

**IN THE UNITED STATES DISTRICT COURT  
FOR THE EASTERN DISTRICT OF PENNSYLVANIA**

EPISCOPAL HOSPITAL	:	CIVIL ACTION
	:	
v.	:	No. 96-3137
	:	
DONNA E. SHALALA, SECRETARY	:	
DEPARTMENT OF HEALTH AND HUMAN	:	
SERVICES	:	
	:	

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**MEMORANDUM AND ORDER**

Anita B. Brody, J. June \_\_\_\_, 1997

Before me are Plaintiff's Motion for Summary Judgment and Defendant's Motion to Dismiss or, in the alternative, for Summary Judgment. Plaintiff Episcopal Hospital challenges the final decision of the Defendant, the Secretary of the Department of Health and Human Services, denying Plaintiff's request for an adjustment to the average per resident amount used in calculating Episcopal's Medicare reimbursements for graduate medical education. Episcopal asked that this amount be adjusted to include the full-year salaries it pays for two positions which were vacant for part of fiscal year 1985, Episcopal's base year for calculation of graduate medical education program reimbursement. For the reasons that follow, Plaintiff's motion will be denied, and Defendant's motion will be granted.

**I. Background**

The Medicare program, established in 1965 under Title XVIII of

the Social Security Act, 42 U.S.C. S 1395 et seq., is a federally funded health insurance program for the elderly and disabled. A hospital which provides care to eligible Medicare beneficiaries receives compensation from the Medicare program. Such reimbursement of costs is administered by independent "fiscal intermediaries," typically insurance companies, under the guidance of the Health Care Finance Administration ("HCFA"), a division of the Department of Health and Human Services ("HHS").

Among the costs for which hospitals are permitted reimbursement are those for graduate medical education ("GME") programs. These programs give interns and residents clinical training in various medical specialties. Teaching hospitals may obtain reimbursement for the salaries and fringe benefits of interns and residents, as well as for that portion of the salary of teaching physicians attributed to the supervising of interns and residents, and for some portion of institutional overhead costs.

Prior to October 1, 1993, reimbursement for all inpatient hospital services was made on a "reasonable cost" basis. Under this scheme, hospitals were reimbursed for costs actually incurred for the year in question. Hospitals completed year-end cost reports, which were audited by the fiscal intermediary assigned to that hospital. The fiscal intermediary then issued a Notice of Program Reimbursement ("NPR"), which gave notice of the fiscal intermediary's determination of the total reimbursement allowable to that hospital. Hospitals could challenge this determination by appealing it to the Provider Reimbursement Review Board (the

"PRRB"). 42 U.S.C. §§ 1395oo(a),(b). The Secretary of HHS (the "Secretary") could then reverse, affirm or modify a PRRB decision, 42 U.S.C. § 1395oo(f)(1), or, by regulation, within three years, reexamine a fiscal intermediary's, the PRRB's, or her own determination. 42 C.F.R. § 405.1885. Hospitals were entitled to obtain judicial review of final HHS decisions. 42 U.S.C. § 1395oo(f)(1).

In 1983, Congress partially replaced the "reasonable cost" reimbursement system for reimbursement of hospital operating costs with a prospective payment system ("PPS"). See Publ.L. No. 99-272, § 9102, codified as amended at 42 U.S.C. § 1395ww(d). In this transition the system of reimbursing hospitals retrospectively for certain operating costs actually incurred in a given year was replaced by one in which reimbursement is based upon prospectively calculated rates which vary according to the type and category of treatment rendered.

Congress designed the PPS to encourage health care providers to improve efficiency and reduce operating costs. S.Rep. No. 23, 98th Cong., 1st Sess 1, 47 (1983), reprinted in 1983 U.S.C.C.A.N. 143, 187. See also Methodist Hospital of Sacramento v. Shalala, 38 F.3d 1225, 1227 (D.C. Cir. 1994). With regard to this, Congress said:

The bill is intended to improve the medicare program's ability to act as a prudent purchaser of services, and to provide predictability [sic] regarding payment amounts for both the Government and hospitals. More important, it is intended to reform the financial incentives hospitals face, promoting efficiency in the provision of services by rewarding cost/effective

hospital practices. In contrast, the cost-based reimbursement arrangements under which medicare has operated in the past lack incentives for efficiency.

H.Rep. No. 25, 98th Cong., 1st Sess. 1, 132 (1983), reprinted in 1983 U.S.C.C.A.N. 219, 351.

