PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON THE RECORD
2000-D53

PROVIDER -
Strong Memorial Hospital
Rochester, NY

Provider No. 33-0285

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Empire Medicare Services (formerly Empire
Blue Cross and Blue Shield)

DATE OF HEARING-
September 14, 2001

Cost Reporting Period Ended -
December 31, 1992

CASE NO. 96-0180

INDEX

ISSUE:

Did the Intermediary use the correct reasonable compensation equivalent (ARCE@) limits to disallow a portion of the Provider=s hospital-based physicians= compensation?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Strong Memorial Hospital (AProvider@) is a 663-bed, acute care, non-profit teaching facility, which is part of the University of Rochester Medical Center, located in Rochester, New York. The Provider also operates a 90 bed psychiatric unit and a 20 bed rehabilitation unit. For the fiscal year ended (AFYE@) December 31, 1992, the Provider incurred compensation costs for its hospital-based physicians which it claimed on its cost report for the purpose of obtaining reimbursement from the Medicare program. Its cost report was audited by Empire Blue Cross and Blue Shield (AIntermediary@) which applied the RCE limits to the physicians= compensation.[1] The RCE limits applied by the Intermediary were issued by the Health Care Financing Administration (AHCFA@) on February 20, 1985, and were applicable to cost years beginning on or after January 1, 1984. The application of the RCE limits reduced Medicare reimbursement by approximately $500,000.

The Provider appealed the Intermediary=s application of the RCE limits to the Provider Reimbursement Review Board (ABoard@) and has met the jurisdictional requirements of 42 C.F.R. '' 405.1835-.1841. The Provider was represented by Leslie Demaree Goldsmith, Esquire, of Ober, Kaler, Grimes and Shriver. The Intermediary=s representative was Bernard M. Talbert, Esquire, of the Blue Cross and Blue Shield Association.

PROVIDER=S CONTENTIONS:

The Provider contends that the Intermediary improperly disallowed portions of the compensation paid to its hospital-based physicians for the fiscal year at issue because the adjustments were based on the obsolete RCE limits applicable to the 1984 cost year. The RCE limits used by the Intermediary were not updated from 1984 through 1997, even though Aupdating@ is required by 42 C.F.R. ' 405.482(b), (f)(1) and (f)(3) which state:

> HCFA will establish a methodology for determining reasonable annual compensation equivalents, considering average physician incomes by

[1] The Intermediary is a subcontractor of the Blue Cross and Blue Shield Association and currently operates under the name of Empire Medicare Services.

> specialty and type of location, to the extent possible using the best available data.
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> 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.
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> 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(b), (f)(1) and (f)(3) (emphasis added).

The Provider contends that the plain language of the regulation requires that the RCE limits be updated annually in order to incorporate the most recent economic index data, i.e., the best available data expressly required by the regulation. In further support of this regulatory requirement, the Provider cites the court=s decision in Rush-Presbyterian-St. Luke=s Medical Center v. Shalala, Case No. 97 C 1726, (N.D. Ill. Aug. 27, 1997) (ARush-Presbyterian@).[2] In that decision, the court ruled that the Secretary=s application of the 1984 RCE limits to the hospital=s 1988 hospital-based physician costs violated the Administrative Procedure Act=s (AAPA@) proscription of arbitrary and capricious agency action. The court found that the RCE regulations Arequire some periodic increase in RCE limits@ and that Aat the very least, . . . the regulations require the Secretary to establish RCE limits that are based on physicians= costs using the most accurate information.@ In this regard, the Provider argues that the fact the regulation requires annual updates is evidenced by HCFA=s own interpretations of 42 C.F.R. ' 405.482. In 1982, when HCFA proposed the RCE limits, it stated: A[w]e propose to update the RCE limits annually on the basis of updated economic index data,@ (emphasis added)) 47 Fed. Reg. 43578 at 43586 (Oct.1, 1982).[3] Then, in 1983, when HCFA adopted the final regulations, it affirmed the need to annually update the RCE limits by stating: A[t]he RCE limits will be updated annually on the basis of updated economic index data@ (emphasis added) 48 Fed. 8902 (March 2, 1983).[4]

Also, HCFA=s course of practice further evidences that published RCE limits apply only to the cost year specified and not to any succeeding cost reporting period as in the instant case. With the promulgation of the final rule, mentioned above, HCFA published RCE limits applicable to Medicare providers= fiscal

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[2] See Provider Exhibit P-11.

