PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

98-D9

PROVIDER -
Albert Einstein Medical Center
Philadelphia, Pennsylvania

DATE OF HEARING-
August 5, 1997

Provider No. 39-0142

Cost Reporting Period Ended -
June 30, 1989

vs.

INTERMEDIARY -
Independence Blue Cross

CASE NO. 92-1679

INDEX

ISSUE:

Was the Intermediary's application of the 1984 Reasonable Compensation Equivalent ("RCE") limits 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, 1989, the Provider incurred physicians' compensation costs for hospital-based physician ("HBP") services, which were claimed on its as-filed Medicare cost report. Independence Blue Cross ("Intermediary") 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 RCEs issued in 1985 to its 1989 cost report resulted in a $40,000 decrease in its total Medicare reimbursement for the period.[1]

On September 30, 1991, the Intermediary issued a Notice of Program Reimbursement reflecting the application of the RCE limits. On March 26, 1992, 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.

The Provider was represented by Jillian Wilson, Esquire, and Leslie Goldsmith, Esquire, of Ober, Kaler, Grimes & Shriver. The Intermediary was represented by Michael F. Berkey, Esquire, of the Blue Cross and Blue Shield Association.

PROCEDURAL MATTERS-JURISDICTION

The Intermediary argued that the Board does not have jurisdiction in this case because the Provider failed to exhaust its administrative remedies.[2] Medicare regulation 42 C.F.R. § 405.482(e) provides for an exception to the RCE limits where a provider demonstrates that it could not hire or maintain physicians at those compensation levels. The Provider, however, did not request an exception but appealed directly to the Board. The Intermediary cites Mercy Hospital of Laredo et al. v. Heckler, No. 84-2382 (5th Cir 1985), in which the court states:

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1 Position Paper and Exhibits in Support of Provider at 2.

2 Transcript ("Tr."). at 23-24.

> [i]n a leading case concerning the doctrine of exhaustion of administrative remedies, the Supreme Court said:
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> [T]he long settled rule of judicial administration [is] that no one is entitled to judicial relief for a supposed or threatened injury until the prescribed administrative remedy has been exhausted.

Mercy Hospital of Laredo et al. v. Heckler, No. 84-2382 (5th Cir 1985) Medicare & Medicaid Guide (CCH) ¶ 35,051.

The Provider disagrees with the Intermediary's jurisdictional challenge. The Provider argues that the enabling statute and regulations require the RCE limits to be updated. Therefore, all it is asking the Board to do is enforce applicable authorities, which it is required to do pursuant to 42 C.F.R. § 405.1867. The Provider notes that the Board has previously assumed jurisdiction in other cases involving this precise issue.[3]

SUBSTANTIVE ARGUMENT

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. 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.[4] The limits had not been updated to apply to cost reporting periods beginning in 1988, 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

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3 Tr. at 6-7.

4 Tr. at 8.

> 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).[5]

The Provider contends that the fact that 42 C.F.R. § 405.482 requires the RCE limits to be updated annually is evidenced by HCFA's own interpretations.[6] 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. 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 at 8923 (March 2, 1983).[8]

The Provider also contends that 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]

Also, 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:

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5 Tr. at 9, 11 and 16. Position Paper and Exhibits in Support of Provider at 9.

6 Id.

7 Exhibit P-11.

8 Exhibit P-5.

9 Id.

10 Exhibit P-6.

> [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).[11]

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.[12]

The Provider contends that the consistency of HCFA's interpretation of its own regulation is further evidenced by a proposed rule published in 1989, although never finalized.[13] In the preamble, HCFA clearly 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

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11 Id.

12 Tr. at 16.

13 Tr. at 17-18. Position Paper and Exhibits in Support of Provider at 12.

> 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.

54 Fed. Reg. 5946 at 5956 (Feb. 7, 1989) (emphasis added).[14]

The Provider asserts that HCFA's statement that the 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.

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 were meant to be updated each year.[15] The first document 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."[16] The second document 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.[17] The third document 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.[18]

The Provider contends that it is inconceivable that HCFA not be required to update the RCE limits after 1984, in order to ensure that a provider is reasonably reimbursed for Part A physician costs. Any conjecture that no upward revisions to the RCE limits were necessary to

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[14] Exhibit P-12.

