX: Well, no, we think that's clear as well, but the point about the redistribution provision is that it's a narrower provision that specifically applies to this case, and this circumstance of a medical school, an educational unit taking over costs.

The community support principle, although it tracks in every respect the effect of the redistribution clause, is a broader principle, and that in itself is also sufficient to get the result in this case, and they both have the same effect, which is that if there's a level of community support that's been established, established by the institution not going to Medicare and claiming costs, then Medicare will presume that there's community support.

It will not pay those costs in the future -- it's a one-way ratchet -- and of course it will not pay those costs even if there is a withdrawal of support, because that would be a redistribution to Medicare, and that is also forbidden by the plain terms of the regulation, and also, we think, contrary to Congress' intent as it is expressed in the AHA rules and in the legislative history.

QUESTION: The thing I find most hard to sort of

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sort out in my mind about this case is, I can envision half-a-dozen different institutions providing precisely the same services with precisely the same costs to do it, the same salaries and everything else. Some will get reimbursed, some will not, depending on what kind of community support they get, and what other accounting worked in the past. Those seem to be totally irrelevant to the fairness of treating all hospitals providing the same services alike.

MS. WAX: Well, they're not -- we don't think that they're arbitrary factors, or that they're irrelevant. The fact is that some institutions have an easier time getting private and public sources of support. I mean, it's easier for Harvard Medical School to get some rich and charitable person to pay their costs than it is for maybe Ohio State to -- that's just a fact of life, but --

QUESTION: Ms. Wax, maybe you would focus on the AHA brief on page 22, where they give specific examples of the kind of arbitrariness that Justice Stevens brought up to you.

That is, two hospitals identically situated, one has a better accountant and starts charging these costs from year 1, and the other one doesn't have such a good accountant and doesn't wake up till 10 years later, and

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that's the whole difference, not whether they belong to Harvard or to Cornell or whatever.

So if you would -- I would like to know your answer to what's set out in that -- page 22 of that brief, where the presentation is hospitals identically situated except one was sleeping and the other was alert.

MS. WAX: Right. Well, the fact is that one may have been sleeping, the other may have been alert, but the one that was sleeping was paying its costs somehow. The fact is, it was incurring those costs, it was employing interns and residents, it was employing faculty, faculty to educate those interns and residents.

Somebody was paying for it, and the assumption is that if we weren't paying for it, if Medicare wasn't paying for it, it was being paid for by some private, eleemosynary source, like grants.

QUESTION: Yes, but you can say that about every hospital and every charge prior to Medicare. Somebody was paying for it.

MS. WAX: Correct, Your Honor, but what we are saying -- we're not saying that we could have the same rule for blood transfusions or for antibiotic therapy. We're not saying that. We rely very heavily on the fact that these sorts of costs are at the margins of what the Medicare program is designed to accomplish.

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This is where the Secretary's discretion is at its greatest, deciding where that line is going to be drawn. We don't think that the Secretary has the same obligation to pay medical education costs that she might have to pay costs of something that lies at the core of medical care and medical services, of what we understand a medical insurance program to cover.

Private insurance doesn't cover medical education. Now, Blue --

QUESTION: You say that here she can draw a line and tell people, that's the way the cookie crumbles, in effect.

MS. WAX: For this kind of expense, yes, because of the kind of expense it is, for the very reasons that Justice Scalia pointed out at the beginning of the argument. These are the kinds of services which arguably enhance the quality of patient care, but there's also an argument on the other side that they don't.

I mean, the fact is anybody who has been in a university hospital as opposed to a private hospital knows that having interns or residents is a mixed bag.

QUESTION: But what gives the Secretary the authority to decide whether to include it in or out on the basis of her notion of, there should be community support, or there should be no declining in the amount of community

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support? I mean, where does she get this policy authority in a totally separate field?

MS. WAX: First of all, the Secretary --

QUESTION: What word in the statute is she interpreting by this regulation?

MS. WAX: Well, first of all she's interpreting the words of 1395x(v)(1)(A).

QUESTION: x(v)(1)(A).

MS. WAX: Right, page 61a of the pet app.

QUESTION: Of the what?

MS. WAX: Of the appendix to the petition. It's 42 U.S.C. section 1395x(v)(1)(A).

QUESTION: Yes. Yes, I have that.

MS. WAX: Right.

QUESTION: I have it.

MS. WAX: And there, the Secretary -- it says the reasonable costs of services shall be the costs incurred, and shall be determined in accordance with regulations establishing the method or methods to be used and the items to be included in determining such costs for various institutions and services.

Now, we read that as essentially -- and then there is another statute, 1395hh, which is not in the appendix, which says that the Secretary has authority to promulgate regulations to implement --

QUESTION: Okay.

MS. WAX: -- the authority under this section.

QUESTION: So it's cost of services, is the language essentially that she's interpreting.

