PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

99-D26

PROVIDER -
Albert Einstein Medical Center
Philadelphia, Pennsylvania

Provider No. 39-0142

vs.

INTERMEDIARY -
Blue Cross and Bllue Shield
Association/ Vertus Medicare Services

DATE OF HEARING-
January 21, 1999

Cost Reporting Period Ended -
June 30, 1990

CASE NO. 94-1159

INDEX

ISSUE:

Was the Intermediary's use of reasonable compensation equivalent ("RCE") limits from 1984 to reduce the amount of compensation paid by the Provider to its hospital-based physicians for fiscal year 1990 proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Albert Einstein Medical Center ("Provider") is a not-for-profit health care facility located in Philadelphia, Pennsylvania. It consists of a 600 bed acute care hospital with a distinct part psychiatric unit, a skilled nursing facility, and a home health agency.

During its fiscal year ended June 30, 1990, the Provider incurred physicians' compensation costs for hospital-based physician ("HBP") services. The Provider claimed these costs on its as-filed cost report for the purpose of obtaining program reimbursement. Independence Blue Cross and Blue Shield ("Intermediary")[1] examined the Provider's cost report and applied RCE limits to the physicians' compensation. The RCE limits used by the Intermediary were issued by the Health Care Financing Administration ("HCFA") on February 20, 1985, and were effective with cost reporting periods beginning on or after January 1, 1984. The Provider estimated that the application of the RCE limits issued in 1985 to its 1990 cost report resulted in an $11,000 decrease in its total Medicare reimbursement for the period.[2]

On July 30, 1993, the Intermediary issued a Notice of Program Reimbursement reflecting the application of the RCE limits. On January 21, 1994, the Provider appealed the Intermediary's determination to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835-.1841, and has met the jurisdictional requirements of those regulations.[3]

The Provider was represented by Carel T. Hedlund and Jillian Wilson of Ober, Kaler, Grimes & Shriver. The Intermediary was represented by Bernard M. Talbert, Associate Counsel, Blue Cross and Blue Shield Association.

---

[1] The current intermediary is Veritus Medicare Services.

[2] Position Paper and Exhibits in Support of Provider at 3.

[3] Intermediary's Position Paper at 1.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary's adjustment is improper because it is based upon RCE limits that were obsolete and not applicable to the subject cost reporting period.[4] The RCE limits used by the Intermediary were published by HCFA on February 20, 1985, and are applicable to cost reporting periods beginning in 1984. The limits had not been updated to apply to cost reporting periods beginning in 1989, which would include the subject reporting period, even though "updating" 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 specialty and type of location, to the extent possible using the best available data.
>
> 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.
>
> 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).

Since HCFA did not update the RCE limits using the most recent available data as required by the regulation, the Intermediary's application of the limits to the subject Medicare cost reporting period is improper.

The Provider maintains that the plain language of the regulation requires that the RCE limits be updated annually.[5] Moreover, if the regulation is found to be ambiguous, it must be construed to require annual updating.[6] 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: "[w]e propose to update the RCE limits annually on the basis of updated economic index data", (emphasis added) 47

---

[4] Position Paper and Exhibits in Support of Provider at 9.

[5] Id.

[6] Position Paper and Exhibits in Support of Provider at 10.

Fed. Reg. 43578 at 43586 (Oct 1, 1982).[7] Then, in 1983, when HCFA adopted the final regulations it affirmed the need to annually update the RCE limits by stating: "[t]he RCE limits will be updated annually on the basis of updated economic index data" (emphasis added) 48 Fed. Reg. 8902 (March 2, 1983).[8]

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 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).[9]

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),[10] 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

---

7 Exhibit P-13.

8 Exhibit P-5.

9 Id.

10 Exhibit P-6.

> 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.

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.[11] 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 . . . 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 propose 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.

---

[11] Position Paper and Exhibits in Support of Provider at 12.

54 Fed. Reg. 5946 at 5956 (Feb. 7, 1989) (emphasis added).[12]

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.[13] HCFA set RCE limits for each of the years 1982, 1983, and 1984. Respectively, in the Provider Reimbursement Manual, Part I ("HCFA Pub. 15-1") HCFA 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.

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: "[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 1990.

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).[14]

---

[12] Exhibit P-14.

[13] Position Paper and Exhibits in Support of Provider at 13.

[14] Exhibits P-17 and P-18, respectively.

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.[15] The document dated July 27, 1983, indicates that HCFA will annually publish 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." 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 of Health and Human Services' ("Secretary") 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.[16] Pursuant to 42 U.S.C. § 1395xx, program reimbursement for Medicare Part A physician costs must be "reasonable." 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).[17]

Respectively, application of the 1984 limits to the subject cost reporting period will not result in reasonable reimbursement for the Provider's HBP costs. A dissenting opinion in Los Angeles County RCE Group Appeal v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of California , PRRB Dec. No. 95-D12, Dec. 8,1994, Medicare & Medicaid Guide (CCH) ¶ 42,983
("Los Angeles")[18] explains that application of the 1984 limits to the 1989 cost year will not result in reasonable HBP reimbursement. The dissenting opinion states:

---

[15] Position Paper and Exhibits in Support of Provider at 14. See Exhibit P-19(A), (B) and (C).

