PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
2001-D42

PROVIDER -
Strong Memorial Hospital
Rochester, NY

Provider No. 33-0285

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Empire Blue Cross and Blue Shield

DATE OF HEARING-
June 6, 2001

Cost Reporting Period Ended -
December 31, 1991

CASE NO. 95-1143

INDEX

ISSUE:

Was the Intermediary's application of the reasonable compensation equivalent (RCE) limits to disallow a portion of the Provider's provider-based physician compensation proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Strong Memorial Hospital (Provider) is an acute care, non-profit teaching hospital located in Rochester, New York. During 1991, the calendar year in dispute, the Provider paid $14,895,244 to its hospital based physicians (HBPs) for Medicare Part A services. These costs are reflected on Worksheet A-2 of the cost report.[1] Empire Blue Cross and Blue Shield (Intermediary) disallowed $ 1,556,059 of the $ 14,895,244, based on the application of 1984 RCE limits. The Provider is appealing this adjustment to the Provider Reimbursement Review Board (Board). The Provider's filing meets the jurisdiction requirements of 42 C.F.R. §§ 405.1835-.1841. The Provider is represented by Leslie Demaree Goldsmith, Esquire, of Ober, Kaler, Grimes & Shriver. The Intermediary is represented by Bernard M. Talbert, Esquire, of Blue Cross and Blue Shield.

PROVIDER'S CONTENTIONS:

The Provider contends that compensation paid to physicians by a hospital for services which benefit patients generally, (e.g., HBPs' services) are reimbursed under the Medicare "Hospital Insurance Program" (Part A). For the year under appeal, all physician services subject to reimbursement under Part A that are allocable to the distinct part psychiatric unit, the outpatient department, the skilled nursing and home health agency, are reimbursed on a reasonable cost basis subject to certain limits. 42 U.S.C. § 1395xx(a). The Medicare Act authorizes the Health Care Financing Administration (HCFA) to establish limits on the allowable compensation for services furnished by physicians to providers generally under Part A. 42 U S.C. § 1395xx(a)(2)(B). These limits are known as the "reasonable compensation equivalents." Under these limits, reimbursement is determined based on the lower of: (l) the actual allowable costs of the physicians' services to the provider or (2) the validly established RCE limits applicable to the physicians' respective specialty in a given year.

[1] See Provider Exhibit P-1.

The Provider notes that in directing HCFA to establish RCE limits, Congress also required that services furnished by physicians generally for the benefit of providers be reimbursed fully, limited only by a "reasonableness standard." 42 U.S.C. § 1395xx(a)(1), (2). Moreover, Congress has stated that the "reasonable cost of any services shall be the costs actually incurred, excluding therefrom any part of incurred costs found to be unnecessary in the efficient delivery of needed health services ...." 42 U.S.C. § 1395x(v)(1)(A). Complying with Congress' mandate that the reasonable costs of a provider's Part A physician services be reimbursed under Medicare, as well as with its own regulatory mandate in 42 C.F.R. § 405.480 to annually update the RCE limits based on updated economic index data, HCFA updated the 1982 RCE limits for 1983 and the 1983 RCE limits for 1984. In each case, application of the prescribed methodology resulted in an increase in the RCE limits in accordance with data on average physician specialty compensation and data on updated economic index. 48 Fed Reg 8902, 8923 (Mar. 2, 1983),[2] 50 Fed. Reg 7125 (Feb. 20, 1985).[3] Subsequently, however, without providing any notice or opportunity for public comment, and in violation of the Administrative Procedure Act (APA) and the RCE regulation itself, 42 C.F.R. § 405.482, HCFA changed the methodology by failing to update the RCE limits despite the fact that there had been increases in both the Consumer Price Index (CPI) and physician net income. 48 Fed. Reg.8919, et seq.

The Provider observes that when calculating the Provider's Medicare reimbursement for the Provider's physician compensation costs for 1991, the Intermediary applied RCE limits developed by HCFA for the 1984 federal fiscal year. In so doing, the Intermediary limited the Provider's claimed physician costs to the published 1984 RCE limits, which had not been updated between 1984 and 1991. As a result of applying these invalid limits, the Intermediary disallowed $1,556,059 of the Provider's Part A HBP costs for FYE 1991.

