PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2001-D49

PROVIDER –
Grant Medical Center
Columbus, Ohio

Provider No. 36-0017

vs.

INTERMEDIARY –
Blue Cross/Blue Shield Association/
AdminaStar Federal

DATE OF HEARING-
August 14, 2001

Cost Reporting Period Ended -
June 30, 1993

CASE NO. 95-1217

INDEX

ISSUE:

Was the Intermediary=s adjustment disallowing portions of the Part A physician compensation paid by the Provider based on the application of the 1984 reasonable compensation equivalents proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Grant Medical Center (the AProvider@) operates a not for profit hospital in Columbus, Ohio. The Provider filed their cost report for the fiscal year ended June 30, 1993 claiming physician compensation cost incurred during the cost reporting period for hospital-based physician (AHBP@) services. The Provider is disputing audit adjustments number 33 and 53 which disallowed portions of the compensation the Provider paid for HBP services. Adminastar Federal (the AIntermediary@) disallowed the HBP costs by applying the most current reasonable compensation equivalent (ARCE@) limits published in the 48 Fed. Reg. 8902 (March 2, 1983).[1] These established RCE limits are applicable to cost years beginning on or after January 1, 1984. The Provider filed a timely appeal with the Provider Reimbursement Review Board (ABoard@) pursuant to 42 C.F.R. '' 405.1835-.1841 and has met the jurisdictional requirements of those regulations. The Medicare reimbursement effect is approximately $561,186.

The Provider was represented by James F. Flynn, Esquire, of Bricker and Eckler, LLP. The Intermediary was represented by Bernard M. Talbert, Esquire, of the Blue Cross and Blue Shield Association.

PROVIDER=S CONTENTIONS:

The Provider contends that hospital-based physicians should not be paid in 1993 at 1984 compensation levels. The Provider indicates that it employs or contracts with hospital-based physicians to provide services in the following departments: Operating Room, Laboratory, Gastrointestinal Services, Clinic, Emergency Room, and Ambulance Services. The compensation paid by the Provider to its hospital-based physicians was consistent with physician income levels in 1993.[2] Nonetheless, the Intermediary applied 1984 RCE limits to 1993 physician compensation, to disallow $561,186.

The Provider notes that during the period between 1984 and 1993, various economic indices show a substantial increase in physician compensation levels during this period. The Physician Net Income Levels as compiled by the American Medical Association (AAMA@) in its publication Socioeconomic

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[1] Provider Exhibit 1.

[2] Provider Exhibits 2 and 3.

Characteristics of Medical Practice, 1993 and 1995, showed in 1993 a Mean Net Income for all physicians of $189,300.[3] The 1992 and 1997 Statistical Abstracts of the United States showed increases in Physicians= Mean Income (All Physicians) for each year from 1984 to 1993.[4]

During the same time period, the Consumer Price Index - Urban (ACPI-U@) for all items and for medical care items also increased 5.9 percent or more for each year from 1984 to 1993.[5]

Likewise, during the 1984 - 1993 time period, relevant Medicare economic indices showed significant increases. The Medicare Economic Index Rates, which are used to adjust Part B, had increased each year from 1984 to 1993.[6]

During the same period, the average hourly earnings for hospital workers, as measured by the market basket, which is used by Medicare as one of the factors in determining adjustments to the ceiling on the rate of increase for hospital inpatient costs, showed the following increases, as reflected in 58 Fed. Reg. 46322 (September 1, 1993):[7]

Percentage

Years	Increase
1984	5.6%
1985	5.4%
1986	4.1%
1987	4.7%
1988	6.5%
1989	6.9%
1990	5.6%
1991	5.6%
1992	4.8%
1993	4.2%

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[3] Provider Exhibit 4.

[4] See Id.

[5] See Provider Exhibit 5.

[6] See Provider Exhibit 6.

[7] See Provider Exhibit 7.

The RCE limits, established pursuant to 42 C.F.R. ' 405.482, have been applied to the compensation paid by the Provider to its hospital-based physicians for services furnished to the Provider, to the extent that such services are not payable under the Prospective Payment System (APPS@). The Provider incurs substantial hospital-based physician costs in connection with its outpatient departments and PPS exempt units.[8]

On February 20, 1985, HCFA published RCE limits as applicable to physician compensation levels in 1984.[9] No RCE limits have been published for application to years after 1984.