[3] See Provider exhibit P-12.

[4] See Provider Exhibit P-5.

years commencing in 1982 and 1983, respectively. In part, HCFA stated:

> [t]he applicable schedule of annual RCE limits is determined by the beginning date of the provider=s cost reporting period. That is, if the provider=s cost reporting period begins during calendar year 1982, the 1982 RCE limits apply to all compensation for physicians in that portion of the period occurring on or after the effective date of these regulations. For provider=s cost reporting period beginning in the calendar year 1983, the 1983 RCE limits will be applied.

48 Fed. Reg. 8902 at 8924 (March 2, 1983).[5]

In addition, when HCFA published new and revised RCE limits for providers= cost reporting periods beginning in 1984, 50 Fed. Reg 7123 (Feb. 20, 1985),[6] it again acknowledged the limited applicability and annual nature of each year=s RCE limits, as follows:

> [o]n 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. 7123 at 7124 (Feb. 20, 1985) (emphasis added).

Nowhere in this regulatory language, 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.

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[5] Id.

[6] See Provider Exhibit P-6.

The Provider maintains that the consistency of HCFA=s interpretation of its own regulation is further evidenced by a proposed rule published in 1989, although never finalized. In the preamble, HCFA indicates the desire that annual updates to the RCE limits no longer be required, and its clear belief that in order to discontinue annual updates, properly, the regulation itself must be changed. HCFA states:

> [s]pecifically, Section 405.482(f) provides that before the start of a cost reporting period to which a set of limits will be applied, we must publish a notice in the Federal Register that sets forth the limits and explains how they were calculated. . . .The latest notice that updated the RCE limits was published in the Federal Register on February 20, 1985 (50 F.R. 7123) and was effective for cost reporting periods beginning on or after January 1, 1984. . . . notice that updated the RCE limits was published in the Federal Register on February 20, 1985 (50 F.R. 7123) and was effective for cost reporting periods beginning on or after January 1, 1984. . . . Although the regulations do not specifically provide for an annual adjustment to the RCE limits, the preamble to the March 2, 1983 final rule, which described the updating process, indicated that the limits would be updated annually. (48 F.R. 8923). In addition, Section 405.482 (f)(1) requires that the limits be published prior to the cost reporting period to which the limits apply. We believe that publishing annual limits, an administratively burdensome procedure, has become difficult to justify. Therefore, we are proposing to make some changes in current Section 405.482. . . . Since we believe that annual updates to the RCE limits will not always be necessary, we proposed to revise current Section 405.482(f) to provide that we would review the RCE limits annually and update the limits only if a significant change in the limits is warranted.

54 Fed Reg. 5946 at 5956 (Fed. 7, 1989) (emphasis added)[7]

The Provider asserts, therefore, that HCFA=s current statement 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 regulation so that annual updates are no longer required.

Furthermore, the Provider asserts that HCFA implemented its interpretation that the regulation requires it to annually update the RCE limits. HCFA set RCE limits for each of the years 1982, 1983, and 1984. Respectively, in the Provider Reimbursement Manual, Part I (AHCFA Pub. 15-1@) HCFA

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[7] See Provider Exhibit P-13.

clearly indicates that the 1984 RCE limits apply only to providers= cost reporting periods beginning in 1984. Specifically, HCFA Pub. 15-1 ' 2182.6C states, in pertinent part:

> [t]he RCE limits are always applied to the hospital=s entire cost reporting year, based on the calendar year in which the cost reporting year begins.

HCFA Pub. 15-1 ' 2182.6C.[8]

In addition, HCFA Pub. 15-1 ' 2182.6F, which sets forth the RCE limit tables and is entitled Estimates of Full-Time Equivalency (FTE) Annual Average Net Compensation Levels for 1983 and 1984, provides: A[t]he following compensation limits apply in the years indicated.@ Id. 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 1991.