The Provider contends that the plain language of the regulation requires HCFA to update the RCE limits annually. The Intermediary improperly disallowed portions of the compensation paid by the Provider to its HBPs because its adjustments were based on obsolete data, i.e., on the RCE limits applicable to the 1984 cost year. The RCE limits used by the Intermediary were not updated from 1984 through 1997. 62 Fed. Reg. 24,483-85 (May 5, 1997).[4] Thus, the last update prior to1991 was for 1984. The Intermediary's application of the 1984 RCE limits to the Provider's 1991 HBP costs constitutes a violation of the RCE regulation, 42 C.F.R. §§ 405.482(b) and (f)(3), which requires HCFA to update these limits on an annual basis.

The Provider observes that the U.S. District Court in Rush-Presbyterian St. Luke's Medical Center v. Shalala, Case No. 97 C 1726, (N.D. III. Aug 27, 1997) [Rush-Presbyterian], ruled that the Secretary's application of the 1984 RCE limits to the hospital's 1988 HBP costs violated the APA proscription of arbitrary and capricious agency action. The court found that the RCE regulations require some periodic increase in RCE limits, and that at the very least, the regulations require the

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[2] See Provider Exhibit P-5.

[3] See Provider Exhibit P-6.

[4] See Provider Exhibit P-10.

Secretary to establish RCE limits that are based on physicians costs using the most accurate information.

The Provider observes that HCFA's interpretation of its own regulation requires annual updating of the RCE limits on the basis of updated economic index data. HCFA stated this in the Federal Register documents published at the time the RCE limit regulations were proposed. It reiterated this when the RCE regulations were finally adopted. It implemented this interpretation when it updated the limits for the first two years immediately following the establishment of the limits. The consistency of HCFA's interpretation of its regulation is further evidenced by a proposed rule published in 1989. These documents, published in the years 1982 through 1989, are discussed below. ln 1982, when HCFA first proposed the RCE limits, HCFA stated, "[w]e propose to update the RCE limits annually on the basis of updated economic index data" (emphasis added). 47 Fed. Reg 43,586 (Oct. 1, 1982).[5] In adopting the final regulation in 1983, HCFA affirmed this, by advising "[t]he RCE limits will be updated annually on the basis of updated economic index data." 48 Fed Reg. 8923 (emphasis added).[6] Significantly, HCFA complied with its own regulations and annually updated the initial RCE limits for the first two fiscal years following their establishment. In each case, the revisions resulted in an increase in the RCE limits in accordance with data on average physician specialty compensation and updated economic index data. 48 Fed. Reg. 8923[7] 50 Fed. Reg. 7125.[8]

The Provider notes that simultaneous with the promulgation of the final rule, HCFA published RCE limits and updates applicable to Medicare providers' fiscal years commencing in 1982 and 1983, respectively. Again confirming its intent, HCFA published a new and revised RCE limit update table for providers' fiscal years beginning in 1984. 50 Fed. Reg. 7124.[9] In the preamble to HCFA's notice of the 1984 limits, it again acknowledged the limited applicability and annual nature

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[5] See Provider Exhibit P-12.

[6] See Provider Exhibit P-5.

[7] See Provider Exhibit P-5. Id.

[8] See Provider Exhibit P-6.

[9] Id.

of each year's RCE limits by stating:

> Annual Update to Reasonable Compensation Equivalent Limits
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> . . . On March 2, 1983, we published in the Federal Register (48 F.R. 8902) the RCE limits . . . that are applicable to cost reporting periods beginning during calendar years 1982 and 1983. . . . More specifically, § 405.482(f) requires that before the start of a period to which a set of limits will be applied, we will publish a notice in the Federal Register that sets forth the limits and explains how they were calculated. If the limits are merely updated by applying the most recent economic index data without revising the methodology, then revised limits will be published without prior publication of a proposal or public comment period. Thus, because we are calculating the 1984 limits using the same methodology that was used to calculate the limits published on March 2, 1983 . . . ., we are now publishing these revised limits in final . . . .

50 Fed Reg. 7124[10] (Emphasis added).

Nowhere in this preamble (or anywhere else, including the rule itself) does HCFA state or imply that the 1984 limits would or could apply to any cost reporting period other than one beginning during the 1984 calendar year.