The method of reimbursement for other (non-operating) hospital costs, including GME costs, was not changed by the 1983 law, and these costs continued to be reimbursed on the retrospective, reasonable cost basis. In 1986, however, Congress enacted § 9202 of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), P.L. 99-272, which added new subsection 1886(h), codified at 42 U.S.C. § 1395ww(h), to the Medicare Act. This subsection operated to switch reimbursement of GME costs from the previously-used reasonable cost based system to a prospective payment system. The prospective payment system for GME expenses provides for the calculation for each hospital of an "average per resident amount" ("APRA"). The APRA reflects a hospital's reasonable costs attributable to the training of interns and residents during a year designated the hospital's "base year" (for most hospitals, fiscal year 1984) divided by the number of full-time equivalent ("FTE") residents. To determine a hospital's GME reimbursement for a subsequent year, the base year APRA is updated for inflation and multiplied by the number of FTE residents working in the hospital in the year in question, and that product is multiplied by the hospital's Medicare patient load for that year. 42 U.S.C. § 1395ww(h)(3).

In 1989, HHS issued regulations implementing the GME

amendment. Despite the fact that, by this time, virtually all hospitals had received NPRs for 1984 and the regulatory three-year opening periods had expired, the regulations permitted fiscal intermediaries, for the purpose of determining the base-period per resident amount, to reaudit the base year GME costs and "exclude[] from the base-period graduate medical education costs any nonallowable or misclassified costs." 42 C.F.R. § 413.86(e)(1)(ii). This provision was included because, "in establishing the base period per resident amount for a specific hospital based on [fiscal year] 1984 costs, it is important that the amount determined be an accurate reflection of legitimate GME costs incurred during the [fiscal year] 1984 base period." Medicare Program; Changes in Payment Policy for Direct Graduate Medical Education Costs, 54 Fed.Reg. 40286, 40288 (1989). The Secretary noted, however, that the regulations "indicate that if a hospital's base-period cost report is no longer subject to reopening under § 405.1185, the intermediary may modify the hospital's GME base-period costs solely for purposes of computing the per-resident amount," and not to change the amount owed under the 1984 NPR. 54 Fed.Reg. 40286, 40301 (emphasis added); see 42 C.F.R. § 413.86(e)(1)(iii). The Secretary also assured hospitals that "no new reimbursement principles will be applied during the reaudit. Rather, our intent is to ensure that the reimbursement principles in effect during the GME base period were correctly

applied." 54 Fed.Reg. 40286, 40301 (1989).<sup>1</sup>

## II. Procedural History

Episcopal's base year for the purpose of GME reimbursement is fiscal year 1985 (July 1, 1984 - June 30, 1985). On February 27, 1991, Episcopal's fiscal intermediary issued a "Notice of Average Per Resident Amount." By letter to the intermediary dated March 25, 1991, Episcopal sought an adjustment of its APRA to reflect a full year's salary and overhead expenses for two residency program director positions which were vacant for part of the base year, but which were filled before and have been filled since fiscal year 1985. Episcopal's Department of Medicine Residency Program was without a director during that year until September 3, 1984, and its Department of Surgery Residency Program was without a director until May 1, 1985.

On July 15, 1993, the fiscal intermediary issued a revised notice. However, it declined to adjust the hospital's APRA as requested by Episcopal. On August 8, 1991, Episcopal appealed this determination to the PRRB. On February 20, 1996, after an oral hearing and consideration of post-hearing briefs, the PRRB issued a decision affirming the intermediary's determination. The

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<sup>1</sup> The validity of this regulation regarding the reauditing of base-year cost reports was upheld by the D.C. Circuit in Administrators of the Tulane Educational Fund v. Shalala, 987 F.2d 790 (D.C. Cir. 1993), cert. denied, 510 U.S. 1064, 114 S.Ct. 740 (1994) and by the Eighth Circuit in St. Paul-Ramsey Medical Center, Inc. v. Shalala, 91 F.3d 57 (8th Cir. 1996), cert. granted, 65 U.S.L.W. 3611 (June 2, 1997).

Administrator of HCFA, upon designation from the Secretary, declined to review the PRRB's decision, and it therefore became the final agency action in this matter. Episcopal sought judicial review of this action by filing its complaint in this Court on April 22, 1996.

### III. Analysis

In Section 1886(h)(2)(A), Congress instructed the Secretary to determine the APRA as follows:

**(A) Determining allowable average cost per FTE resident in a hospital's base period**

The Secretary shall determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this subchapter for direct graduate medical education costs of the hospital for each full-time-equivalent resident.

