PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON THE RECORD
2000-D22

PROVIDER -
University of North Carolina Hospitals
Chapel Hill, North Carolina

Provider No. 34-0061

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Blue Cross and Blue Shield of North Carolina

DATE OF HEARING-
December 15, 1999

Cost Reporting Periods Ended -
June 30, 1993, 1994 and 1995

CASE NOs. 96-1930, 97-1708
and 98-2034

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ISSUE:

Did the Intermediary properly use the Reasonable Compensation Equivalent limits from 1984 to reduce the amount of reasonable compensation paid by the Provider to its hospital-based physicians for 1993, 1994, and 1995?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

University of North Carolina Hospitals ("Provider") is a not-for-profit medical center located in Chapel Hill, North Carolina. During its fiscal years ended June 30, 1993, June 30, 1994, and June 30, 1995, the Provider incurred physicians' compensation costs for hospital-based physician ("HBP") services. The Provider claimed these costs on its as-filed cost reports for the purpose of obtaining program reimbursement. Blue Cross and Blue Shield of North Carolina ("Intermediary") reviewed the Provider's cost reports and applied reasonable compensation equivalent ("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 1993, 1994, and 1995 cost reports resulted in decreases in its Medicare reimbursement amounting to $29,079, $15,421, and $33,029, respectively.[1]

On September 30, 1995, the Intermediary issued a Notice of Program Reimbursement ("NPR") reflecting the application of the subject RCE limits to the Provider's 1993 cost reporting period. On March 22, 1996, the Provider appealed the Intermediary's determination to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835-.1841, and met the jurisdictional requirements of those regulations. Similarly, the Intermediary issued an NPR for the Provider's 1994 cost reporting period on September 30, 1996, and an NPR for the Provider's 1995 cost reporting period on September 30, 1997. The Provider properly appealed the Intermediary's application of the subject RCE limits to these reporting periods on March 24, 1997 and March 24, 1998, respectively.[2]

On June 15, 1999, the parties submitted a Joint Stipulation to the Board. In part, the parties agree that the Board may decide the sole issue in the three cases consolidated herein, based upon position papers submitted for the Provider's 1993 cost reporting period. Accordingly, all references to position papers contained in this decision pertain to CN: 96-1930.

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[1] See Provider's Requests for Board Hearing.

[2] Id.

The Provider was represented by Carel T. Hedlund of Ober, Kaler, Grimes & Shriver. The Intermediary was represented by Eileen Bradley, Associate Counsel, Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary's adjustments are improper since they are based upon RCE limits that were obsolete.

The Provider contends that application of the 1984 RCE limits to the subject cost reporting periods violates the plain reading of the enabling regulation which requires the limits to be updated annually. [3] The Provider cites 42 C.F.R. § 405.482, which states:

> (b) 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.
>
> (f)(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.
>
> (f)(2) 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 even if the enabling regulation is found to be ambiguous, it must nevertheless be construed to require annual updates.[4] The Provider asserts that this fact is evidenced by HCFA's own interpretation of 42 C.F.R. § 405.482.

Specifically, 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 Fed. Reg.

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[3] Provider Position Paper at 8.

[4] Provider Position Paper at 9.

43,577 at 43586 (October 1, 1982).[5] 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 at 8923 (March 2, 1983).[6]

The Provider also points out that HCFA complied with its own regulations and annually updated the initial RCE limits for the first two years following their establishment. In each case, the revisions resulted in an increase in the RCE limits.[7] Moreover, with the promulgation of the final rule HCFA simultaneously 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).[8]

Also, when HCFA published new and revised RCE limits for providers' cost reporting periods beginning in 1984, 50 Fed. Reg. 7123 (Feb. 20, 1985)[9], 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

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5 Exhibit P-13.

6 Exhibit P-5.

7 Provider Position Paper at 10.

8 Exhibit P-5.

9 Exhibit P-6.

> 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).

The Provider asserts that 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.[10] In the preamble, HCFA indicates the desire that annual updates to the RCE limits no longer be required. HCFA also expresses its clear belief that in order to discontinue annual updates, properly, it would have to amend the RCE regulation in order to effectuate its intent to only update the RCE limits if a significant change is warranted. In part, 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.

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[10] Provider Position Paper at 11.

54 Fed. Reg. 5946 at 5956 (February 7, 1989) (emphasis added).[11]

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.