The Provider observes that the consistency of HCFA's interpretation of its own regulation is further evidenced by a proposed rule published in 1989. In the preamble, HCFA clearly indicates the desire that annual updates to the RCE no longer be required and its clear belief that in order to discontinue them properly, the regulation itself must be changed. Significantly, this proposed rule was never finalized, leaving in place HCFA's regulation that requires annual updates of the RCE limits. Therefore, HCFA's post hoc statement now that the existing regulations do not require annual updates is clearly disingenuous and self serving in light of its expressed desire to change the existing regulations so that they would no longer require annual updates. Furthermore, HCFA implemented its interpretation that the regulation requires it to annually update the RCE limits. In its Provider Reimbursement Manual (PRM), HCFA clearly indicates that the last published RCE limits prior to the year at issue, i.e., the 1984 RCE limits, apply only to providers' cost reporting periods beginning in 1984. Not only did HCFA set the RCE limits for the 1982, 1983, and 1984 cost years, it also clearly indicated that the 1984 RCE limits apply only to providers' cost reporting periods beginning in 1984 in its PRM. HCFA Pub. 15-1 § 2182.6C states, in pertinent part:

> The RCE limits are always applied to the hospital's entire cost reporting year, based on the calendar year in which the cost

[10] Id.

> reporting year begins.

Id.

In addition, subsection 2182. 6F, which sets forth the RCE limit tables and is entitled "Estimates of FTE Annual Net Compensation Levels for 1983 and 1984," provides: "The following compensation limits apply in the years indicated." The only years indicated in the table are fiscal years commencing in 1983 and 1984. This manual provision on its face does not apply to FYE 1991. These manual provisions are indicative of HCFA's interpretation of the regulation. Referring to HCFA, the Seventh Circuit stated:

> As the Administration is an arm of HCFA, the [Provider Reimbursement] Manual is best viewed as an administrative interpretation of regulations and corresponding statutes, and as such it is entitled to considerable deference as a general matter.

Daviess County Hospital v. Bowen, 811 F.2d 338 (7th Cir. 1987). See also Shalala v. Guernsey Memorial Hospital, 115 S. Ct. 1232 (1995).

Finally, the Provider notes that three internal HCFA memoranda[11] also substantiate HCFA's repeatedly expressed interpretation of its regulation as requiring annual updates. One document, dated October 7, 1983, indicates that HCFA will publish annually an update of the RCE limits, and that the regulation provides that HCFA will publish a notice in the Federal Register setting forth the amounts of reasonable compensation equivalents (RCE) for hospital cost reporting periods beginning in the following calendar year.[12] Another document clearly suggests that HCFA was aware of its requirement that RCE limits be updated annually, and that updated limits be published even if the RCE limit setting methodology is unchanged.[13] HCFA recognizes the fact that providers, in negotiating physician contracts, rely on the Secretary's expressed acknowledgment of her duty to update the RCE limits on an annual basis.[14]

The Provider observes that although Congress authorized HCFA to publish and apply limits, those limits must nevertheless be valid and reasonable, i.e., comply with Congress' mandate that they be reasonable, not violate Congress' prohibition against "cost shifting," and comply with the notice and comment rulemaking requirements of the APA and the express language of the RCE regulation. Thus, even if the Board is inclined to accept HCFA's interpretation of its own regulation, an interpretation with which the Provider disagrees, that is not the end of the matter. The Board cannot stop there without also considering whether the regulation, so interpreted, is consistent with

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[11] See Provider Exhibit P-17 (a), (b), (c).

[12] See Provider Exhibit P-17(c).

[13] See Provider Exhibit P-17(a).

[14] See Provider Exhibit P-17(c).

the statute under which it is promulgated. United States v. Larionoff, 431 U.S. 864, 873 (1977). While it is true that Congress has mandated that HCFA may not recognize as "reasonable" those Part A provider costs that exceed the RCE limits, this does not mean that any limit will automatically suffice just because it has been set by HCFA. The RCE limit must be valid and reasonable. Further, the federal district court in Rush-Presbyterian ruled in favor of a provider challenging the application of the outdated RCE limits on two grounds. One of those grounds was that the statute does not give the Secretary absolute discretion to determine what constitutes reasonable costs.

The Provider notes that HCFA itself established the particular RCE methodology that was to be used to update the RCE limits, a methodology that requires updating the RCE limits with a corresponding CPI increase. HCFA's stated rationale for implementing this particular methodology was that in its view, the CPI is the best estimate of the increases in physician income and should thus be accounted for in setting the RCE limits. 48 Fed. Reg. 8923.[15] The American Medical Association (AMA) information, increases to Part B costs, and increases in the CPI demonstrate the real increases in the cost of HBP services. The RCEs must reflect increases in HBP service costs in order to be consistent with the statutory mandate. The Provider is not suggesting that HCFA adopt this precise data in increasing the RCE limit. Rather, the provider asserts that since the 1984 RCE limit applied by the Intermediary is invalid, the Provider must be reimbursed for its actual Part A HBP costs. The CPI has significantly increased from 1984 through 1991. For example, the CPI for all urban consumers for items in 1984 was 103.9. In 1985, it increased to 107.6. In 1991, the CPI soared to 136.2.[16] Any conjecture that no upward revisions were necessary to assure reasonable compensation after 1984 is also completely refuted by the following:

(1) Information compiled by the AMA clearly demonstrates that a rapid escalation of physicians' salaries across specialties and locations occurred during the latter half of the 1980s.[17] For example, in 1984, the mean physician net income (in thousands of dollars) of all physicians was 108.4. This amount increased to l70.6 in l991. It is simply inconceivable that HCFA not be required to update the RCE limits after 1984 in order to ensure that a provider is reasonably reimbursed for Part A physician costs in the face of more than a 55 percent increase in physician net income ((170.6 - 108.4)÷ 108.4 = .574).

(2) HCFA has continued to update Part B physician screens available for Part B payments to physicians, even after 1984. These fee screens are based on the Medical Economic Index which is both readily available and used by

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[15] See Provider Exhibit P-5.

[16] See Provider Exhibit P-8.

[17] See Provider Exhibit P-9.

HCFA. See, 51 Fed Reg 42,007 (Nov. 20, 1986).[18] An update of Part B physician compensation without a concomitant update of Part A physician compensation is, per se, proof of unreasonableness.

[18] See Provider Exhibit P-19.

(3) Recently, HCFA revised the RCE limits for 1997, which it published in the Federal Register 62 Fed Reg 24,484 ("[W]e are calculating the 1997 [RCE] limits. . . we are able to produce an array of estimated 1997 average FTE compensation levels for nine specialty categories by type of location.")[19] Using the same methodology as it used for the last updates provided in 1985 for FYE 1984, HCFA increased the total RCE limits for 1997 by 56.21% for nonmetropolitan areas and metropolitan areas less than one million and by 59.50% for metropolitan areas greater than one million.[20]

HCFA thus had annual economic data reflecting substantial physician compensation increases and physician fee increases but failed to utilize such data to update the RCE limits. It is indefensible for HCFA to have failed to take these increases into account and to have not updated the RCE limit from 1984 to 1997.

The Provider argues that the application of the 1984 RCE limits to the Provider's 1991 calendar year will not result in reasonable reimbursement. As the court stated in Rush-Presbyterian, the Secretary does not dispute that physicians' costs increased between 1984 and 1988. She decided to leave those limits intact over that period. She does not attempt to justify that decision. Similarly, the dissenting opinion in the PRRB decision for Los Angeles County noted:

> Clearly, physicians' salaries were increasing during the periods in question and at least some updated RCE limit would have been necessary to assure that reimbursement to providers under the Medicare program for Part A physician services would continue to be reasonable The Intermediary proffered no evidence to the contrary, including any evidence which could have suggested that, on a national or regional basis, Medicare providers' Part A physician costs were static during the cost reporting periods in question in this appeal.

Los Angeles County RCE Group Appeal v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Hearing Dec. No. 95-D12, December 8, 1994, Medicare and Medicaid Guide (CCH) ¶ 42,983 "Dissenting Opinion," aff'd sub nom., County of Los Angeles v. Shalala , Case No. CV 95-0163 LGB (SHx) (C.D. Cal 1995), aff'd, 113 F.3d 1240 (9th Cir. 1997). (Los Angeles County).

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[19] See Provider Exhibit P-10.

[20] See Provider Exhibit P-20.

The Provider contends that the application of the 1984 RCE limits would deprive the Provider of reasonable and allowable physician compensation reimbursement. Furthermore, 42 C.F R. § 413.9(c)(1) requires that payment to providers be "fair." Thus, the Secretary's failure to update the RCE limits for FYE 1991, in the face of such inflation, effectively violates this regulatory requirement as well. No valid RCE limits have been established for 1991, and consequently, the Provider must be reimbursed for its actual Part A physicians' costs. See Abington Memorial Hospital v. Heckler, 750 F.2d 224, 242 (3rd Cir. 1984) (the court ruled that where a particular rule or method of reimbursement is held not to apply, the prior method of reimbursement must be utilized).

The Provider notes that HCFA's failure to apply annual CPI updates violates the APA and the RCE regulation. Before HCFA may establish a legal standard, the APA requires that a notice of the proposed standard be published in the Federal Register, and that interested persons be afforded the opportunity to participate by means of written comment or oral presentation. A final rule can only be adopted after consideration of public comment. 5 U.S.C. § 553. Substantive rules affecting Medicare reimbursement are invalid unless promulgated in accord with APA procedures. Buschmann v. Schweiker, 676 F.2d 352, 355, 356 (9th Cir. 1982).