42 U.S.C. § 1395ww(h)(2)(A) (emphasis added). At issue is the interpretation of the emphasized language. The Secretary has used the "reasonable cost" standard of § 1861(v), codified at 42 U.S.C. § 1395x(v), to interpret the word "reasonable" in that phrase. Since "reasonable cost" of services is defined as the "cost actually incurred," the Secretary has, in rejecting Episcopal's argument, interpreted the phrase "average amount recognized as reasonable" also to be limited to costs actually incurred. According to her brief, it is on the basis of this interpretation that the Secretary has refused in this case to include in the APRA upon which Episcopal's GME reimbursements are calculated costs which, while undisputedly incurred in subsequent years, were not "actually incurred" in Episcopal's base year.

The Court's review of this matter is governed by § 706 of the Administrative Procedure Act. This section provides that the court shall

(2) hold unlawful and set aside agency action, findings, and conclusions found to be (A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law...

5 U.S.C. § 706(2)(A). An agency action "may be invalidated by a reviewing court under the 'arbitrary and capricious' standard if...[the action is] not rational and based on consideration of the relevant factors." FCC v. Nat'l citizens Committee for Broadcasting, 436 U.S. 775, 803, 98 S.Ct. 2096, 2116, 56 L.Ed.2d 697 (1978). Or, stated differently, to make a finding that the choice made was arbitrary and capricious, a court must "consider whether the decision was based on a consideration of the relevant factors and whether there has been a clear error of judgment." C.K. v. New Jersey Dept. of Health and Human Services, 92 F.3d 171, 182 (3d Cir. 1996) (quoting Citizens to Preserve Overton Park v. Volpe, 401 U.S. 402, 416, 91 S.Ct. 814, 823-24, 28 L.Ed.2d 136 (1971)).

Furthermore, the Supreme Court has said the following about a court's review of an agency's interpretation of a statute:

First, always, is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress....[However,] if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible reading of the statute.

Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 842-43, 104 S.Ct. 2778, 2781-82, 81 L.Ed.2d 694 (1984). Here, the parties agree that the statutory phrase at issue, the "average amount recognized as reasonable," is ambiguous. Therefore, I must determine whether the Secretary's interpretation is a "permissible reading of the statute." That is, I must ask whether the statute can be reasonably read to say what the Secretary says it does. If so, I must defer to her reading. Dep't of the Navy v. FLRA, 836 F.2d 1409, 1410 (3d Cir. 1988). The Chevron standard is similar to the "arbitrary and capricious" standard set forth in the APA, as the Court in that case said: "If Congress has explicitly left a gap for the agency to fill, there is an express delegation of authority to the agency to elucidate a specific provision of the statute by regulation. Such legislative regulations are given controlling weight unless they are arbitrary, capricious, or manifestly contrary to the statute." Chevron, at 843-44, 104 S.Ct. at 2782.

Episcopal argues that, for several reasons, the Secretary's interpretation of the phrase "average amount recognized as reasonable" as referencing the "reasonable costs" definition and thereby including only costs actually incurred is arbitrary and capricious and an impermissible interpretation of the statutory language. I will address Episcopal's arguments in turn.

A. Language used by Congress

Episcopal makes several arguments that "amount recognized as reasonable" could not be referencing the definition of "reasonable

costs" or mean "costs actually incurred" which are based upon the language used by Congress in the statute.

1. "Recognized as reasonable" in the "reasonable cost" definition.

Episcopal observes that the phrase "recognized as reasonable" is also contained in the "reasonable cost" definition section. The "reasonable cost" section, § 1861(v)(1)(A), contains the sentence:

Such regulations...may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of...services to be recognized as reasonable based on estimates of the costs necessary....

42 U.S.C. § 1395x(v)(1)(A) (emphasis supplied by Episcopal). This, Episcopal says, is proof that the phrase "average amount recognized as reasonable" is not meant to be synonymous with the term "reasonable cost," and that, whatever the former phrase does mean, it does not mean "reasonable costs."

This reasoning is incorrect. In contrast to Episcopal's contention, the language it highlights is referring specifically to the same reasonable costs which the section is defining, and is in fact meant to be synonymous.

The entire relevant language of the "reasonable cost" definition is as follows:

The reasonable cost of any services shall be the cost actually incurred,...and shall be determined in accordance with regulations establishing the...methods to be used, and the items to be included, in determining such costs....Such regulations...may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of...services to be recognized as reasonable based on estimates of the costs necessary...."