The Provider also maintains that HCFA recently revised the RCE limits for 1997.[12] In 62 Fed. Reg. 24,483 at 24,484 (May 5, 1997) HCFA states: "[w]e are calculating the 1997 [RCE] limits. . . we are able to produce an array of 1997 estimated annual FTE compensation levels for nine speciality categories by type of location."[13] The Provider points out that HCFA increased the RCE limits for 1997 by 56.21 percent for nonmetropolitan areas and by 59.50 percent for metropolitan areas with populations greater than 1 million.[14] The Provider contends that by increasing the limits for 1997, HCFA acknowledged that Part A physician costs have increased significantly since 1984.

Furthermore, the Provider asserts that HCFA implemented its interpretation that the regulation requires it to annually update the RCE limits.[15] HCFA set RCE limits for each of the years 1982, 1983, and 1984. In the Provider Reimbursement Manual, Part I ("HCFA Pub. 15-1") § 2182.6C, HCFA clearly indicates that the 1984 RCE limits apply only to providers' cost reporting periods beginning in 1984. In part, the manual states:

> [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.

The Provider asserts the program instructions are indicative of HCFA's interpretation of the regulation. The Provider refers to the Seventh Circuit which, in reference to HCFA, stated:

> [a]s the Administration is an arm of HCFA, the [Provider Reimbursement] Manual is best viewed as an administrative

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[11] Exhibit P-14.

[12] Provider Position Paper at 12.

[13] Exhibit P-12.

[14] Exhibit P-15.

[15] Provider Position Paper at 13.

> interpretation of regulations and corresponding statutes, and as such it is entitled to considerable deference as a general matter.

Davies County Hospital v. Bowen, 811 F.2d 338 (7th Cir. 1987).[16] See also Shalala v. Guernsey Memorial Hospital, U.S. 115 S. Ct. 1232 (1995).[17]

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.[18] 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." Exhibit P-19 at (C). 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. Exhibit P-19 at (A). 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. Exhibit P-19 at (B).

The Provider contends that HCFA's failure to update the 1984 RCE limits violates the intent of the enabling statute and Congress.[19] Pursuant to 42 U.S.C. § 1395xx(a)(2)(B), program reimbursement for Medicare Part A physician costs must be "reasonable." Accordingly, HCFA does not have unlimited authority to simply set limits. Rather, limits established by HCFA must be set at a "reasonable" level to be valid. In this regard, the subject limits are not valid. Clearly, any conjecture that no upward revisions to the limits were necessary to assure reasonable compensation after 1984 is 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.

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[16] Exhibit P-17.

[17] Exhibit P-18.

[18] Provider Position Paper at 14.

[19] Id.

[20] Provider Position Paper at 15.

- 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 (November 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 (March 2, 1983). In this regard, the CPI increased from 1984 through 1993. For example, the CPI for all urban consumers for all items in 1980, was 82.4. In 1985, it increased to 107.6. In 1993, the CPI soared to 145.8. See Exhibit P-9.

- 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. 24,483, May 5, 1997. See Exhibits P-12 and P-15.

The Provider maintains that 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.[22] 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." Id.

Also, Congress expressly stated that the intent in differentiating between Part A and Part B physicians' costs was to:[23]

> 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. 43,577 at 43,579 (October. 1, 1982) (emphasis added).[24]

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[21] Exhibit P-21.

[22] Provider Position Paper at 17.

[23] Id.

[24] Exhibit P-13.

Respectively, application of the 1984 limits to the Provider's 1993, 1994, and 1995 fiscal years 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 and Medicaid Guide (CCH)¶ 42,983 ("Los Angeles"), explains that application of the 1984 limits to the 1989 cost year will not result in reasonable HBP reimbursement. The dissenting opinion notes:

> [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 at Medicare & Medicaid Guide (CCH) ¶ 42, 983.[25]

The Provider maintains, therefore, that no valid RCE limits have been established for its 1993, 1994 and 1995 cost reporting periods; accordingly, it must be reimbursed for its actual Part A physicians' costs. Abington Memorial Hospital v. Heckler, 750 F.2d 242, 224 (3rd Cir. 1984) (if a particular rule or method of reimbursement is held not to apply, the prior method of reimbursement must be utilized).[26]

The Provider contends that HCFA's failure to apply annual CPI updates violates the Administrative Procedure Act ("APA") and the RCE regulation.[27] 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. See Buschmann v. Schweiker, 676 F.2d 352, 355-56 (9th Cir. 1982).[28]

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

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[25] Exhibit P-22.