The Provider further contends that HCFA, in compliance with the APA's notice and comment rulemaking requirement, established the methodology that was to be applied in annually updating the RCE limits. This methodology outlined five steps that were to be followed in the annual update. 48 Fed. Reg 8919, et seq.[21] The first step requires an estimation of the national average income for all physicians. This data is extrapolated from the AMA Periodic Survey of Physicians. The second step requires the projection of future year incomes to "account for changes in net income levels occurring after the period for which we have data."[22] HCFA, after considering alternative methods for doing this, determined that "we can achieve more accurate projections by using the historical relationship . . . between physician incomes and the CPI, and projecting this using forecasts of the CPI for future years."[23]

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[21] See Provider Exhibit P-5.

[22] Id.

[23] Id.

The Provider observes that HCFA's failure to update the RCE limits in compliance with its published methodology constitutes a change in methodology which is invalid because it violates the express requirements of this subsection, and the change was not preceded by prior notice and opportunity for public comment. As the Supreme Court noted in Morton v Ruiz, 415 U. S. 199, 235 (1974), 94 S Ct. 1055 (1974), an agency must comply with its own procedures when the rights of individuals are at stake. The Board is thus foreclosed from giving effect to a change in methodology that violates the clear wording of the RCE regulation and the APA. Failure to update the RCE limits violates congress' prohibition against "cost-shifting." Congress has stated that HCFA must assure through regulations that Medicare providers' costs of providing Medicare services are reimbursed and that "the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, ..." 42 U.S.C. § 1395x(v)(1)(A). See also 42 C.F.R. § 413.5. The failure of HCFA to continue updating the RCE limits from 1984 to 1997 has caused Medicare providers to be under reimbursed for their Medicare Part A physicians' costs for those years. HCFA has acknowledged that these costs increased by its greater than fifty percent increase in the RCE limits when it finally updated them in 1997. 62 Fed. Reg 24,485[24] 1984 And 1997 RCE Limit Comparison Chart.[25] The failure to update consequently resulted in non- Medicare patients bearing increased Part A physician costs, which should have been borne pro rata by the Medicare program. This is contrary to the direct instructions of Congress. If the Medicare program does not pay its fair share of a provider's allowable HBP costs for Medicare patients, these Medicare costs will be borne by individuals not so covered. This violates Medicare's cost-shifting prohibition.

The Provider observes that the case law to date is split. The issue of whether HCFA is bound to annually update the RCE limits has, to date, been raised in seven Board decisions. In the first case, Good Samaritan Hospital and Health Center v. Blue Cross and Blue Shield Association /Community Mutual Insurance Co., PRRB Hearing Dec. No. 93-D30, April 1, 1993, Medicare and Medicaid Guide (CCH) ¶ 41,399, the Board, in a two-to-one decision, concluded that the RCE regulation promulgated by HCFA did not mandate that the RCE limits be updated annually. The Board plurality came to the same conclusion in Los Angeles County. The Board recently issued seven decisions regarding the failure of HCFA to update the RCE limits since 1984. Palomar Memorial Hospital v. Blue Cross and Blue Shield Association / Blue Cross of California, PRRB Dec. No. 96- D21, March 13, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,073; Pomerado Hospital v. Blue Cross and Blue Shield Association/ Blue Cross of California, PRRB Dec. No. 96-D19, March 13, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,071; Pomerado Hospital v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 96-D20, March 13, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,072; Rush-Presbyterian- St. Luke's Medical Center v. Blue Cross and Blue Shield Association Blue Cross and Blue Shield of Illinois, PRRB Dec. No. 97-D22, January 15, 1997, Medicare and Medicaid Guide (CCH) ¶

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[24] See Provider Exhibit P-10.

[25] See Provider Exhibit P-20.

45,037; Albert Einstein Medical Center v. Independence Blue Cross, PRRB Dec. No. 98-D9, December 15, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,907; Albert Einstein Medical Center v. Blue Cross and Blue Shield Association/ Veritus Medicare Services, PRRB Dec. No. 99-D18, December 17, 1998, Medicare and Medicaid Guide (CCH) ¶ 80,151; Albert Einstein Medical Center v. Blue Cross and Blue Shield Association/lndependence Blue Cross (Veritus Medicare Services, PRRB Hearing Dec. No. 99-D26, February 26, 1999, Medicare and Medicaid Guide (CCH) ¶ 80,163 (Albert Einstein). While conceding that HCFA was not required to annually update the RCE limits, the Board plurality in the four earlier cases stated as follows:

> The Board majority fully considered the physician compensation study published by the American Medical Association which illustrates undisputed increase in mean physician net income spanning the period from 1984 to the fiscal year in contention. While the majority of the Board finds the Provider's argument persuasive in demonstrating that the applied RCEs may be unreasonable in light of the increased compensation during this time period, the Board majority is bound by the governing law and regulations.