42 U.S.C. § 1395x(v)(1)(A) (emphasis added). To summarize this: "Reasonable cost" equals costs actually incurred, and is determined in accordance with regulations, which may limit what costs are recognized as reasonable. With the words "costs...recognized as reasonable," Congress was still referring to reasonable costs, although the term was paraphrased such that the wording was inverted. Congress was essentially saying: Here is what qualifies as a reasonable cost, but the Secretary can make regulations that limit what will be recognized as a reasonable cost. The fact that Congress has paraphrased the term "reasonable costs" in the definition of that term as "costs...recognized as reasonable," and that this paraphrase is similar to the phrase "average amount recognized as reasonable," supports the Secretary's interpretation of the phrase "average amount recognized as reasonable" as simply another paraphrase of the term "reasonable costs." Therefore, it is at the very least reasonable for the Secretary to conclude that "average amount recognized as reasonable" is referencing the "reasonable cost" language of the subchapter.

## 2. Use of different terms

Episcopal also relies on the fact that Congress did not use the term "reasonable cost" or its definition in the GME statute. That is, Congress did not use the phrase "average amount recognized as reasonable costs" or "amount of costs actually incurred." The meaning of the phrase Congress did in fact use, Episcopal contends, is "clearly different" from the statutory definition of "reasonable cost," and this choice of words by Congress "illustrates that

Congress intended for HCFA and the Secretary to look beyond the amount of reasonable costs actually incurred in the base year and to consider the historical costs incurred by specific providers for GME purposes. 'Where Congress chose different language, we must presume that Congress intended the terms to have different meanings.'" (citation and internal quotations omitted).

I disagree with the assumption upon which Episcopal's argument is predicated, that the phrase "average amount recognized as reasonable" is "clearly different" than the definition of "reasonable costs." Although it is true that Congress' use of different language will sometimes indicate an intent that the different phrases have different meanings, it is also true that a term or phrase may be varied or paraphrased, but still intended to have the same meaning. This is essentially what the Secretary reasons that Congress has done: she argues that the phrase "average amount recognized as reasonable" is simply a paraphrase of the term "reasonable cost." Given that Congress has paraphrased that term very similarly in the very definition of "reasonable costs," as discussed in Section III.B.1. of this opinion, immediately above, I find this to be a reasonable interpretation. Therefore, I cannot find, on the basis of Congress' failure to use the terms "reasonable costs" or "costs actually incurred" in § 1861(h)(2)(A), that the Secretary's interpretation of that subsection is impermissible or arbitrary and capricious.

Episcopal also argues that, without a specific cross-reference to the definition of "reasonable cost," or a mention of a

requirement that the costs actually be incurred, the word "reasonable" should be given its "everyday meaning." If Episcopal's implication is that application of such an "everyday meaning" would preclude a reference to the "reasonable cost" definition (which it would have to do to keep me from deferring to the Secretary), I cannot agree.

3. "Notwithstanding section 1861(v),..."

Episcopal also argues that Congress expressly directed the Secretary to ignore the "reasonable costs" definition in determining the "amount recognized as reasonable...." "Payments for direct graduate medical education costs" are governed by subsection (h) of Section 1886 of the Social Security Act (at 42 U.S.C. § 1395ww(h)), and the phrase at issue here is in subsection (h)(2)(A). Episcopal points to the first provision of this subsection, § 1886(h)(1), which immediately precedes the provision containing the phrase at issue, "average amount recognized as reasonable," and which reads, in pertinent part:

Notwithstanding section 1861(v), instead of any amounts that are otherwise payable under this title with respect to the reasonable costs of hospitals for direct graduate medical education costs, the Secretary shall provide for payments for such costs in accordance with paragraph (3) of this subsection.

42 U.S.C. § 1395ww(h)(1) (emphasis added by Episcopal).

Section 1886(h)(1) operates to switch the payment of the GME expenses from a cost-based system (governed by § 1861(v)) in which hospitals are reimbursed retrospectively for their reasonable costs, to the prospective payment system. That is, this

effectuates the switch of these payments that occurred by law in 1986 and by regulation in 1989, discussed in Section I., above.

A reading of the above-quoted paragraph demonstrates that it was for the purpose of this substitution that Congress directed that § 1861(v) be ignored here. The paragraph goes on to read that, "instead," the Secretary shall provide for payments in accordance with paragraph (3). Thus, Paragraph (3) is meant to replace what is being here ignored due to the "notwithstanding" clause. It is telling that paragraph (3) gives a method of calculating "hospital payment amount per resident," and not a definition of "reasonable."