The compensation in excess of the 1984 RCE limits, which was necessarily incurred by the Provider in retaining its hospital-based physicians, did not exceed the change in physician mean net income during the 1984 to 1993 period, as reflected in the AMA studies.[10] Likewise, the excess compensation incurred did not exceed the change in the CPI-U for medical care during that same period.[11] The excess compensation incurred by the Provider was incurred to provide necessary services to both Medicare and non-Medicare patients. The Provider was forced, however, as a result of the Intermediary=s application of 1984 RCE limits, to allocate the excess compensation, as part of the Provider=s budget process, entirely to non-Medicare patients through higher rates and charges.

The Provider contends that the Intermediary=s application of 1984 RCE limits to determine hospital-based physician compensation in FY 1993 is inconsistent with the Medicare statute that established RCE limits. Section 1887 of the Social Security Act, 42 U.S.C. ' 1395xx,[12] was enacted as part of the Tax Equity and Fiscal Responsibility Act of 1982, and provides in relevant part that:

> (a)(1) The Secretary shall by regulation determine criteria for distinguishing those services (including inpatient and outpatient services) rendered in hospitals or skilled nursing facilities--
>
> (A) which constitute professional medical services, which are personally rendered for an individual patient by a physician and which contribute to the diagnosis or treatment of an individual patient, and which may be reimbursed as physicians= services under part B, and

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8 Provider Exhibit 1.

9 Provider Exhibit 8.

10 See Provider Exhibits 3 and 4.

11 See Provider Exhibit 5.

12 Provider Exhibit 14.

> (B) which constitute professional services which are rendered for the general benefit to patients in a hospital or skilled nursing facility and which may be reimbursed only on a reasonable cost basis or on the bases described in section 1395ww of this title.
>
> (2)(A) For purposes of cost reimbursement, the Secretary shall recognize as a reasonable cost of a hospital or skilled nursing facility only that portion of the costs attributable to services rendered by a physician in such hospital or facility which are services described in paragraph (1)(B), apportioned on the basis of the amount of time actually spent by such physician rendering such services.
>
> (B) In determining the amount of the payments which may be made with respect to services described in paragraph (1)(B), after apportioning costs as required by subparagraph (A), the Secretary may not recognize as reasonable (in the efficient delivery of health services) such portion of the provider=s costs for such services to the extent that such costs exceed the reasonable compensation equivalent for such services. The reasonable compensation equivalent for any service shall be established by the Secretary in regulations.

Id.

By using the term Areasonable compensation equivalents,@ Congress clearly intended that the Secretary establish compensation limits that are (i) Areasonable@ and fair in amount, and (ii) Aequivalent@ or equal in amount to compensation levels being earned by physicians. In an economy in which all major economic indices had increased by double digits over the period between 1984 and l993, the Secretary=s application of 1984 compensation levels to 1993 physician salaries results in neither reasonable nor equivalent compensation, and therefore violates the plain language of ' 1887(A) of the Social Security Act.

The Provider further contends that the Intermediary=s application of 1984 RCE limits to fiscal year (AFY@) 1993 costs violates the Medicare regulation that governs RCE limits and that provides in relevant part:

> (A) Principle and scope. (1) Except as provided in paragraphs (a)(2) and (3) of this section, HCFA will establish reasonable compensation equivalent (RCE) limits on the amount of compensation paid to physicians by providers. These limits will be applied to a provider's

> costs incurred in compensating physicians for services to the provider, as described in ' 405.480(a).
>
> . . .
>
> (b) Methodology for establishing limits. HCFA will establish a methodology for determining reasonable annual compensation equivalents, considering average physician incomes by specialty and type of location, to the extent possible using the best available data.
>
> (c) Application of limits. If the level of compensation exceeds the limits established under paragraph (b) of this section, Medicare payment will be based on the level established by the limits.
>
> . . .
>
> (f) Notification of changes in methodologies and payment limits. (1) Before the start of a cost reporting period to which limits established under this section will be applied, HCFA will publish a notice in the Federal Register that sets forth the amount of the limits and explains how the limits were calculated.
>
> (2) If HCFA proposes to revise the methodology by which payment limits under this section are established, HCFA will publish a notice, with opportunity for public comment, to that effect in the Federal Register. The notice would explain the proposed basis for setting limits, specify the limits that would result, and state the date of implementation of the limits.
>
> (3) Revised limits updated by applying the most recent economic index data without revision of the limit methodology will be published in a notice in the Federal Register without prior publication of a proposal or public comment period.

42 C.F.R. ' 405.482 (redesignated ' 415.70).[13]

Subsection (b) of the above-quoted regulation describes the Amethodology@ for establishing limits. The methodology includes specifically the determination of Areasonable annual compensation equivalents..