The full Board in all three Albert Einstein cases found similarly. In all of these cases, the HCFA Administrator declined to review the Board's decisions.

The Provider observes that in Rush-Presbyterian the Provider appealed to the federal district court in the Northern District of Illinois. The court ruled in favor of the provider, holding that the Secretary's failure to update the RCE limits for the provider's FYE 1988 violated the APA. The court found the Secretary acted arbitrarily and capriciously in not updating the limits in light of the fact that physician costs did increase over the period at issue here, and that the language of the regulations appears to require some periodic increase in RCE limits as a result. The court therefore concluded that the Secretary's application of the 1984 RCE limits unlawful. There is no appeal of this decision pending. In Los Angeles County, the District Court for the District of Central California and the Ninth Circuit affirmed the Board's decision.[26] The Provider disagrees with the holdings in the Board decisions and the court decisions in Los Angeles County cases as they are flawed on a number of grounds. For example, the Board did not consider whether the enabling statute would sustain the interpretation that the intermediaries sought to apply to the regulation. In Los Angeles County, the district and appeals courts concluded that the plain meaning of the regulation did not mandate annual updates of the RCE limits despite the fact that HCFA itself had interpreted the regulation to require annual updating. The courts refused to give any weight to HCFA's discussion of the RCE updates promulgated in 1989. 54 Fed. Reg. 5956 (Feb 7, 1989)[27]

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[26] See Provider Exhibits P-22, P-23.

[27] See Provider Exhibit P-13.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the RCE limits as promulgated must be applied to determine reasonable costs pursuant to Medicare regulations. In this regard, the Intermediary asserts that it has complied with existing regulations and applied the RCE limits in effect for the subject cost reporting period in question. See, 42 CFR § 405.480 and 405.482(a).

The Intermediary contends that HCFA is not required to update RCE limits annually. The Board has consistently ruled that HCFA is not mandated by regulation or statute to update the RCE limits and cites the following cases in support of its position. Good Samaritan Hospital and Health Center v. Blue Cross and Blue Shield Association/Community Mutual Insurance Company, PRRB Decision 93-D30, April 1,1993, Medicare and Medicaid Guide (CCH) ¶ 41,399, declined rev., HCFA Administrator, May 21, 1993 (Good Samaritan); Los Angeles County RCE Group Appeal v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Decision 95-D12, December 8, 1994, Medicare and Medicaid Guide (CCH) ¶42,983, declined rev., HCFA Administrator, January 12, 1995; Pomerado Hospital v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Decision Number 96-D19, March 13, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,071, declined rev., HCFA Administrator, May 1, 1996; Pomerado Hospital v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Decision 96-D20, March 13, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,072, declined rev., HCFA Administrator, May 1, 1996; Palomar Memorial Hospital v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 96-D21, March 13, 1996, Medicard and Medicaid Guide (CCH) ¶ 44073, declined rev., HCFA Administrator, May 1,1996; Belmont Center for Comprehensive Treatment v. Blue Cross Blue Shield Association et al., PRRB Dec. No. 99-D5, November 16, 1998, Medicare and Medicaid Guide (CCH) ¶ 80142 Rush-Presbyterian St. Luke's Medical Center v. Blue Cross and Blue Shield Association et al., PRRB Dec. No. 97-D22, January 15, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,037, and Albert Einstein Medical Center v. Independence Blue Cross, PRRB Decision 98-D9, December 15, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,907. In Good Samaritan, a Board majority found that 42 C.F.R. § 405.482 only established the notification procedure to be followed regarding the update of RCE limits and did not mandate annual updates. Since that case, the Board has consistently found that HCFA was authorized to apply the RCE limits as published and was not required to make annual updates.

The Intermediary recognizes that an Illinois district court overturned the Board decision in Rush-Presbyterian, addressed supra. However, the Board is not bound by the ruling of a district court. Indeed, the Board squarely rejected the district court's reasoning when it upheld the Intermediary in Albert Einstein, addressed supra. Moreover, further supporting the Intermediary's position, the Board's decision in Los Angeles County, addressed supra, was upheld in a California district court, which was then affirmed in an unpublished opinion by the Ninth Circuit Court of Appeals.[28] In

[28] See Intermediary Exhibit 13

that case the Court found that 42 C.F.R. § 405.482 anticipates annual updates for RCE limits, but does not require them.