Thus, the phrase "notwithstanding section 1861(v)" was not effecting anything so narrow as precluding the Secretary from considering the definition of "reasonable costs" in determining the meaning of "amounts recognized as reasonable." Rather, this phrase was doing away with the cost-based system altogether for these payments. Since this was the purpose of the "notwithstanding" phrase, it was not put in by Congress to in any way affect the permissible definitions of "reasonable" from which the Secretary could choose in defining the phrase which Congress left without definition, "amounts recognized as reasonable."

#### 4. "Activist" language

Episcopal also points to a footnote in the D.C. Circuit's opinion in Administrators of the Tulane Educational Fund v. Shalala, 987 F.2d 790 (D.C.Cir. 1993), which reads:

We also note that because the statute directs the HHS to

"determine" the "average amount" of GME costs per FTE resident "recognized as reasonable," it seems unlikely that Congress intended for the HHS to simply look up a hospital's approved NPR for [the base year] and plug it into the statutory formula. This activist language suggests that Congress must have intended for the agency to make some kind of substantive calculation on its own, which might involve as well a current assessment of the reasonableness of prior determinations.

Id., at 796 n.6.

As the Court notes, the use of this language by Congress is some evidence of Congress's intent. However, it is not so compelling as to convince me of Congress's intent on the issue before me. Had Congress intended a certain degree of activism on the part of the HHS in determining APRAs, it could have so provided. Furthermore, the reasoning quoted above from Tulane in fact supported the Secretary's position in that case. The Secretary was there saying that the base years could be reaudited, and the Court found that this was a reasonable interpretation, i.e., it deferred to this interpretation. Thus, in Tulane, the inference from this "activist" language of Congressional intent upon which the Circuit Court relied only had to be strong enough to allow deference to the Secretary's interpretation. In the instant action, where Episcopal seeks to use the same inference to overcome the deference owed to the Secretary's interpretation, rather than to support that interpretation, the inference must meet a much higher standard. I do not find that such a strong inference of Congressional intent can be made from this language.<sup>2</sup>

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<sup>2</sup> This caveat applies to many of the cases Episcopal cites. While Episcopal sometimes contends, "This is what this

B. Consistency with allowance of an adjustment/exception mechanism.

Episcopal's claim is also based upon the fact that the Secretary has authorized (and several courts have upheld) the reaudit of base-year costs for the purposes of excluding costs that had previously been misclassified or improperly counted. Episcopal argues:

[I]nasmuch as the GME Regulations permit fiscal intermediaries to reaudit hospitals' base year cost reports and to exclude certain cost items deemed to be excessive or unwarranted for purposes of calculating a hospital's APRA, the Secretary's failure to include a specific adjustment or "exception" mechanism within the GME Regulations to permit a hospital to request a warranted increase in its APRA in order to take into account unusual and unanticipated circumstances such as the short-lived director position vacancies at Episcopal, renders the regulations contrary to the intent of Congress, unreasonable, arbitrary and capricious, and an abuse of agency discretion.

Plaintiff's Motion for Summary Judgment, at 16. Episcopal further propounds this argument in its response to the Secretary's Motion for Summary Judgment, saying that the Secretary "ignores" the "reasonable cost" rules when allowing reaudits to lessen the costs, in that it does not accept as the base year amount the amount previously determined, but nevertheless considers herself "restrained" by the very "reasonable cost" definition previously ignored when considering whether to increase the amount of costs,

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court said," the court cited is often saying only "The Secretary interprets it this way and that is a permissible interpretation," not, as Episcopal would like, "This is the way it must be interpreted."

as Episcopal requests here. Plaintiff's Response, at 4.

The Secretary did not, as Episcopal seems to believe, "ignore" the definition of "reasonable cost," i.e. that such costs must be those "actually incurred," in allowing the reauditing and revision of the base year amounts for the purpose of determining the GME cost figures. Contrary to Episcopal's contention, only costs "actually incurred" were included in the revised APRAs in the reaudits: these incurred costs were checked to make sure they had properly been classified as GME costs, and where found not to be, were excluded. Thus, whether costs were or were not actually incurred was not reevaluated, but merely the labels that such costs had been given (as GME or non-GME costs). Since only costs "actually incurred" were reevaluated in these audits, the "reasonable cost" definition was not ignored as Episcopal contends.

The distinction made by the Secretary is between reauditing to reconsider costs which had been incurred in the base year but had been improperly counted or classified, which she has done, and revising a hospital's base year numbers to consider costs that had not in fact been incurred in the base year but were incurred in later years, which Episcopal urges she do. The Secretary has set out in her brief her reasons for declining to include in a hospital's APRA non-incurred costs. First, she believes that the phrase "average amount recognized as reasonable" is a reference to the "reasonable costs" section and its "costs actually incurred" requirement. This reasoning was discussed in the preceding section of this opinion. I have found this to be a reasonable

interpretation of the statutory language.