[16] Position Paper and Exhibits in Support of Provider at 15.

[17] Exhibit P-13.

[18] Exhibit P-22.

> [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 question in this appeal.

Los Angeles, CCH ¶ 42,993. [19]

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:[20]

- Information compiled by the American Medical Association demonstrates that a rapid escalation of physicians' salaries across specialties and locations occurred during the latter half of the 1980s and early 1990s. For example, in 1983, the mean physician net income (in thousands of dollars) of all physicians was 104.1. This amount increased to 164.4 in 1990. See Exhibit P-10.

- HCFA updated physician screens for Part B payments to physicians every year since 1983, except for 1985. 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).[21]

- HCFA's methodology for updating the limits requires an update corresponding with the increase in the Consumer Price Index ("CPI"). HCFA's stated rationale for implementing this particular methodology was that 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. 8902 at 8923 (Mar. 2, 1983).[22] In this regard, the CPI increased from 1984 through 1990. For example, the CPI for all urban consumers for all items in 1980, was 82.4. In 1985, it increased to 107.6. In 1990, the CPI soared to 130.7. See Exhibit P-9.

---

[19] Exhibit P-22.

[20] Position Paper and Exhibits in Support of Provider at 16 and 17.

[21] Exhibit P-21.

[22] Exhibit P-5.

- HCFA finally increased the RCE limits for 1997, acknowledging a greater than 50 percent increase in HBP compensation costs between 1984 and 1997. 62 Fed. Reg. 24484 (May 5, 1997). See Exhibits P-12 and P-15.

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 "best 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 "fair." 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 ("APA").[23] 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.[24] See Buschmann v. Schweiker, 676 F.2d 352, 355-56 (9th Cir. 1982),[25] where 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:

---

[23] Position Paper and Exhibits in Support of Provider at 19.

[24] Exhibit P-7.

[25] Exhibit P-26.

> [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. at 235 (1974), where the Supreme Court noted that an agency must comply with its own procedures when the rights of individuals are at stake.
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 "the 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.[26] 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 contends that prior case law is not applicable to the instant case because it is unpersuasive and distinguishable.[27] Specifically, 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,[28] 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 majority came

---

[26] Position Paper and Exhibits in Support of Provider at 22.

[27] Position Paper and Exhibits in Support of Provider at 23.

[28] Exhibit P-29.

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 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, CCH ¶ 42,993.

In all of these cases the HCFA Administrator declined to review the Board's decisions.[29] The providers in Los Angeles appealed to the District Court for the District of Central California. County of Los Angeles v. Shalala, Case No. CV 95-0163 LGB (SHx) (C.D. Cal.1995).[30] The District Court, in an unpublished decision, ruled in favor of the Secretary concluding that the plain meaning of the regulation did not mandate annual updates of the RCE limits despite the fact that HCFA had itself interpreted the regulation to require annual updating. The Provider argues, however, that the Court refused to give any weight to HCFA's discussion of the RCE updates promulgated in 1989, 54 Fed. Reg. 5946 (Feb. 7, 1989),[31] or to the three HCFA intra-agency memoranda that clearly demonstrate HCFA's commitment to annually update the limits. Supra at Exhibit P-19.

---

[29] See also Palomar Memorial Hospital v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 96-D21, Medicare and Medicaid Guide (CCH) ¶ 44,073 (March 13, 1996) (Exhibit P-30); Pomerado Hospital v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 96-D19, Medicare and Medicaid Guide (CCH)¶ 44,071 (March 13, 1996) (Exhibit P-31); Pomerado Hospital v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 96-D20, Medicare and Medicaid Guide (CCH) ¶ 44,072 (March 13, 1996) (Exhibit P-32); and 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, Medicare & Medicaid Guide (CCH) ¶ 45,037 (January 15, 1997) (Exhibit P-33).

[30] Exhibit P-23

[31] Exhibit P-14.

The Provider explains that the Ninth Circuit affirmed the decision of the District Court in an opinion not designated for publication. County of Los Angeles, d/b/a/ LAC/USC Medical Center, et al. v. Secretary of Health and Human Services, 113 F.3d 1240 (9th Cir. 1997).[32] The Provider also explains that the Ninth Circuit's decision is illogical. The Provider argues that the court, on one hand, acknowledged the Secretary's intention to update the limits annually while, on the other hand, accepted the Secretary's argument that the regulations do not require annual updating.