[26] Provider Position Paper at 18.

[27] Provider Position Paper at 19.

[28] Exhibit P-26.

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. Accordingly, the change in the RCE methodology is invalid for noncompliance with the requirements of the APA.

The Provider asserts that HCFA's failure to update the RCE limits, which constitutes 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 maintains 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, where the Supreme Court noted that an agency must comply with its own procedures. 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 also contends that HCFA's failure to update the RCE limits violates Congress' prohibition against cost shifting.[29] Statutory provisions at 42 U.S.C. § 1395x(v)(1)(A) direct HCFA to assure through regulations that providers' costs of providing Medicare services are reimbursed and that "the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be born by individuals not so covered, and the costs with respect to individuals not so covered will not be born by such insurance programs. . ." Id. See also 42 C.F.R. § 413.5. Respectively, the Provider argues that HCFA's failure to continue updating the RCE limits from 1984 through 1997 has caused Medicare providers to be under-reimbursed for their Medicare Part A physicians' costs. The 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 at 42 U.S.C. § 1395x(v)(1)(A).

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[29] Provider Position Paper at 22.

The Provider contends that case law upholding the Secretary's interpretation of the RCE regulation is legally unsound.[30] 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, 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 to the same conclusion in Los Angeles.[31] 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. The providers in Los Angeles appealed to the District Court for the District of Central California. County of Los

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[30] Provider Position Paper at 23.

[31] 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 (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 (Exhibit P-31); 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 (Exhibit P-32); Rush Presbyterian St. Luke's Medical Center v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Illinois, PRRB Dec. No. 97-D22, January 15, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,037 (Exhibit P-33); Albert Einstein Medical Center v. Blue Cross and Blue Shield Association, PRRB Dec. No. 98-D9, December 5, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,907 (Exhibit P-34).

Angeles v. Shalala, Case No. CV 95-0163 LGB (SHx) (C.D. Cal.1995) (Dec. 13, 1995).[32] The District Court, in an unpublished decision, ruled in favor of the Secretary. The District Court concluded that the plain meaning of the regulation did not mandate annual updates of the RCE limits despite the fact that HCFA itself had interpreted the regulation to require annual updating. The District Court refused to give any weight to HCFA's discussion of the RCE updates promulgated in 1989, 54 Fed. Reg. 5956,[33] or to three intra-agency memoranda proffered by the plaintiffs that clearly demonstrate the agency's commitment to annually update the RCE limits.[34] The preamble and the memoranda were excluded from the court's consideration on the ground that they had not been placed in evidence before the PRRB.[35]

The Provider also points out 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).[36] The Provider notes that while the Circuit court acknowledged that both the regulations and program instructions clearly contemplate yearly updates of the RCE limits, it nevertheless deferred to the Secretary's contention that she had never interpreted the RCE regulation to require annual updating. The Provider asserts that the Ninth Circuit's decision is illogical. On one hand, the court acknowledges that the Secretary, on numerous occasions, stated her intention to annually update the RCE limits. On the other hand, the court accepts the Secretary's argument that she has never interpreted the regulation to require annual updates. Moreover, the Provider argues that the Ninth Circuit is bound by the Supreme Court decision in Thomas Jefferson University d/b/a/ Thomas Jefferson University Hospital v. Shalala,U.S. 114 S. Ct. 2381 (1994),[37] where the Court held that if a regulation is ambiguous (which the Ninth Circuit found to be the case with the regulation at issue) a court is required to defer to "the Secretary's intent at the time of the regulation's promulgation"(emphasis added). The Provider notes that the Ninth Circuit's opinion began by stating: [i]t is about as clear as can be that when HHS issued its RCE limit regulation, it intended to update the limits every year. County of Los Angeles, 1997 WL 257492 at 1.

The Provider also disagrees with the holdings of the Board and the district court and circuit court because their reasoning is legally unsound. Specifically, the Provider argues that these authorities failed

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[32] Exhibit P-23.

[33] Exhibit P-14.

[34] Exhibit P-19.

[35] Provider Position Paper at Footnote 5.

[36] Exhibit P-24.