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[13] Provider Exhibit 15.

.using the best available data.@ (Emphasis added). Subsection (f) of Section 405.482, which describes notification of changes in methodologies and payment limits, requires that HCFA publish the amount of the limits A[b]efore the start of a cost reporting period to which such limits will be applied.@ Subsection (f) further provides that revised limits updated by applying the most recent economic data without revision of the methodology will be published without proposal and comment period. The above-referenced provisions of ' 405.482 clearly require the Secretary to update RCE limits annually using the Abest available data,@ and to publish the RCE limits that will be applied to a cost reporting period prior to the start of the cost reporting period. The Provider submits that HCFA failed to comply with these provisions of 42 C.F.R. ' 405.482 with respect to the FY 1993 cost reporting period.

This conclusion finds further support in the preamble to the proposed rule making of ' 405.482, and in the preamble to the final rule. The Secretary published ' 405.482 as a proposed rule. 47 Fed. Reg. 43578 (October 1, 1982).[14] In the preamble to the proposed rule, the Secretary proposed establishing RCE limits based upon Athe national average (mean) income for all physicians using 1979 physician net incomes from the American Medical Association (AMA) Periodic Survey of Physicians (PSP),@ updated to 1982 Ausing the medical component of the Consumer Price Index (CPI).@ Id. at 43585. The Secretary further made clear in the preamble that RCE limit will be updated annually. AWe propose to update the RCE limits annually on the basis of updated economic index data.@ Id. at 43586.

The preamble in the final rule for ' 405.482 also clearly stated the Secretary=s interpetation that annual updates are required.

> The RCE limits will be updated annually on the basis of updated economic index data. When we do this without revising the methodology for computing the limits, we will publish a single general notice in the Federal Register, setting forth the new limits and their effective date. We will not publish a notice proposing revised limits for public comment unless there is a good cause due to unforeseen problems with the limits or the data. However, if we change the methodology by which limits are calculated or the way in which they are applied, we will publish the proposed changes in methodology in a Federal Register notice in accordance with the Department=s established rulemaking procedures.

48 Fed. Reg. 8902, 8923 (March 2, 1983).[15]

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[14] Provider Exhibit 16.

[15] Provider Exhibit 17.

It is clear from both the proposed and final rule that ' 405.482 required, and that the Secretary intended, that RCE limits be updated and published before each cost reporting period to which they applied. This conclusion again was reconfirmed in the Final Notice of RCE limits for application to 1984, as follows:

> 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 are calculated. If the limits are merely updated by applying the most recent economic index data without revising the methodology, then the revised limits will be published without prior publication of a proposal or public comment period.

50 Fed. Reg. 7123, 7124 (February 20, 1985) (Emphasis added).[16]

Consistent with this expressed intent, the Secretary published a table of AFTE Annual Average Net Compensation Levels for 1984.@ Id. at. 7126 (Emphasis added). Nothing in the February 20, 1985 Notice of RCE limits indicated that the 1984 RCE limits would be applied to any cost reporting periods other than those beginning in 1984.

No further publication of RCE limits or methodology occurred until the February 7, 1989 Federal Register, which proposed to change the methodology of updating RCE limits from annual to periodic, as follows:

> We propose to update the RCE limits periodically, when an update would result in a significant change in the limits, rather than annually.

54 Fed. Reg. 5946 (February 7, 1989).[17]

As proposed in the Federal Register, ' 405.482(f) (redesignated ' 415.70(f)), would have provided:

> (f) Notification of changes in methodologies and payment limits: HCFA annually reviews the limits established under this section and updates them if it determines that an update is necessary.

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[16] Provider Exhibit 18.

[17] Provider Exhibit 19.

> (1)Before limits established under this section are applied, HCFA publishes a notice in the Federal Register that sets forth the amount of the limits and explains how the limits were calculated.
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> (2)If HCFA proposes to revise the methodology by which payment limits under this section are established, HCFA publishes a notice, with opportunity for public comment, to that effect in the Federal Register. The notice would explain the proposed basis for setting limits, specify the limits that would result, and state the date of implementation of the limits.
>
> (3)Revised limits updated by applying the most recent economic index data without revision of the limit methodology are published in a notice in the Federal Register without prior publication of a proposal or public comment period.
>
> (4)Limits established under paragraph (f)(l) of this section remain in effect until newly updated limits are published.