With respect to the authoritative nature of HCFA=s manual provisions, the Provider refers to the Seventh Circuit, which stated:

> [a]s 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, U.S. 115 S. Ct. 1232 (1995).[9]

Finally, with respect to the requirements of 42 C.F.R. ' 405.482, the Provider asserts that three internal HCFA memoranda also substantiate that the RCE limits must be updated each year.[10] The document dated July 27, 1983, indicates that HCFA will annually publish an update of the RCE limits, and that the regulation Aprovides 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.@ Id. The document dated October 7, 1983, clearly suggests that HCFA was aware of the requirement that RCE limits be updated annually and that updated limits be published even if the RCE limit setting methodology is unchanged. The last document, dated May 5, 1983, is one in which HCFA recognizes the fact that providers, in negotiating physician contracts, rely on the Secretary

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8 See Provider Exhibit P-14.

9 See Provider Exhibits P-15 and P-16, respectively.

10 See Provider Exhibit P-17 (A)(B) and (C).

of Health and Human Services= (ASecretary@) expressed acknowledgment of her duty to update the RCE limits on an annual basis.

The Provider contends that HCFA=s failure to update the 1984 RCE limits violates the intent of the enabling statute and Congress. Pursuant to 42 U.S.C. ' 1395xx, program reimbursement for Medicare Part A physician costs must be Areasonable.@ Congress expressly stated that the intent in differentiating between Part A and Part B physicians= costs was to:

> assure the appropriate source of payment , while continuing to reimburse physicians a reasonable amount for the services they perform. Our intention was not to penalize but rather to create some equity between the way we pay physicians generally and the way we pay those who are hospital based.(Congressional Record, vol.128, No. 15, August 19, 1982. S 10902.)

47 Fed Reg. 43578 (Oct. 1, 1982) (emphasis added).[11]

Although Congress authorized HCFA to publish and apply RCE limits, the Provider contends that these limits must 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. The Provider notes that 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 cites the following pertinent portion of the district court=s decision:

> The APA (as well as basic notions of due process) requires that she not exercise this authority arbitrarily and capriciously. While we are required to afford the Secretary significant discretion in the exercise of the authority, we do not afford her absolute discretion: she must have some basis for exercising her authority in the way that she does . .

Rush - Presbyterian.[12]

The Secretary established a mechanism for determining RCE limits for 1984. She does not dispute that physicians= costs increased between 1984 and 1988 [the cost year at issue]. She decided to leave

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[11] See Provider Exhibit P-12.

[12] See Provider Exhibit P-11.

those limits intact over that period. She does not attempt to justify that decision; she argues simply that she has the authority to make whatever decision she deems proper. This is exactly the type of absolute discretion that the APA prohibits: while agencies are afforded significant discretion, their decisions must have some basis. The Secretary has offered none here. Therefore, under the APA, we must hold unlawful and set aside her application of 1984 RCE limits to costs incurred in 1988.

Id.

The Provider further advises that the Secretary withdrew her appeal of the district court=s decision in Rush-Presbyterian, and the Seventh Circuit dismissed the appeal with prejudice on January 26, 1998. The case was subsequently remanded to the HCFA Administrator with orders to update the RCE limits applicable to the fiscal year at issue in that appeal.

The Provider argues that the application of the 1984 limits to the cost reporting period at issue will not result in reasonable reimbursement for its hospital-based physicians= costs. As the court stated in Rush-Presbyterian, A[the Secretary] does not dispute that physicians= costs increased between 1984 and 1988 [the year at issue]. She decided to leave those limits intact over that period. She does not attempt to justify that decision Y.@ Id. Similarly, the Provider cites the dissenting opinion in the Board=s decision for 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 & Medicaid Guide (CCH) & 42,983 (ALos Angeles@),[13] aff=d sub nom., County of Los Angeles v. Shalala, Case No. CV 95-0163 LGB (SHx) (C.D. Cal. 1995) Dec. 13, 1995),[14] aff=d. County of Los Angeles v. Secretary of Health and Human Services, 113 F. 3d 1240 (9th Cir. 1997).[15] The dissenting opinion noted the following:

> [c]learly, 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 questions in this appeal.

Id.

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[13] See Provider Exhibit P-21.

[14] See Provider Exhibit P-22.

[15] See Provider Exhibit P-23.