MS. WAX: Right, and the --

QUESTION: And she says that it constitutes --

MS. WAX: What is a reasonable --

QUESTION: Right, and it constitutes a service which you have to pay for if it's been charged before, but if it hasn't been charged before, it doesn't cons -- how does that have anything to do with whether it -- it either is a service, or it isn't a service.

I mean, I can see a lot of factors that give her discretion to decide whether it's a service or not, but whether it's been provided before or not, you know, charged a certain way before? That seems to me totally irrelevant.

MS. WAX: Well, it's not irrelevant to whether it's reasonable to pay it, for the following reason. The Secretary is trying to -- essentially to reconcile a number of competing goals, and one of the goals is the goals expressed in the legislative report, for better or worse, to promote, to encourage the community to pay these education costs, okay.

QUESTION: Can we skip the community, because

you told Justice Stevens that the redistribution clause in and of itself would do it, so I'd like to hear your rationale for this, forgetting about the community. You said that sentence of your regulation alone is independently sufficient to reach the result that you agree with.

MS. WAX: With all due respect, Justice Ginsburg, we can't forget about the community, because the point of the redistribution clause is that the medical school and its donors is part of the community. That's what makes sense of the redistribution clause and the community support.

It's -- the redistribution clause implements the community support idea, which is --

QUESTION: But the community support constitutes everything except Medicare, is that right? All sources that pay for this service, other than Medicare, is community.

MS. WAX: That's not entirely correct.

QUESTION: What else is left out?

MS. WAX: Well, hospital fees, the amounts that patients pay out of pocket to the institution, the Secretary has taken the position, or at least currently takes the position that that would not be community support, so you could rebut the presumption of community

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support. You could rebut it.

The presumption is raised by not charging Medicare, but the provider, the hospital could rebut the presumption by showing either that it ran a deficit hat was tied to their program, or that the money was not coming from the usual State and charitable sources, but out of the pocket of patients, which we think probably Congress did not consider community support, but apart from that, any other source would be community support.

So to get back to Justice Scalia's point, there is a rational policy behind this one-way ratchet, this rule, which is, the Secretary on the one hand wants to promote and not discourage community support, and she certainly doesn't want to come in and supplant and displace any community support that's already in place, which is what happened if she came in and paid when community support diminished.

QUESTION: The statutory language that you called our attention to talks about costs for various types or classes of institutions, agencies, and services, which conveys to me a message that there are groups of institutions that should be treated like, and you read that as sort of saying we can do it on a community support. It certainly doesn't change the class or type of institution, does it?

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MS. WAX: Your Honor --

QUESTION: You don't -- Well, I'm sorry. Go ahead.

MS. WAX: We would not read the language that way. I mean, it implies, we think, the contrary, which is that the Secretary can make rules that are tailored to each kind of institution.

QUESTION: The classes of institution could be, if you've got 100 hospitals, each one is in a different class.

MS. WAX: Well, there's teaching hospitals, there's nonteaching hospitals. The Secretary --

QUESTION: Yes, those are classes, but we're talking about discrimination among -- within the class of teaching hospitals.

MS. WAX: Well, we still think this language accommodates. We don't consider it discrimination, but we consider it --

QUESTION: You're saying it's a separate class of hospital if it gets a lot of money from charity, or doctors pay high tuition, or something like that. That is, the students pay high tuition. That's -- different kinds of community support make it a different class of hospital.

MS. WAX: Well, no. We only say that we don't

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think it's irrational and unreasonable, and that's the standard, for the Secretary to have a rule that takes into account the willingness of private sources to fund an institution, because we don't think the Secretary --

QUESTION: Ms. Wax, would it matter if the hospital -- this hospital were able to show that its sources were no different from the sources of a hospital who started to make these costs -- pay these costs from day 1? In other words, coming back to the example that was given, and I think you say, yes, that's the way our regulation works, on page 22.

The American Hospital Association wasn't inaccurate in setting that out, and what they're giving is examples of a hospitals identically situated except for one started charging earlier, and the other didn't.

MS. WAX: Well, the one that started charging earlier charged under our rules for a new program which entailed new financial --

QUESTION: But not because it had a richer endowment, or got more money from the State in which it operated.

MS. WAX: Well, that's not necessarily so. An institution -- you know, just because money is available doesn't mean an institution has to claim it. An institution might have its own good reasons not to go to

Medicare if it's got a generous donor. It involves red tape, you have to comply with the Government's rules --

QUESTION: Suppose the institution proves that it wasn't in any of these fortunate situations, it just had a sleepy accountant?

MS. WAX: Once again, Your Honor, somebody paid for this, and the Secretary finds it significant that somebody paid for it. The Secretary fears being engulfed with a huge shifting of costs.

QUESTION: Well, I presume the Secretary is entitled to act in gross, and to make some assumptions that are generally true, even if they're not true in every instance, and I guess he's assuming that if you haven't charged them before, they were not incurred before, or there was funding from elsewhere to take care of them before, and he can apply that --

MS. WAX: Well, how could the Secretary assume anything else?

QUESTION: I'm trying to help you, Ms. Wax.