54 Fed. Reg. 5946, 5960 (February 7, 1989)(Emphasis added).[18]

The language added to subsection (f) and by new paragraph (f)(4) eliminates the requirements that RCE limits be updated annually and that the RCE limits be published prior to the cost reporting period to which they apply. The proposed amendment would have effected a substantial change from the existing ' 405.482(f). The above amendment to 42 C.F.R. ' 405.482, however, was never adopted nor made final.

The Secretary published a final notice of RCE limits effective for cost reporting periods beginning on or after May 5, 1997. 62 Fed. Reg. 24483 (May 5, 1997).[19] In updating the RCE limits, the Secretary retained existing RCE methodology, and based upon intervening economic data, increased the 1984 RCE limits by fifty-six percent in every physician specialty.

The Provider contends that, based upon the language of 42 C.F.R. ' 405.482 and the policy statements made in the Federal Register for October 1, 1982, March 2, 1983, February 20, 1985, and February 7, 1989, the application of the 1984 RCE limits to 1993 physician compensation violates 42 C.F.R. ' 405.482 in all of the following respects:

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[18] Provider Exhibit 19.

[19] Provider Exhibit 20.

1. The application of 1984 RCE limits in 1993 violates ' 405.482(b) because the 1984 RCE limits do not use the best available data for determining reasonable compensation equivalents for physician compensation in 1993.

2. The application of 1984 RCE limits to FY 1993 costs violates ' 405.482(f)(l) because HCFA did not, before the start of FY 1993, publish a notice in the Federal Register that set forth the amount of the limits that would apply to the FY 1993 cost reporting period. Therefore, no RCE limits apply to FY 1993 physician compensation.

3. The failure to update RCE limits on an annual basis violates ' 405.482(f)(3) because HCFA did not publish revised RCE limits updated by applying the most recent economic index data.

4. The change from annual updates to periodic updates constitutes a revision to the RCE limit methodology in violation of ' 405.482(f)(2) because HCFA did not publish the notice of the change until 1989, and has never formally finalized the change. HCFA cannot change the RCE limit methodology and reporting requirements of 42 C.F.R. ' 405.482 without satisfying the formal rulemaking procedures of the Administrative Procedure Act (AAPA@), 5 U.S.C. ' 551 et seq.

The Provider further submits that the application of 1984 RCE limits to physician compensation in FY 1993 violates Provider Reimbursement Manual (HCFA Pub. 15-1) ' 2182.6.F, which sets forth at Table I, Estimates of FTE Annual Average Net Compensation Levels for 1983 and 1984. The Intermediary applied the 1984 RCE limits for metropolitan areas greater than one million from Table I to the Provider=s FY 1993 physician compensation. HCFA Pub. 15-1 ' 2182.6.F, by its express terms, however, states as to Table I that A[t]he following compensation limits apply in the years indicated.@ (emphasis added).[20] The only years indicated in Table I are 1983 and 1984. The Intermediary has identified no authority and no authority exists to support the Intermediary=s application of 1984 RCE limits to FY 1993 costs.

Based upon the plain language of 42 C.F.R. ' 405.482, based upon the clear intent of the Secretary in her published comments to update RCE limits and publish revised RCE limits before the cost reporting periods to which they apply, and based upon the plain language of HCFA Pub. 15-1 ' 2182.6.F, the 1984 RCE limits do not apply to and cannot be enforced in connection with the Provider=s physician compensation costs in FY 1993.

The Provider submits that the application of 1984 RCE limits to FY 1993 costs violates Medicare's reasonable cost reimbursement principles, as reflected in 42 U.S.C. ' 1395x(v)(1)(A), and 42 C.F.R.

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[20] Provider Exhibit 8.

'' 413.5 and 413.9. The Medicare statutory definition of Areasonable cost,@ as reflected in ' 1861(v)(1)(A) of the Social Security Act, 42 U.S.C. 1395x(v)(1)(A), allows the Secretary to promulgate regulations to establish cost limits on specific items and services, but the cost limits must be based on Aestimates of the costs necessary in the efficient delivery of needed health services to Medicare beneficiaries.@ As established by the AMA surveys, CPI indices and Medicare economic indices for the periods between 1984 and 1993, 1984 RCE limits do not adequately estimate the costs necessary to efficiently deliver health care services to Medicare patients in 1993.