[37] Exhibit P-36.

to give any rational and sustainable reason for rejecting the following issues raised by the providers:[38]

- 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 failure to annually update the RCE limits constitutes a change in the published methodology and is 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 1989 Proposed Rule. 54 Fed. Reg. 5946 (Feb. 7, 1989)[39] where HCFA acknowledges its intent to annually update the RCE limits;

- the relevancy and amount by which the RCE limits were increased by HCFA in 1997. 62 Fed. Reg. 24,483 (May 5, 1997) (Exhibit P-12); and

- how cost shifting was avoided, and how providers were able to receive reasonable reimbursement considering the Board's acknowledgment of the amount by which RCE limits were increased by HCFA in 1997, the increase in the CPI, and the increase in mean physician income.

The Provider contends that the District Court for the Northern District of Illinois recently handed down its decision in Rush-Presbyterian - St. Luke's Medical Center v. Shalala, No. 97-C-1726, 1997 WL 543061 (N.D. Ill. Aug. 28, 1997) ("Rush-Presbyterian"). The Provider explains that this court found the Secretary's application of the 1984 RCE limits to the provider's 1988 cost reporting period to be invalid on two grounds.[40]

First, the court noted that 42 U.S.C. § 1395x(v)(1)(a), among other things, requires the Secretary, when setting the RCE limits, to take into account the direct and indirect costs of providers in determining what constitutes "reasonable costs." The court noted that the statute does not give the Secretary absolute discretion to determine what constitutes reasonable costs. The court noted that the Secretary "has not offered any explanation . . . for the way in which the RCE limits were

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[38] Provider Position Paper at 26.

[39] Exhibit P-14.

[40] Provider Position Paper at 27. Exhibit P-35.

determined." In the court's view, "[t]his exercise of authority without any explanation whatsoever constitutes 'arbitrary and capricious' action." Id.

Second, the court noted that in the preamble to the RCE regulations, the Secretary originally intended to update the RCE limits annually. In the court's view, although the RCE regulations do not explicitly require annual updates, "they do explicitly contain the more general requirement that the limits be based on average physician incomes 'using the best available data.'" Id. (Emphasis added). The court stated that: "[t]he 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." Id. The court thus concluded that the Secretary's interpretation of the
RCE regulation as not requiring annual updates contravenes the regulation's mandates.

The Provider also explains that in Albert Einstein Medical Center v. Blue Cross and Blue Shield Association, PRRB Dec. No. 98-D9, December 5, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,907, declined rev. HCFA Administrator, January 14, 1998, the Board reviewed the district court's opinion in Rush-Presbyterian.[41] The Board rejected the first of the two grounds upon which the court relied in invalidating the Secretary's interpretation of the RCE limit regulation. In the Board's opinion, the district court's opinion was "not persuasive" because its "analysis hinged on the factor that the Secretary failed to articular her reasons for not updating the RCE limits. Id. However, the Board failed to offer any comment on the second of the district court's holding that "the regulations require the Secretary to establish RCE limits that are based on physicians' costs using the most accurate information.. The Board conceded that the RCE limits were "lower than the actual market conditions. . .," thereby implicitly acknowledging that the RCE limits were not established for the year at issue by "using the best available data" as required by the regulation.

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 years, and three HCFA intra-agency memoranda, that the RCE limits were intended to, and should have been updated annually.[42] The RCE limits published to date were specifically limited to the years indicated; therefore, they do not apply to the subject cost reporting periods. Moreover, HCFA made no upward revisions to the limits from 1984 through 1997 failing to abide by its own regulations. Since the Supreme Court has long held that an agency may not violate its own regulation, Morton v. Ruiz, 415 U.S. 199, 235 (1974),[43] no valid RCE limits apply to the fiscal years at issue. Consequently, the Provider must be reimbursed its actual Part A physicians' costs so long as they are otherwise reasonable. Abington Memorial Hospital v. Heckler, 750 F2d 242, 244 (3rd. Cir. 1984), where the

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[41] Provider Position Paper at 28. Exhibit P-34.

[42] Provider Position Paper at 29.