(Laughter.)

QUESTION: And he can apply that rule generally even if you have some instances where it's not true.

MS. WAX: I agree absolutely, Your Honor.

QUESTION: Or she.

(Laughter.)

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QUESTION: Ms. Wax, I thought there was a general provision to the effect that costs can't exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere, so there's an overall cap and an overall mechanism in any event, is there not, to hold down costs that are reimbursed?

MS. WAX: Well --

QUESTION: I mean, suppose you lose on this particular theory of yours, there is another mechanism in place, is there not?

MS. WAX: It's rather anemic, because we still have for the base year, and the base year carries forward to the future forever, we still have a reasonable cost regime, which will --

QUESTION: But there is a provision that says, whatever costs you allow a hospital, it can't be more than that which could be purchased elsewhere, so she has an overall cap in effect.

MS. WAX: Yes, well, it's not a very effective cap, because reasonable cost means that the institution gives you a bill for what it actually spent, and unless the Secretary can show that that's vastly inflated, the Secretary has to pay that.

That's the reasonable cost rule, and the fact is that if we don't win this case there's going to be a

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massive shifting of costs that medical schools and institutions have previously paid for by other means into the base year amount for dozens of institutions, and the bill is going to shoot way up. That's just a fact. There's going to be a massive redistribution.

QUESTION: No, but you do agree, if I understand your position correctly, that a teaching hospital can get paid more for precisely the same services than a nonteaching hospital.

MS. WAX: It depends on what services you're talking about.

QUESTION: Well, just the cost of having the interns participate in the training, and the education, the whole thing. The educational function of the teaching hospital will qualify for a higher payment for precisely the same services that would be available in a nonteaching hospital.

MS. WAX: There's a separate line -- there's a separate provision for the reimbursement of education costs, on the theory that that enhances care.

QUESTION: But that's a response really to Justice O'Connor's suggestion that there's an overall cap. There really isn't as to teaching hospitals.

MS. WAX: Yes.

QUESTION: Thank you, Ms. Wax. Mr. Sutter, you

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have 3 minutes remaining.

REBUTTAL ARGUMENT OF RONALD N. SUTTER

ON BEHALF OF THE PETITIONER

MR. SUTTER: Thank you, Mr. Chief Justice.

I'd like to briefly address community support. I think it's important to analyze that a little bit.

Suppose in 1985 the hospital had received a $10 million contribution from someone in the community. Could that be offset as community support? The answer is, it could not be.

An unrestricted gift would never have been offset from the beginning of the Medicare program, and that was -- by the ORA 1980 legislation that was made part of legislation, and Congress encouraged the Secretary also not to offset restricted grants. That is, a grant that says, this is specifically for GME.

QUESTION: What do you mean when you say, Congress encouraged the Secretary not to?

MR. SUTTER: The -- in paragraph 3 of that legislation, which is on page 1 of the reply brief, Congress authorized the Secretary to not offset restricted grants, and that is an encouragement which the Secretary responded to in the 1983 Federal Register, so that now you could have someone actually in the community donate $10 million directly to the hospital, say this is for GME,

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and that could not be offset.

QUESTION: Well, Congress authorized the Secretary to but didn't require her to.

MR. SUTTER: But she did.

QUESTION: But she did.

MR. SUTTER: She did, in 1983, so are we going to say a $10 million contribution from someone in the community is not community support, but somehow you're getting services from a related medical school, and that is community support?

Or you could have the medical school actually giving $5 million to the hospital. That could never have been offset by Medicare under section 607 of the Provider Reimbursement Manual, which is on page 21a of the Ohio State amicus brief appendix. I don't think it makes any sense to say that these services constitute community support, when those don't.

Now, I will say whatever rules apply to the hospital should apply to the medical center. If there's something that the medical center receives that should be offset if received directly by the hospital, then you should have an offset. But we don't have that situation here, and under the Secretary's current regulations, the only thing that is offset is tuition, and interns and residents do not pay tuition. Instead, they receive a

stipend.

QUESTION: Mr. Sutter, is the same charge that you're contesting or claiming to make here also being made against insurance payers and self-payers?

MR. SUTTER: Well, insurance payers don't usually pay on a cost basis. They will pay charges, and the medical education costs will be a component in the hospital's charges, so the answer is yes.

QUESTION: The answer is yes?

MR. SUTTER: Yes, that's correct.

Thank you, Mr. Chief Justice.

CHIEF JUSTICE REHNQUIST: Thank you, Mr. Sutter.

The case is submitted.

(Whereupon, at 11:03 a.m., the case in the above-entitled matter was submitted.)

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THOMAS JEFFERSON UNIVERSITY, dba THOMAS JEFFERSON UNIVERSITY HOSPITAL Petitioner v. DONNA E. SHALALA, SECRETARY OF HEALTH & HUMAN SERVICES

CASE NO.: 93-120

and that these attached pages constitutes the original transcript of the proceedings for the records of the court.

BY Ann Marie Federico

(REPORTER)