The statutory definition of Areasonable cost@ also requires that the Secretary=s regulations Atake 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 the insurance programs established by this title will not be borne by individuals not so covered . . . .@ 42 U.S.C. ' 1395x(v)(l)(A).[21]

Part of the necessary costs of delivering covered services to Medicare patients in FY 1993 was the cost of hospital-based physician compensation. The Provider has established that a significant increase in physician compensation levels occurred between 1984 and 1993. The Provider could not have secured the services of such physicians in 1993 at 1984 compensation levels, and the Intermediary does not dispute that the physician compensation paid by the Provider was necessary. Nonetheless, Medicare is refusing to undertake its appropriate share of physician compensation costs because HCFA has frozen reimbursement of physician compensation at 1984 levels. Unless Medicare shares in FY 1993 costs at current compensation levels, the difference between 1988 and 1993 compensation levels will be borne entirely by non-Medicare patients, in violation of ' 1861(v)(l)(A). University Hospital v. Bowen, 875 F.2d 1207 (6th Cir. 1989)(Only when the costs of Medicare services are properly allocated to the Medicare program is the cost shifting prohibition of ' 1861(v)(1)(A) satisfied.)[22]

The application of 1984 RCE limits to 1993 costs also violates the Medicare cost reimbursement regulation, which provides in relevant part:

> (a) In formulating methods for making fair and equitable reimbursement for services rendered beneficiaries of the program, payment is to be made on the basis of current costs of the individual provider, rather than costs of a past period or a fixed negotiated rate. All necessary and proper expenses of an institution in the production of services, including normal standby costs, are recognized. Furthermore, the share of the total institutional cost that is borne by the program is related to the care

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[21] Provider Exhibit 21.

[22] Provider Exhibit 22.

> furnished beneficiaries so that no part of their cost would need to be borne by other patients.

42 C.F.R. ' 413.5(a).[23]

The application of 1984 RCE Limits to FYE 1993 hospital-based physician compensation violates the express provisions of ' 413.5(a) in all of the following respects:

1. the failure to update RCE limits is neither fair nor equitable;

2. the use of RCE limits based upon outdated statistical estimates is not made on the basis of Acurrent costs of the provider . . . rather than costs of a past period;@

3. the use of outdated RCE limits fails to recognize all necessary and proper costs of the Provider;

4. the use of outdated RCE levels shifts necessary and proper Medicare costs to non-Medicare patients.

Finally, the Medicare regulation governing costs related to patient care provides:

> It is the intent of Medicare that payments to providers of services should be fair to the providers, to the contributors of the Medicare trust funds, and to other patients.

42 C.F.R. ' 413.9(c).[24]

The Provider submits that the application of 1984 RCE limits to 1993 hospital-based physician compensation is not fair to the Provider or its non-Medicare patients. The Secretary, in effect, has imposed a permanent reimbursement freeze on hospital-based physician compensation at the 1984 levels. There is no authority in statute or regulation for such a freeze.

To the contrary, the Medicare cost reimbursement regulations require the payment of current costs. Even if 42 C.F.R. ' 405.482 is interpreted by the Board to not require annual updates to RCE limits, the Medicare reasonable cost statute and regulations would require updates to recognize current necessary costs of the Provider.

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[23] Provider Exhibit 23.

[24] Provider Exhibit 24.

The Provider submits that pursuant to the plain language of 42 C.F.R. ' 405.482 and HCFA Pub. 15-1 ' 2182.6, the 1984 RCE limits can be applied only to 1984 physician compensation, and that in the absence of publication of 1993 RCE limits, no RCE limits can be applied to FY 1993 hospital-based physician costs. In the event, however, that the Board determines that 42 C.F.R. ' 405.482 and HCFA Pub. 15-1 ' 2182.6 permit the application of 1984 RCE limits to FY 1993 costs, the Provider submits that the Medicare reasonable cost statute, 42 U.S.C. ' 1395x(v)(l)(A), and regulations, 42 C.F.R. '' 413.5 and 413.9, require that the 1984 RCE limits be adjusted to recognize current necessary costs of the Provider. In the Federal Register preamble to ' 405.482, the Secretary proposed to update the RCE limits using the CPI-U - Medical Care. The Provider has shown that from 1984 to 1993, the CPI-U Medical Care Index increased 65.6 percent. The Provider=s hospital-based physician compensation, in the aggregate, does not exceed the 1984 RCE limits adjusted by the change in the CPI-U Medical Care. The Provider submits that increasing the 1984 RCE limits by the change in the CPI-U - Medical Care from 1984 to 1993
would recognize the necessary hospital-related physician costs incurred by the Provider and would be consistent with the intent of the Secretary as reflected in the preamble to 42 C.F.R.
' 405.482. At the very least, the 1984 RCE limits should be increased by the applicable proportion of the 56 percent RCE limit increase reflected in the Secretary=s May 5, 1997 notice of RCE update.