The Intermediary notes that the Provider has raised no new or novel argument or interpretation of the Medicare statute or implementing regulations that warrants the Board's abandoning its long held position that HCFA is not obliged to make annual updates to the RCE limits. The Board has heard the Provider's arguments before and has rejected them. The Intermediary submits that the Board should reaffirm its prior position and find that the Intermediary's application of the most recent published limits at the time was in accordance with controlling, applicable regulations.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - 5 U.S.C.:

§ 553	-	Rule Making

2. Law - 42 U.S.C:

§ 1395x(v)(1)(A)	-	Reasonable cost
§ 1395xx et seq.	-	Payment of Provider-Based Physicians and Payment Under Certain Percentage Arrangements

3. Regulations- 42 C.F.R.:

§ 405.480	-	Payment for Services of Physicians to Providers: General Rules
§ 405.482 et seq.	-	Limits on Compensation for Services of Physicians in Providers
§§ 405.1835-.1841	-	Board Jurisdiction
§ 413.5	-	Cost Reimbursement: General
§ 413.9(c)(1)	-	Cost Related to Patient Care-Application

4. Program Instructions-Provider Reimbursement Manual (HCFA Pub.15-1):

§ 2182.6C	-	Reasonable Compensation

Equivalents (RCEs)

§ 2182.6F - Table I -- Estimates of Full-Time Equivalency (FTE) Annual Average Net Compensation Levels for 1983 and 1984.

5. Case Law:

Good Samaritan Hospital and Health Center v. Blue Cross and Blue Shield Association/Community Mutual Insurance Co., PRRB Dec. No. 93-D30, April 1, 1993, Medicare and Medicaid Guide (CCH) ¶ 41,399, declined rev. HCFA Admin., May 21, 1993.

Los Angeles County RCE Group Appeal v. Blue Cross and Blue Shield Assoiation/Blue Cross of California, PRRB Dec. No. 95-D12, December 8, 1994, Medicare and Medicaid Guide (CCH) ¶ 42,983, declined rev. HCFA Admin., January 12, 1995, aff'd sub nom., County of Los Angeles v. Shalala, Case No. CV 95-0163 LGB (Shx) (C.D. Cal. 1995) aff'd. County of Los Angeles v. Secretary of Health and Human Services, 113 F.3d 1240 (9th Cir. 1997).

Pomerado Hospital v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. No. 96-D19, March 13, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,071, declined rev. HCFA Admin., May 1, 1996.

Pomerado Hospital v. Blue Cross and Blue Shield Asociation/Blue Cross of California, PRRB Dec. No. 96-D20, March 13, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,072, declined rev. HCFA Admin., May 1, 1996.

Palomar Memorial Hospital v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 96-D21, March 13, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,073, declined rev. HCFA Admin., May 1, 1996.

Rush-Presbyterian - St. Lukes Medical Center v. Blue Cross and Blue Shield Association/BlueCross and Blue Shield of Illinois, PRRB Dec. No. 97-D22, Janaury 15, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,037, declined rev. HCFA Admin., February 25, 1997, rev'd. Rush-Presbyterian - St. Lukes's Medical Center v. Shalala, Case No. 97 C 1726, (N.D. Ill. Aug. 27, 1997).

Albert Einstein Medical Center v. Independence Blue Cross, PRRB Dec. No. 98-D9, December 15, 1997, Medicare and Medicaid Guide (CCH) ¶45,907, declined rev. HCFA Admin., January 14, 1998.

Albert Einstein Medical Center v. Blue Cross and Blue Shield Association/ Veritus

Medicare Services, PRRB Dec. No. 99-D18, December 17, 1998, Medicare and Medicaid Guide (CCH) ¶ 80,151, declined rev. HCFA Admin., February 10, 1999.

Albert Einstein Medical Center v. Blue Cross and Blue Shield Association/Independence Blue Cross (Veritus Medicare Services), PRRB Dec. No. 99-D26, February 26, 1999, Medicare and Mdicaid Guide (CCH) ¶ 80,163, declined rev. HCFA Admin., April 13, 1999.

Belmont Center for Comprehensive Treatment v. Blue Cross and Blue Shield Association, et al, PRRB Dec. No. 99-5, November 16, 1998, Medicare and Medicaid Guide (CCH) ¶ 80,142.

Morton v. Ruiz, 415 U.S. 199, 235 (1974).