[43] Exhibit P-27.

court ruled that where a particular rule or method of reimbursement is invalidated the prior method of reimbursement must be utilized.[44]

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its adjustments restricting program payments for the Provider's 1993, 1994, and 1995 HBP costs to the 1984 RCE limits is proper. The Intermediary asserts that RCE limits, as promulgated, must be applied to determine reasonable costs pursuant to Medicare regulations. In this regard, the Intermediary maintains that it complied with existing regulations and applied the RCE limits in effect for the subject cost reporting periods. 42 C.F.R. § 405.480(c) and 405.482(a).[45]

Contrary to the Provider's position, the Intermediary contends that HCFA is not required to update the RCE limits on an annual basis. The Intermediary notes that the Board has consistently ruled that HCFA is not mandated by regulation or statute to update the RCE limits, and cites the following cases in support of its argument: 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 ("Good Samaritan"); 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. 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 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; Belmont Center for Comprehensive Treatment v. Blue Cross Blue Shield Association et al., PRRB Dec. No. 99-D5, November 16, 1998, Medicare & Medicaid Guide (CCH) ¶ 80,142, declined rev. HCFA Admin., January 8, 1999; 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-C- 1726, 1997 WL 543061 (N.D.ILL.)("Rush-Presbyterian"); Albert Einstein Medical Center v. Blue Cross and Blue Shield Association, PRRB Dec. No. 98-D9, December 5,

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[44] Provider Position Paper at Footnote 6.

[45] Intermediary Position Paper at 4.

1997, Medicare & Medicaid Guide (CCH) ¶ 45,907, declined rev. HCFA Admin., January 14, 1998 ("Albert Einstein").

The Intermediary explains that in Good Samaritan a Board majority found that 42 C.F.R. § 405.482 only establishes the notification procedure to be followed regarding the update of RCE limits and did not mandate annual updates. Since that case the Board has consistently found that HCFA was authorized to apply the RCE limits as published and was not required to make annual updates.

The Intermediary recognizes that an Illinois district court overturned the Board's decision in Rush-Presbyterian (Exhibit I-14). However, the Intermediary adds that the Board is not bound by this ruling. Notably, the Board squarely rejected the district court's reasoning when it upheld the Intermediary in Albert Einstein. Moreover, the Board's decision in County of Los Angeles was upheld in a California district court, which was then affirmed in an unpublished opinion by the Ninth Circuit Court of Appeals (Exhibit I- 15). In that case the court found that 42 C.F.R.
§ 405.482 anticipates annual updates for RCE limits but does not require them.

Finally, the Intermediary contends that the Provider has raised no new or novel arguments or interpretations of the enabling statute or implementing regulations that warrant the Board's abandoning its long held position that HCFA is not obliged to make annual updates to the RCE limits. The Board has heard the Provider's arguments before and has rejected them.

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

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

§ 553 et seq.	-	Administrative Procedure Act

3. 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

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

§ 2182.6C - Reasonable Compensation Equivalents (RCEs)

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-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 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.

Belmont Center for Comprehensive Treatment v. Blue Cross Blue Shield Association et al., PRRB Dec. No. 99-D5, November 16, 1998, Medicare & Medicaid Guide (CCH) ¶ 80,142, declined rev. HCFA Admin., January 8, 1999.

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-C- 1726, 1997 WL 543061 (N.D.ILL.)

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

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).

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

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

Thomas Jefferson University d/b/a/ Thomas Jefferson University Hospital v. Shalala,U.S. 114 S. Ct. 2381 (1994).

6. Other:

47 Fed. Reg. 43577 (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, after consideration of the facts, parties' contentions, and evidence presented, finds and concludes as follows:

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 years ended June 30, 1993, 1994, and 1995. The Provider's fundamental argument regarding this application is that the limits were obsolete and not applicable to the subject cost reporting periods, i.e., because HCFA failed to update them on an annual basis as required by the enabling 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 Register notices, internal HCFA memoranda, and program instructions indicate that HCFA had 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.

Finally, the Board acknowledges the Provider's argument that data compiled by the AMA, increases in the CPI, and increases in the RCE limits that were issued by HCFA in 1997, clearly indicate that net physician income increased throughout the period spanning 1984 through the fiscal years 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 periods, the Board concludes that it is bound by the governing law and regulations.

In sum, the Board continues to find, as it has in the previous cases cited by the parties, that the application of the 1984 RCE limits to subsequent cost reporting periods 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 adjustments are affirmed.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esq.
Martin W. Hoover, Jr., Esq.
Charles R. Barker

Date of Decision: March 1, 2000

FOR THE BOARD:

Irvin W. Kues
Chairman