The Secretary also bases this distinction between the making of upward and downward adjustments on Congressional policy and intent. She argues that, since Congress' purpose in changing from a reasonable cost reimbursement system to a prospective rate system was to do away with the inflationary incentives which resulted from the cost-based system, see H.Rep. No. 25, 98th Cong., 1st Sess. 1, 132 (1983), reprinted in 1983 U.S.C.C.A.N. 219, 351, it did not want hospitals to be reimbursed for increased costs in years after the base year. Defendant's Response Brief, at 6. Rather, Congress intentionally omitted adjustments or exceptions that would effectively permit future rate-based payments to become retrospective cost-based reimbursements, Defendant's Brief, at 17. Congress, by limiting upwards adjustments in reimbursements, intended to give hospitals an incentive to keep costs down.

The Secretary has explained this view in her responses to comments that were submitted when the regulations were proposed, which responses she issued at the time the regulations became final. The Secretary responded to these comments in pertinent part as follows:

It is true that the revised GME payment method established by section 1886(h) of the Act locks into place a teaching hospital's cost circumstances as they existed during the base period with no provision for modifying per resident amounts to reflect changes in those circumstances. **We infer from the lack of an exception for capital or any other category of costs related to GME programs that it was the intent of Congress to do this.**

54 Fed. Reg. 40286, 40302 (emphasis added).

We believe that Congress intended to establish a payment method that has a historical basis in the GME costs of individual hospitals during the base period, but which is not based on actual costs incurred for GME programs in any year thereafter. Thus, section 1886(h) of the Act does not provide for any exceptions procedure that would raise or lower per resident amounts based on some new circumstances of the program...**We can only infer that had Congress intended a more general exceptions process exist, it would have provided for this in provisions of the law or in the conference report.** Further, it could be argued that if it were intended that the per resident amounts reflect actual costs, there would have been little point in changing the payment method already in effect in 1986. Congress could have simply retained reasonable cost reimbursement with some limiting factor on the rate-of-increase in the costs of these programs.

**...We believe that it was the intent of Congress not to take these sorts of program changes into account but, rather, to leave it to the hospitals to adjust for such changes in view of the amount of payment they are receiving.**

Id. at 40309 (emphasis added).

We have inferred from the revised payment method established by section 1886(h) of the Act that, for Medicare payment purposes, Congress intended to freeze direct GME financial arrangements as they existed during the base period subject to an update factor for inflation and recognition of changes in the number of residents in approved programs. It has the effect of tying Medicare payments to the financial arrangements that existed in the base year, regardless of any future changes in such arrangements.

Id. at 40310.

I find the Secretary's interpretation of Congressional policy and intent to be well-reasoned. Because I have so found, and because I have found the Secretary's interpretation of "amount recognized as reasonable" as referring to the "reasonable costs" definition to be reasonable as well, I cannot find her distinction between, on the one hand, reauditing to reconsider costs which had

been incurred in the base year but had been improperly counted or classified and, on the other, revising a hospital's base year numbers to consider costs that had not in fact been incurred in the base year but would be incurred in later years to be arbitrary and capricious. The distinction rests upon these bases which I have found to be rational and well-reasoned.

C. Introduction of costs not previously claimed in the reaudit.

Episcopal points to the preamble to the 1989 GME Regulations, which stated that legitimate costs that had been inadvertently omitted could be introduced during the reaudit. Episcopal apparently contends that the costs in question were "inadvertently" omitted from its base year cost report.

Episcopal cites a Provider Reimbursement Review Board decision saying that "inadvertent" should not be strictly construed. Cleveland Clinic Foundation v. Blue Cross and Blue Shield Assoc./Community Mutual Ins. Co., PRRB Hearing Dec. No. 94-D56 (July 20, 1994), Medicare & Medicaid Guide (CCH) ¶42,593. However, this decision was reversed by the Administrator of the HCFA, upon delegation from the Secretary, Cleveland Clinic Foundation v. Blue Cross and Blue Shield Assoc./Community Mutual Ins. Co., HCFA Admin. Dec. (Sept. 21, 1994), Medicare & Medicaid Guide (CCH) ¶42,746, and this reversal was upheld by the District Court for the Northern District of Ohio, based in part upon the "inadvertent" language. Cleveland Clinic Foundation v. Shalala, No. 94 Civ. 2414, CCH

Medicare & Medicaid Guide ¶44,682 (N.D. Ohio 1996).