The Provider disagrees with the holdings in these cases on a number of grounds, as discussed above.[33] However, the Provider also argues that even if the reasoning in these cases is adopted they are distinguishable. That is, the issue in all these cases was whether or not the regulation promulgated by HCFA bound it to annually update the RCE limits. But the Board majorities, the District Court, and the Ninth Circuit did not consider:

- whether HCFA, by failing to annually update the RCE limits, acted contrary to the Congressional mandate that only costs found to be unreasonable by virtue of application of valid RCE limits be disallowed;

- whether HCFA's misrepresentation to the public regarding its intention to annually update the RCE limits, and its failure to give the public a meaningful opportunity to comment on the timing of the updating process renders the RCE regulation void for noncompliance with the notice and comment requirements of the APA;

- whether or not HCFA's failure to annually update the RCE limits resulted in "cost - shifting" in violation of Congress' prohibition against program costs being born by non-Medicare patients;

- the relevancy of the language in the preamble to HCFA's proposed rule at 54 Fed. Reg. 5946 (Feb. 7, 1989) (Exhibit P-14), where HCFA acknowledges its intent to annually update the RCE limits and its obligation to amend the regulation if it decides to change its RCE limit methodology; and

- the relevancy and the amount by which the RCE limits were increased by HCFA in 1997, 62 Fed. Reg. 24483 (May 5, 1997) (Exhibit P-12).

The Provider asserts that the Board, having not considered these challenges to HCFA's failure to update the RCE limits since 1984, is thus free to depart from its earlier determinations of this issue.

---

[32] Exhibit P-24.

[33] Position Paper and Exhibits in Support of Provider at 26.

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 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).[34] HCFA also failed to comply with Congress' mandate that the reasonable cost of HBP services be fully reimbursed, since it did not update the RCE limits in accordance with available updated economic index data. This failure resulted in "cost-shifting," which is prohibited by Congress.

Accordingly, no valid RCE limits apply to the fiscal year at issue in this case, and the Provider should be reimbursed for its actual Part A physicians' costs so long as they are otherwise reasonable. See Abington Memorial Hospital v. Heckler, 750 F2d 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.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its adjustment restricting program payments for the Provider's fiscal year ended June 30, 1990 HBP costs to the 1984 RCE limits is proper. 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 Intermediary contends that 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 initial RCE limits in 48 Fed. Reg. 8902, on March 2, 1983.[35] 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.[36]

---

[34] Exhibit P-27.

[35] Exhibit I-3.

[36] Exhibit I-4.

Contrary to the Provider's contention that the RCE limits published in 1985 should not have been applied to its fiscal year 1990 HBP costs because they had not been updated and were obsolete, the Intermediary argues that HCFA is not required to annually update the limits. In support of its position, the Intermediary refers to the same decisions cited by the Provider where the Board found that the language of the enabling regulation does not require annual updates and that the intermediaries have properly applied the existing regulations.[37] The Intermediary notes County of Los Angeles v. Shalala, Case No. CV 95-0163 LGB (SHx) affirming the Board's decision. Since HCFA had chosen not to revise the limits, the already published limits remain in effect and are applicable to the subject cost reporting period.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. 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
5 U.S.C. § 553 et seq.	-	Administrative Procedure Act

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

§ 405.480(c)	-	Limits on Allowable Costs
§ 405.482 et seq.	-	Limits on Compensation for Services of Physicians in Providers
§§ 405.1835-.1841	-	Board Jurisdiction
§ 413.5	-	Cost Reimbursement: General

[37] Intermediary's Position Paper at 3. Exhibit I-6 at A through F.

§ 413.9(c)(1)	-	Cost Related to Patient Care-Application

3. 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

4. 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-Dl2, December 8, 1994, Medicare and Medicaid Guide (CCH) ¶ 42,983, declined rev. HCFA Admin., January 12, 1995, aff'd. County of Los Angeles v. Shalala, Case No. CV 95-0163 LGB (SHx) (C.D. Cal. 1995), aff'd. County of Los Angeles, d/b/a LAC/USC Medical Center, et al. 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 and 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 and 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 & Medicaid Guide (CCH) ¶ 45,037, declined rev. HCFA Admin., February 25, 1997, rev'd. Rush-Presbyterian-St. Luke's Medical Center v. Shalala, No. 97 97-C- 1726, 1997 WL 543061 (N.D.ILL.)

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

Abington Memorial Hospital v. Heckler, 750 F2d 242 (3rd. Cir.1994).

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).

4. 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 June 30, 1990. 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 "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 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 rejects the Provider’s argument that the instant case is distinguishable from previous cases challenging the application of the 1984 RCE limits to subsequent period physicians’ costs. First, the Provider argues 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(a)(2)(B). However, 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 next argument that the instant case is distinguishable because 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 last argument distinguishing the instant case from prior cases, 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 (E.D. IL. filed Aug. 27, 1997). However, the Board finds that the court’s analysis seemly 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 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's application of the 1984 RCE limits to the Provider's physicians' compensation costs is proper. The Intermediary's adjustment is affirmed.

Board Members Participating:
Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esq.
Martin W. Hoover, Jr. Esq.

Date of Decision: February 26, 1999

FOR THE BOARD:

Irvin W. Kues
Chairman