The Provider acknowledges that similar issues were addressed by the Board in 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 Administrator, May 21, 1993, Los Angeles County RCE Group Appeal v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 95-D12, December 8, 1994, Medicare and Medicaid Guide (CCH) & 42,983, declined rev. HCFA Administrator, 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)(ALos Angeles@), Rush-Presbyterian - St. Lukes 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) & 45,037, declined rev. HCFA Administrator, February 25, 1997, rev=d. Rush-Presbyterian - St. Lukes=s Medical Center v. Shalala, Case No. 97C 1726, (N.D. Ill. Aug.27, 1997), Medicare and Medicaid Guide (CCH) & 45,697 (ARush-Presbyterian@), and Albert Einstein Medical Center v. Independence Blue Cross, PRRB Dec. No. 98-D9, December 5, 1997, Medicare and Medicaid Guide (CCH) & 45,907, declined rev. HCFA Administrator, January 14, 1998. The Provider requests the Board to reconsider these decisions for the following reasons set forth in the District Court=s decision in Rush-Presbyterian which reversed the Board decision:

> Based on the two preambles to the regulations, it is clear that the Secretary originally intended to update the RCE limits annually. While the Secretary may not be bound by these preambles, the language of

> the regulations themselves also hints at this: it requires HCFA to establish a methodology for determining Aannual [RCE] limits.@ It is true that the regulations do not explicitly require annual updates. However, they do explicitly contain the more general requirement that the limits be based on average physician incomes Ausing the best available data.@ The net effect of all this is, at the very least, that the regulations require the Secretary to establish RCE limits that are based on physicians costs using the most accurate information.
>
> The question again is whether the Secretary=s action or inaction in interpreting and implementing the regulations was arbitrary and capricious -- whether the Secretary's interpretation of her own regulations was A>plainly erroneous or inconsistent with the regulation.@= Thomas Jefferson University, 114 S. Ct. at 2387 (quoting Udall v. Tallman, 380 U.S. 1, 16-17 (1965)). Again, we think that it was. The Secretary has interpreted the regulations as not requiring annual (or even quadrennial) updates. This interpretation comes in the face 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 mere fact that she refused to update the limits is not Aplainly erroneous;@ she might have any number of reasons for interpreting the regulations as not requiring an update. If she were to articulate such a reason, we would be limited to determining whether her explanation could reasonably be related to her decision not to update the limits.
>
> However, she has not articulated any reasoning for her decision not to update the limits. This is an apparent contravention of the regulations= mandates. It is true that the Secretary is usually given a wide berth in interpreting her own regulations. However, when she acts in apparent contravention of those regulations without offering any justification whatsoever, she violates the APA=s proscription on arbitrary and capricious agency action. Therefore, for this reason as well, we hold unlawful the Secretary's decision to apply the 1984 RCE limits to 1988 costs.

Medicare and Medicaid Guide (CCH) & 45,697 at 55,717.

If the Secretary=s application of 1984 RCE limits to 1988 costs were improper in Rush-Presbyterian, the application of those same 1984 RCE limits to 1993 costs in this case are certainly improper. The Provider submits that the 1984 RCE limits should be increased at a minimum by thirty-six percent. This

increase reflects an annual increase of four percent per year, which is consistent with the fifty-six percent increase that was ultimately applied by the Secretary in the May 5, 1997 regulations.

For the foregoing reasons, the Provider requests reversal of the Intermediary=s adjustments as indicated herein.

INTERMEDIARY=S CONTENTIONS:

The Intermediary=s adjustment restricting program payments for the Provider=s fiscal year ended December 31, 1993 HBP costs to the 1984 RCE limits is proper. The RCE limits must be applied to determine reasonable costs pursuant to 42 C.F.R. ' 405.480(c) and 42 C.F.R. ' 405.482. In this regard, the Intermediary asserts that it complied with existing regulations and applied RCE limits in effect for the subject cost reporting period.

The Statute at 42 U.S.C. '1395xx(a)(2)(B) directs the Secretary to establish by regulation RCE limits applicable to professional services rendered in hospitals. In compliance with the statute, HCFA published RCE limits in 48 fed. Reg. 8902 (March 2, 1983). Subsequently, the RCE limits were updated in 50 Fed. Reg. 7123 (February 20, 1985), effective for cost reporting periods beginning on or after January 1, 1984.

The Medicare regulation at 42 C.F.R. ' 415.70 (previously stated in 42 C.F.R. ' 405.482) states:

> (A) Principle and scope. (1) . . . HCFA establishes reasonable compensation equivalency limits on the amount of compensation paid to physicians by providers....

Id.