Episcopal makes no argument in its motion that the costs in question were inadvertently omitted. In fact, it states that it purposely omitted such costs in its cost report for its base year because those costs were not incurred in that year. This is not an "inadvertent" omission under even the loosest definition of the term.

D. Avoiding the "Cementing" of Miscalculations

1. Congress' authorization of a current assessment of reasonableness of base year costs

Episcopal cites Tulane, supra, for the D.C. Circuit's holding that the GME statute is susceptible to the interpretation that Congress meant to give the Secretary the "option of using a [base year cost] figure that would be 'recognized as reasonable under this title' at a later time after more careful assessment." Id. at 796. Episcopal cites this and similar language of the Tulane opinion.

Again, this argument, and the impact of the D.C. Circuit's holding to the issue before me, are undermined by the fact that the D.C. Circuit was saying only that the statute was susceptible to this interpretation, not that it required it. This is evident when the above quoted language is read in context. This section of the Court's opinion, quoted more fully, reads:

[I]t is decidedly unclear that the statute meant to allow the Secretary to use only the GME cost figure that would emerge as reasonable through the regular NPR review and

three year reopening process. It might just as well have permitted the Secretary the option of using a figure that would be "recognized as reasonable under this title" at a later time after more careful assessment.

Id. (emphasis added). The Court, in the language of Tulane relied upon by Episcopal, was simply giving deference to the decision of the Secretary, as I must here.

2. The Secretary's Acknowledgment of the Need for Reauditing to Ensure Fairness and Accuracy.

Episcopal next points to the comments to HHS's proposal of the GME Regulations, in which the Secretary stated that the purpose behind the reaudit of base year GME costs was to ensure that "the amount determined [was] an accurate reflection of legitimate costs incurred during the...base period." 53 Fed. Reg. 36589, 36591 (1988). Episcopal also points to the language that follows this statement:

[W]e believe that it is very important that inappropriate costs not be included in the base-period amount. We are concerned that, in the past, there have been some questionable costs erroneously reimbursed through the direct medical education pass through. In particular, we are concerned with misclassified costs and nonallowable costs.

Id. at 36591. Finally, Episcopal quotes the statement made in this comment that "the provisions of section 1886(h) of the Act would seem to require that we correct these discrepancies in the base period since there is no provision in the law for correcting them later," id. at 36593, and Episcopal concludes that "it follows that such policy should extend across the board to those providers who, such as Episcopal, had an extraordinary event occur during their

base year which, in the interest of fairness and accuracy, needs to be accounted for going forward." Plaintiff's Brief, at 26.

First of all, I will note that I am not sure what effect Episcopal wants these statements to have. The Supreme Court has said:

We must give substantial deference to an agency's interpretation of its own regulations. Our task is not to decide which among several competing interpretations best serves the regulatory purpose. Rather, the agency's interpretation must be given "'controlling weight unless it is plainly erroneous or inconsistent with the regulation.'" In other words, we must defer to the Secretary's interpretation unless an "alternative reading is compelled by the regulation's plain language or by other indications of the Secretary's intent at the time of the regulation's promulgation."

Thomas Jefferson Univ. v. Shalala, 512 U.S. 504, 512, 114 S.Ct. 2381, 2386-87, 129 L.Ed.2d 405 (1994) (citations omitted). Thus, courts are to be extremely deferential to the Secretary's interpretation of HHS's regulations. What Episcopal here cites are not regulations, but merely comments on what were then proposed regulations. Even if these statements reflected policy that would be helpful to Episcopal's case, it is not the job of this Court to hold the Secretary or HHS to policy statements made in comments to proposed regulations.

In any event, these statements concerning the Secretary's reasoning and policy, even if given weight here, would not weigh in Episcopal's favor. The statement made by the Secretary evinces the goal of obtaining an accurate reflection of GME costs "incurred during the...base period." The Secretary spoke of the disallowance of "misclassified and nonallowable" costs, and said that § 1886(h)

required that "these discrepancies [i.e. the misclassified and non-allowable costs] in the base period" be corrected. Nowhere does the language of this comment reflect a policy of accurately reflecting costs incurred in years other than the base period, nor of costs other than "misclassified and nonallowable" ones.

#### E. Cross-Subsidization

Section 1861(v)(1)(A) provides that the regulations establishing the methods for determining the reasonable costs of services

shall (i) take into account both direct and indirect costs of providers of services...in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by [Medicare] will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by [Medicare].