The Provider argues that any conjecture that no upward revisions to the limits were necessary to assure reasonable compensation after 1984 is clearly refuted by the following:

- Information complied by the American Medical Association demonstrates that a rapid escalation of physicians= salaries across specialities and locations occurred during the latter half of the 1980s and early 1990s. For example, in 1984, the mean physician net income (in thousands of dollars) of all physicians was 108.4. This amount increased to 181.7 in 1992.[16]

- HCFA continued to update 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 HCFA. See 51 Fed. Reg. 42007 (Nov. 20, 1986).[17]

- HCFA revised the RCE limits for 1997, which it published in the Federal Register. See 62 Fed Reg. 24483 at 24484 (May 5, 1997).[18] Using the same methodology as it used for the last updates provided in 1985 for FYE 1984, HCFA increased the total RCE limits by greater than 50 percent between 1984 and 1997.

The Provider asserts that an update of Part B physician compensation without a concomitant update of Part A physician compensation is clearly proof of unreasonableness. HCFA had annual economic data relating to physician compensation increases and physician fee increases but failed to utilize this data to update the RCE limits. This failure is inconsistent with program instructions at HCFA Pub. 15-1 ' 2182.6C, which states that the Abest available data are [to be] used . . . [and] [t]he RCE limit represents reasonable compensation for a full-time physician.@ Moreover, 42 C.F.R. ' 413.9(c)(1) requires that payments to providers be Afair.@ Thus, HCFA=s failure to update the RCE limits effectively violates this regulatory requirement as well.

The Provider contends that HCFA=s failure to update the RCE limits on an annual basis constitutes a substantive change to a program standard which is invalid, since it was not implemented in accordance with the Administrative Procedure Act (AAPA@). 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 be adopted only after consideration of public comments pursuant to 5 U.S.C. ' 553.[19] See Buschmann v. Schweiker, 676 F. 2d 352, 355-56 (9th Cir. 1982),[20] where

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16 See Provider Exhibit P-9.

17 See Provider Exhibit P-19.

18 See Provider Exhibit P-10 and P-20.

19 See Provider Exhibit P-24.

substantive rules affecting Medicare reimbursement are invalid unless promulgated in accordance with APA procedures.

In compliance with the APA=s notice and comment requirement, HCFA established the methodology that was to be applied in annually updating the RCE limits. HCFA, complying with this methodology, set the RCE limits for the 1982, 1983 and 1984 cost years. For each year, application of this methodology resulted in an increase in the limits in accordance with data on average physician specialty compensation and updated economic index data. However, without providing any notice or opportunity for comment, and without offering any explanation for departing from its prior practice of annually updating the RCE limits in compliance with the published methodology, HCFA abruptly stopped updating the RCE limits even though inflationary changes mandated an update. This change is invalid for noncompliance with the APA.

The Provider notes that HCFA=s failure to update the RCE limits, constituting a substantive change in the RCE methodology, is also inconsistent with 42 C.F.R. ' 405. 482(f)(2), which provides:

> [i]f HCFA proposes to change 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.

42 C.F.R. ' 405. 482 (f)(2)(emphasis added).
The Provider asserts 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 the quoted subsection; the change was not preceded by prior notice and opportunity for public comment. The Provider cites Morton v. Ruiz, 415 U.S. 199, 235 (1974), where the Supreme Court noted that an agency must comply with its own procedures

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[20] See Provider Exhibit P-26.

when the rights of individuals are at stake.[21] Therefore, the Board is foreclosed from giving effect to a change in methodology that violates the clear wording of the RCE regulation and the APA.

The Provider contends that failure to update the RCE limits violates 42 U.S.C ' 1395x(v)(1)(A), which directs HCFA to assure through regulations that Medicare providers= costs of providing services are reimbursed and that Athe necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be born by individuals not so covered, and the costs with respect to individuals not so covered will not be born by such insurance programs. . . .@ See also 42 C.F.R. ' 413.5.[22] Respectively, HCFA=s failure to continue updating the RCE limits after 1984 means that Medicare providers are under- reimbursed for their Medicare Part A physicians= costs. This failure to update consequently resulted in non-Medicare patients bearing increased Part A physician costs, which should have been born pro rata by the Medicare program. This is contrary to the direct instructions of Congress as Medicare costs were shifted to non-Medicare patients.