Subparagraph (A) specifies that HCFA will be the entity that has the authority and is responsible for establishing RCE limits. Nowhere in subparagraph (A) does it require or refer to limits being updated yearly or annually. It also states:

> (b) Methodology for establishing limits. HCFA establishes a methodology for determining annual reasonable compensation equivalency limits...

42 C.F.R. ' 415.70.

This part of the regulation substantiates that HCFA will be the entity that is responsible for constructing the method by which RCE limits are calculated. HCFA could decide at any time to recalculate the RCE limits. However, they are not currently updating these limits yearly. In section (b) the term Aannual@ is used. Taken in context, this is an identifiable term and not a descriptive term. The word Aannual@ is

used in section (b) to identify the period by which the amount of salary is measured. It is not meant to describe the time frame in which HCFA must update RCE limits.

Subsection (f)(1) of 42 C.F.R. ' 415.70 requires that prior to the beginning of a cost report period to which limits apply, HCFA will publish in the Federal Register the amounts and calculation of the limits. This has occurred. The same limits have been applied to several years. Before the fiscal year at issue began, the limits were applied and published in the Federal Register. 48 Fed. Reg. 8902 (March 2, 1983).

The remainder of the regulation at 42 C.F.R. ' 415.70(f)(2) and (3) is in regard to varying notification procedures to be used if HCFA decides to make changes to the RCE limits based on mere economic index data or change in the calculation methodology. These areas of the regulation clearly indicate that HCFA has notification options depending on the changes it decides to implement. Since HCFA has decided not to make any changes up to the year at issue (FYE June 30, 1993) in economic data used or calculation methodology, it is obvious that the RCE limits will remain constant. Therefore, the Intermediary properly applied the most current RCE limits established by HCFA to the Provider=s HBP compensation for the cost reporting period ending June 30, 1993.

The statute at 42 U.S.C. ' 1395xx(a)(2)(B) directs the Secretary to establish by regulation RCE limits applicable to professional services rendered in hospitals. In compliance with the statute, HCFA published RCE limits in the Federal Register. 48 Fed. Reg. 8902 (March 2, 1983). Subsequently, the RCE limits were updated in 50 Fed. Reg. 7123 (February 20, 1985), effective for cost reporting periods beginning on or after January 1, 1984.

Contrary to the Provider=s contention that the RCE limits published in 1985 should not have been applied to its fiscal year ended June 30, 1993 HBP costs because they had not been updated and were obsolete, HCFA is not required by regulation or statute of update the limits. The support for this position is found in the numerous Board decisions, one district court decision and one court of appeals decision which have held that HCFA is not mandated by the Medicare law or regulations to update the RCLs on an annual basis.

For example, in the Board decision in Los Angeles, supra, it states:

> HCFA is required under Reg. Sec. 405.482(a) to establish reasonable compensation equivalent limits that are applied to the costs incurred by providers in compensating physicians for services rendered to providers. The regulation does not require that the RCE be updated annually... Contrary to the providers= contentions, the governing re-regulation does not mandate that the RCE be updated annually, but merely establishes the notification procedure to be followed. The Intermediary properly applied the existing RCE limits that were

> published in the Federal Register on February 20, 1985, and were applied to cost reporting periods beginning on or after January 1, 1984.

Id. at CCH ¶42,983 at 42,955.

This conclusion was affirmed by the Board in Rush-Presbyterian, supra, which states:

> The principle and scope stated at 42 C.F.R. § 405.482(a)(1) require HCFA establish RCE limits on the amount of compensation paid to doctors by providers, and such limits are to be applied to a provider's costs incurred in compensating physicians for services to the provider. However, 42 C.F.R. § 405.482(A) does not require such limits to be updated annually. Contrary to the Provider=s contentions, the Board majority finds that this regulation does not mandate that the RCLs used to limit allowable physician compensation are to be updated annually, but merely establishes the notification procedure to be followed. The Board majority finds that the Intermediary properly applied the most recent RCLs published by HCFA in 1984.

Id. at CCH ¶45,037 at 52,571.

More recently, this conclusion was affirmed by the Board in Albert Einstein, supra, which states:

> [t]he principle and scope of the enabling regulation, 42 C.F.R. § 405.482(a)(1), require HCFA to establish RCE limits on the amount of compensation paid to physicians by providers, and that such limits Abe 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.

Id. at CCH ¶45,907 at 56,250.