42 U.S.C. § 1395x(v)(1)(A) (emphasis added by Episcopal).

Episcopal argues that "the net effect of the Secretary's GME Regulations and the Intermediary's refusal to include the disputed salary and overhead costs in the calculation of Episcopal's APRA, is that Episcopal has been, and will continue to be, forced to pass on some of its Medicare GME expenses to non-Medicare patients."

The Secretary counters by arguing that the ban on cross-subsidization was a feature of the former cost-based reimbursement system, governed by § 1861(v) where this ban is found, and so does not apply to the current prospective payment system.

As the Secretary argues, the ban on cross-subsidization is found in the sections enacted to govern the cost-based system;

there is no analogous ban in the sections governing the prospective payment system. By its own language, the ban specifically applies to the regulations establishing methods used for determining reasonable costs. Therefore, the ban on cross-subsidization does not have any effect on regulations or agency decisions regarding the prospective payment system that now applies to GME reimbursement.

Furthermore, as discussed above, § 1861(h) was meant to replace § 1861(v) insofar as it concerned the reimbursement of GME costs. That Congress did not include the cost-based system's explicit ban on cross-subsidization in the prospective payment system which replaced it for reimbursement of GME costs indicates that Congress did not intend that such a ban be in place with regard to the prospective payment system.

#### F. Analogy to other statutes

Finally, Episcopal argues that "[t]he interpretation of the GME Statute being urged here is consistent with the direction of Congress, as shown by other Medicare provisions where by statute and/or regulation providers have been given remedies for atypical base years." Episcopal cites adjustments that are permitted for (1) base year capital-related costs under the prospective payment system; (2) base year operating costs under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA); (3) base year operating costs under the prospective payment system; and (4) yearly routine operating cost limits.

This argument in no way compels an interpretation of this statute as mandating the adjustment of base year costs to reflect higher costs incurred in other years. That adjustment mechanisms are found explicitly elsewhere does not mean that the Secretary's decision not to infer one here, where Congress has not placed such a mechanism, is arbitrary and capricious or impermissible. In fact, the Secretary very reasonably decided that, had Congress intended such a mechanism to be available in this instance, it would have explicitly included language effecting such an adjustment mechanism as it had in other contexts. 54 Fed. Reg. 40286, 40302 (relevant language quoted supra). Thus, the fact that Congress did explicitly include an adjustment mechanism in the provisions cited by Episcopal but did not with regard to GME costs in fact supports the Secretary's interpretation.

#### **IV. Conclusion**

None of Episcopal's arguments convinces me that the Secretary's reading of the statute, her defining of "average amount recognized as reasonable" in accordance with the "reasonable costs" definition, and her decision to decline to include for the purpose of calculating Episcopal's APRA costs that were incurred in years other than its base year, are "arbitrary and capricious" or are impermissible readings of the statute. The Secretary has clearly made a "consideration of the relevant factors," C.K. v. New Jersey Dept. of Health and Human Services, 92 F.3d 171, 182 (3d Cir. 1996), and I cannot say there has been a "clear error of judgment."

Id. The Secretary has considered the organization and wording of the statute, the history of the Welfare Act, and Congressional policy and intent, and has come to a reasonable conclusion as to their effect. Her interpretation is consistent with Congress's intent in revising the GME reimbursement system of encouraging predictability, efficiency, and cost reduction. See H.Rep. No. 25, 98th Cong., 1st Sess. 1, 132 (1983), reprinted in 1983 U.S.C.C.A.N. 219, 351.

For these reasons, and because I find no issue of material fact, I will grant the Secretary's Motion for Summary Judgment, and I will deny Episcopal's Motion for Summary Judgment.

**IN THE UNITED STATES DISTRICT COURT  
FOR THE EASTERN DISTRICT OF PENNSYLVANIA**

EPISCOPAL HOSPITAL	:	CIVIL ACTION
	:	
v.	:	No. 96-3137
	:	
DONNA E. SHALALA, SECRETARY	:	
DEPARTMENT OF HEALTH AND HUMAN	:	
SERVICES	:	
	:	

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**ORDER**

**AND NOW**, on this \_\_\_\_\_ day of June, 1997, **IT IS ORDERED** that Plaintiff's Motion for Summary Judgment is **DENIED**. **IT IS FURTHER ORDERED** that Defendant's Motion to Dismiss or, in the alternative, for Summary Judgment, is **GRANTED**.

\_\_\_\_\_  
BRODY, J.