Abington Memorial Hospital v. Heckler, 750 F. 2d 224 (3rd Cir. 1984).

Buschmann v. Schweiker, 676 F. 2d 352 (9th Cir. 1982).

Daviess County Hospital v. Bowen, 811 F. 2d 338 (7th Cir. 1987).

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

United States v. Larionoff, 431 U.S. 864 (1977).

6. Other - Federal Register

47 Fed. Reg. 43586.

48 Fed. Reg. 8902, 8919, et seq. (March 2, 1983).

50 Fed. Reg. 7123, 7124, 7125 (Feb. 20, 1985).

51 Fed. Reg. 42007 (Nov. 20, 1986).

54 Fed. Reg. 5956 (Feb. 7, 1989).

62 Fed. Reg. 24483-85 (May 5, 1997).

FINDINGS OF FACT, CONCLUSION OF LAW AND DISCUSSION:

The Board finds that the Intermediary applied RCE limits published in the Federal Register on February 20, 1985, and effective with cost reporting periods beginning on or after January 1, 1984, to the Part A physicians' compensation paid by the Provider for 1991. Additionally, the Board acknowledges the Provider's fundamental argument that this application was improper because the

RCE limits were obsolete and not applicable to the subject cost reporting period, i.e., because HCFA failed to update the limits on an annual basis as required by regulation.

The principal and scope of enabling regulation, 42 C.F.R. § 405.482(a)(1), require HCFA to establish RCE limits on the amount of compensation paid to physicains by providers, and that such limits " be applied to a provider's costs incurred in compensating physicians for services to the provider. . ." (emphasis added). However, contrary to the Provider's contentions, the Board finds that this regulation does not mandate that the RCE limits be updated annually or on any other stipulated interval.
The Board agrees with the Provider that language used in the Federal Register, internal memoranda, and manual instructions indicate that HCFA had apparently intended to update the limits on an annual basis. However, the Board concludes that the pertinent regulation is controlling in this instance, and as discussed immediately above, does not require annual updates.

The Board fully considered the Provider's argument that data compiled by the AMA, increases in the CPI, and increases in the RCE limits issued by HCFA for 1997, clearly illustrate undisputed increases in net physicain income throughout the period spanning 1984 through the year in contention. While the Board finds this argument persuasive in demonstrating that the subject RCE limits may be lower than actual market conditions would indicate for the subject cost reporting period, the Board finds that it is bound by the governing law and regulations.

The Board rejects the Provider's argument that HCFA's failure to update the RCE limits results in Medicare reimbursing providers' less than their "reasonable costs," which it is required to do pursuant to 42 U.S.C. § 1395xx. The Board finds that this argument was considered in Rush-Presbyterian, addressed supra, which was decided in favor of the intermediary. Likewise, in Rush-Presbyterian, the Board considered and rejected the Provider's argument that HCFA's failure to update the RCE limts results in cost shifting in violation of 42 U.S.C. § 1395(v)(1)(A). With respect to the Provider's argument that HCFA violated the APA by not allowing for public comment on its decision not to update the RCE limits, the Board refers to the Los Angeles County Court decision. In that decision, the court rejected any obligation on the part of the Secretary to promulgate a new rule if she decided not to update the limits.

Finally, the Board notes that the United States District Court for the Northern District of Illionois, Eastern Division, did find in favor of the provider in Rush-Presbyterian-St. Luke's Medical Center v. Shalala, Case No. 97 C 1726 (N.D. Ill. Aug. 27, 1997). However , the Board finds that the court's analysis seemingly hinged on the single factor that the Secretary failed to articulate her reasons for not updating the RCE limits. The Board believes that if the Secretary had presented her arguments for not revising the limts, the court would likely have decided the case against the provider as the courts have done in County of Los Angeles v. Shalala, Case No. CV 95-0163 LGB (Shx) (C.D. Cal. 1995), and County of Los Angeles v. Secretary of Health and Human Services, 113 F. 3d 1240 (9th Cir. 1997). The Board concludes, therefore, that the District Court's decision in Rush-Presbyterian is not persuasive, and that the application of the 1984 RCE limits to subsequent period physicians' costs is proper.

DECISION AND ORDER:

The Intermediary used the correct RCE limits to disallow a portion of the Provider's hospital-based physicians compensation. The Intermediary's adjustment is affirmed.

BOARD MEMBERS PARTICIPATING:

Irvin W. Kues
Henry C. Wessman, Esquire
Stanley J. Sokolove

Date of Decision: August 22, 2001

FOR THE BOARD

Irvin W. Kues
Chairman