The Provider addresses the fact that the decision in Rush-Presbyterian was overturned by the District Court in the Northern District of Illinois, Eastern Division. The Intermediary contends that this decision was rendered in a different district than the instant case and is, therefore, not applicable. Furthermore, this decision was acknowledged in the Board=s decision on Albert Einstein where the Board found:

> the court=s analysis hinged on the factor that the Secretary failed to articulate her reasons for not updating the RCE limits. In light of

> previous decisions, as well as the court decisions issued in County of Los Angeles v. Shalala and County of Los Angeles v. Secretary of Health and Human Services, the Board chooses to affirm its prior position. The Board concludes 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.

Id. at CCH & 45,907 at 56,250.

The regulations are clear that 42 C.F.R. ' 415.70 requires HCFA to establish RCE limits on the amount of compensation that is paid to physicians by providers and these limits are to be applied by the intermediary to the provider=s costs incurred in compensating physicians for services provided. Nowhere does it state that HCFA is required to update the RCE limits every year. Therefore, the Intermediary properly applied the most current RCE limits established by HCFA to the Provider=s HBP compensation for the cost reporting period ending June 30, 1993.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

' 551 et seq.	-	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 et seq. (Redesignated as 415.55	-	General Payment Rules
' 405.482 et seq. (redesignated as ' 415.70)	-	Limits on Compensation for Services of Physicians in Providers
'' 405.1835-.1841	-	Board Jurisdiction

' 413.5 et seq. - Cost Reimbursement: General

' 413.9 et seq. - Cost Related to Patient Care-Application

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

' 2182.6 - Conditions for Payment for Costs of Physicians= Services to Providers

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

5. Case Law:

Albert Einstein Medical Center v. Independence Blue Cross, PRRB Dec. No. 98-D9, December 5, 1997, Medicare and Medicaid Guide (CCH) & 45,907, declined rev. HCFA Administrator, January 14, 1998.

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 Administrator, May 21, 1993.

Los Angeles County RCE Group Appeal v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 95-D12, December 8, 1994, Medicare and Medicaid Guide (CCH) & 42,983, declined rev. HCFA Administrator, 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).

Rush-Presbyterian - St. Lukes 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) & 45,037, declined rev. HCFA Admininistrator, February 25, 1997, rev=d, Rush-Presbyterian - St. Lukes=s Medical Center v. Shalala, Case No. 97C 1726, (N.D. Ill. Aug.27, 1997), Medicare and Medicaid Guide (CCH) & 45,697.

University Hospital v. Bowen, 875 F.2d 1207 (6th Cir. 1989)

6. Other

47 Fed Reg. 43578 (Oct. 1, 1982).
48 Fed. Reg. 8902 (March 2, 1983).
50 Fed Reg. 7123 (Feb. 20, 1985).
51 Fed. Reg. 42007 (Nov. 20, 1986).
54 Fed. Reg. 5946 (Feb.7, 1989).
58 Fed. Reg. 46322 (September 1, 1993)
62 Fed. Reg. 24483 (May 5, 1997).
American Medical Association, Chicago, IL., Socioeconomic Characteristic of Medical Practice, 1989 and 1995.

FINDINGS OF FACT, CONCLUSIONS 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 its fiscal year ended June 30, 1993. 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 principle and scope of the enabling regulation, 42 C.F.R. ' 405.482(a)(1), require HCFA to establish RCE limits on the amount of compensation paid to physicians by providers, and that such limits Abe 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 Federal Registers, 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, it does not require annual updates.

The Board fully considered the Provider=s argument that data compiled by the American Medical Association, increases in the CPI, and increases in the RCE limits issued by HCFA for 1997, clearly illustrate undisputed increases in net physician income throughout the period spanning 1984 through the fiscal year in contention. The Board also notes that the Provider has presented other inflation data sources that clearly indicate costs had increased during this time.[25] While the Board finds the data and argument persuasive in demonstrating that the subject RCE limits may be lower than actual market

[25] See Provider Exhibits 4, 6 and 7.

conditions would indicate for the subject cost reporting period, the Board finds that it is bound by the governing law and regulations.

The Board also rejects the Provider=s argument that HCFA=s failure to update the RCE limits results in Medicare reimbursing provider=s less than their Areasonable 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 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 limits results in cost shifting in violation of 42 U.S.C. ' 1395x(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 County of Los Angeles, supra. 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 Illinois, Eastern Division, did find in favor of the provider in Rush-Presbyterian, supra. 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 had the Secretary presented her arguments for not revising the limits, the court would likely have decided the case against the provider as the courts have done in the County of Los Angeles v. Shalala cases. 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: September 18, 2001

FOR THE BOARD

Irvin W. Kues
Chairman