The Provider points out that the issue of whether or not HCFA is bound to annually update the RCE limits has, to date, been raised in a number of appeals. In Good Samaritan Hospital and Health Center v. Blue Cross and Blue Shield Association/Community Mutual Ins. Co., PRRB Dec. No. 93-D30, April 1, 1993, Medicare and Medicaid Guide (CCH) & 41,399,[23] declined rev. HCFA Admin, May 21, 1993, the Board, in a two-to-one decision, concluded that the RCE regulation promulgated by HCFA did mandate that the RCE limits be updated annually. The Board majority came to the same conclusion in Los Angeles. However, the Board majority, while conceding that HCFA was not required to annually update the RCE limits, stated:

> [t]he Board majority fully considered the physician compensation study published by the American Medical Association which illustrates undisputed increases 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

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[21] See Provider Exhibit P-27.

[22] See Provider Exhibit P-28.

[23] See Provider Exhibit P-29.

> 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.

Los Angeles, Medicare & Medicaid Guide (CCH) at ' 42,983.

The Provider further notes that the Board ruled similarly in several recent decisions, and the HCFA Administrator declined to review the Board=s decisions.[24] With respect to Los Angeles, the Provider disagrees with the holdings in the Board=s decision and the District Court=s and Ninth Circuits=s decisions because it believes 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. As to the decisions of the District and Appeals Courts, the 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. See supra. The courts refused to give any weight to HCFA=s discussion of the RCE updates promulgated in 1989, 54 Fed. Reg. 5946 (Feb. 7, 1989) (Provider Exhibit P-13).

In summary, the Provider contends that it is clear from HCFA=s Federal Register discussions, its own actions in initially setting and then updating the RCE limits on an annual basis for three consecutive fiscal

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[24] See also 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 (Provider Exhibit P-30); 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 (Provider Exhibit P-31); Pomerado Hospital v. Blue Cross and Blue Shield Association/Blue Shield Association/Blue Cross of California, PRRB Dec. No. 96-D20, March 13, 1996, Medicare and Medicaid Guide (CCH) & 44,072 (Provider Exhibit P-32); 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 (Provider Exhibit P-33) (ARush-Presbyterian@); Albert Einstein Medical Center v. Independence Blue Cross, PRRB Dec. No. 98-D9, December 5, 1997, Medicare and Medicaid Guide (CCH) & 45,907, (AAlbert Einstein@) (Provider Exhibit P-34); 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 (Provider Exhibit P-35); and 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 Medicaid Guide (CCH) & 80,163 (Provider Exhibit P-36).

years, HCFA Pub. 15-1 '' 2182.6C and 2182.6F, and three HCFA intra-agency memoranda, that the RCE limits were intended to, and should have been updated annually. The RCE limits published to date are specifically limited to the years indicated, i.e., fiscal years beginning in 1982, 1983, 1984, and 1997, respectively. Therefore, they do not apply to the subject cost reporting period. Moreover, HCFA abruptly departed from its consistent practice of annually updating the RCE limits without providing any notice or opportunity for public comment. HCFA failed to make any upward revisions to the limits from 1984 through 1997 thereby failing to abide by its own regulations. The Supreme Court has long held that an agency may not violate its own regulation. Morton v. Ruiz, 415 U.S. 199, 235 (1974).[25] By failing to update the RCE limits from 1984 to 1997 in accordance with its prescribed methodology, HCFA has failed to abide by its own regulation and, thus, no RCE limits apply to the Provider=s fiscal year at issue. Consequently, the Provider contends that it should be reimbursed for its actual Part A physicians= costs so long as they are otherwise reasonable. See Abington Memorial Hospital v. Heckler, 750 F.2d 242, 244 (3rd Cir. 1984), where the court ruled that where a particular rule or method of reimbursement is invalidated, the prior method of reimbursement must be utilized. In the alternative, the Provider requests that the Intermediary or HCFA be ordered to update the RCE limits for the cost year at issue using the methodology established in the 1982 and 1983 Federal Registers for updating the RCE limits, and adopted by the Secretary to update the RCE limits for 1983, 1984 and 1997, and apply the newly updated RCE limits to the Provider=s hospital-based physicians= costs for the fiscal year in contention.

INTERMEDIARY=S CONTENTIONS:

The Intermediary contends that it properly applied the relevant RCE limits to the physician compensation costs claimed by the Provider on its Medicare cost report for the fiscal year ended December 31, 1992. RCE limits must be applied to determine reasonable costs pursuant to

[25] See Provider Exhibit P-27.

42 C.F.R. ' 405.480(c) and ' 405.482.[26] The Intermediary asserts that it complied with the existing regulations and applied RCE limits in effect for the subject cost reporting period.

The RCE limits applied to the Provider=s physicians= compensation were published by HCFA in 50 Fed. Reg. 7123 (February 20, 1985), and were effective for cost reporting periods beginning on or after January 1, 1984.[27] In accordance with the regulation, HCFA is the entity that has the authority and responsibility for establishing RCE limits. Whereas HCFA may have expressed its intent to issue annual updates when it published the initial RCE limits, which is also expressed in 42 C.F.R. ' 405.482(b), the Intermediary contends that the rule contains no language compelling HCFA to publish RCE limits on an annual basis. Moreover, HCFA has consistently interpreted its rule as not mandating annual updates.

The regulation at 42 C.F.R. ' 405.482 (f)(1) requires HCFA to publish in the Federal Register the amounts and calculation of the RCE limits prior to the beginning of a cost reporting period to which the limits apply. The remainder of the regulation at 42 C.F.R. ' 405.482 (f)(2) and (f)(3) relates to varying notification procedures to be used by HCFA if it decides to make changes to the RCE limits based on economic index data or to change the calculation methodology. The Intermediary maintains that the regulatory provisions impose no obligation on HCFA to make annual updates, but merely set forth the steps which must be followed if it elects to update the RCE limits or modify the formula for calculating them.

In support of its position, the Intermediary cites numerous Board decisions and a district court and court of appeals decision, which have held that HCFA is not mandated under Medicare law and regulations to update the RCE limits on an annual basis. The Intermediary refers to some of the same decisions cited by the Provider where the Board has consistently found that the language of the enabling regulation does not require annual updates, and that the intermediaries have properly applied the existing regulations. For example, in an early decision rendered in 1993 for Good Samaritan, the Board majority found that the regulations at 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 decision, the Board has consistently held that HCFA is not mandated by the statute or regulations to update the RCE limits each year.

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[26] See Intermediary Exhibits I-2 and I-3.

[27] See Intermediary Exhibit I-1.

The Intermediary recognizes that the Board=s decision in Rush-Presbyterian was overturned by the district court in Rush-Presbyterian - St. Luke=s Medical Center v. Shalala, Case No. 97C 1726, (N.D. Ill. August. 27, 1997).[28] However, the Intermediary points out that the Board is not bound by the ruling of a district court. In fact, the Board squarely rejected the district court=s reasoning when it upheld the intermediary in the decision rendered for Albert Einstein on December 5, 1997.[29] Moreover, the Board=s decision in Los Angeles was upheld by a California district court, whose decision was affirmed on appeal in an unpublished opinion by the United States Court of Appeals for the Ninth Circuit.[30] In that decision, the Court of Appeals held that the regulation at 42 C.F.R. ' 405.482 does not unambiguously compel annual updates of the RCE limits.

Based on the arguments presented and the Board=s rulings in prior decisions, the Intermediary requests that the Board affirm its application of the RCE limits promulgated in 1985 to the fiscal year at issue in the instant appeal.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

' 553 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 CertainPercentage Arrangements

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

' 405.480 (c) (Redesignated as 415.55(c)	-	Limits on Allowable Costs

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[28] See Intermediary Exhibit I-12.

[29] See Intermediary Exhibit I-11.

See Intermediary Exhibit I-13.

' 405.482 et seq. (Redesignated as 415.70)	-	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)
' 2182.6C	-	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 Ins. 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 Association/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. 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 Association/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/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 Admin., February 25, 1997, rev'd. Rush-Presbyterian - St. Lukes's Medical Center v. Shalala, Case No. 97C 1726, (N.D. Ill. Aug.27, 1997).

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 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 Medicaid Guide (CCH) **&** 80,163, declined rev. HCFA Admin., April 13, 1999.

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

Abington Memorial Hospital v. Heckler, 750 F.2d 242 (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, U.S. 115 S. Ct. 1232 (1995).

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

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 December 31, 1992. 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, ie., 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. 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 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. 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-St. Luke=s Medical Center v. Shalala, No. 97C 1726 (N.D. Ill. Aug. 27, 1997). However, the Board finds that the courts= 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 County of Los Angeles v. Shalala, Case No. CV 95-0163 LGB (SHx) (C.D. Cal. 1995), and County of Los Angles 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: September 28, 2001

FOR THE BOARD

Irvin W. Kues
Chairman