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

[16] Exhibit P-13 at C.

[17] Exhibit P-13 at A.

[18] Exhibit P-13 at B.

assure reasonable compensation after 1984, is completely refuted.[19] Information compiled by the American Medical Association clearly demonstrates that a rapid escalation of physicians' salaries occurred from 1984 to 1989.[20] For example, the mean physician net income of all physicians increased from $104,100 in 1983 to $155,800 in 1989, which is a 50 percent increase.[21]

Also, HCFA updated Part B physician screens available for Part B payments to physicians every year since 1983, except for 1985. An update of Part B physicians' compensation without a concomitant update of Part A physicians' compensation is proof of unreasonableness.[22] And finally, the fact that the Consumer Price Index ("CPI") increased from 1984 through 1989 demonstrates the need to update the RCE limits.[23] Clearly, HCFA possessed annual economic data relating to physician compensation increases and physician fee increases but failed to utilize such data to update the RCE limits.

The Provider cites Morton v. Ruiz, 415 U.S. 199, 235 (1974), and explains that the Supreme Court has long held that an agency may not violate its own regulation.[24] In view of the fact that HCFA failed to abide by its own regulation, by failing to update the RCE limits after 1984, in accordance with its prescribed methodology, no valid RCE limits apply to the Provider's fiscal year at issue.

Accordingly, the Provider argues that it should be reimbursed for its actual Part A physicians' costs so long as they are otherwise reasonable. See, e.g., Abington Memorial Hospital v. Heckler, 750 F.2d 242, 244 (3rd.Cir.1994), where the court ruled that where a particular rule or method of reimbursement is invalidated, the prior method of reimbursement must be utilized.[25]

The Provider contends that prior case law is not applicable to the instant case because it is unpersuasive and distinguishable.[26] Specifically, the issue of whether or not HCFA is bound

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19 Tr. at 13.

20 Id.

21 Exhibit P-9.

22 Tr. at 9 and 14.

23 Exhibit P-8.

24 Position Paper and Exhibits in Support of Provider at 16. Exhibit P-18.

25 Id.

26 Id.

to annually update the RCE limits has, to date, been raised in five appeals. In the first case, Good Samaritan Hospital and Health Center v. Blue Cross and Blue Shield Association/Community Mutual Ins. Co., PRRB Dec. No.93-D30, Medicare and Medicaid Guide (CCH) ¶ 41,399 (April 1, 1993),[27] 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 County of Los Angeles RCE Group Appeal v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 95-Dl2, Medicare and Medicaid Guide (CCH) ¶ 42,993 (December 8, 1994) ("Los Angeles").[28] Recently, the Board issued three decisions regarding HCFA's failure to update the RCE limits since 1984,[29] and the Board majority, while conceding that HCFA was not required to annually update the RCE limits, stated as follows:

> [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.

In all five 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 Angeles v. Shalala, Case No. CV 95-0163 LGB (SHx) (C.D. Cal.1995) (Dec. 13, 1995), appeal docketed, (9th Cir. Jan. 11, 1996).[30] The district court, in an unpublished decision, ruled in favor of the Secretary. The providers have appealed this decision to the Ninth Circuit.

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[27] Exhibit P-19.

[28] Exhibit P-20.

[29] 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-29); 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-28); 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-27).

[30] Exhibit P-21.

The Provider believes the holdings in the prior cases are unpersuasive because, for example, they did not consider whether the enabling statute would sustain the intermediaries' positions, and because the courts refused to give weight to HCFA's discussions of RCE updates contained in 54 Fed. Reg. 5946 (February 7, 1989), or HCFA's internal memoranda. The Provider contends that the instant case is also distinguishable from the prior cases for three reasons, and the Board, having not considered these added challenges, is free to depart from its earlier decisions.[31]

First, the Provider contends that the Board never considered that HCFA's failure to update the RCE limits violates the enabling statute which mandates that Medicare reimburse providers the reasonable cost of HBP services. 42 U.S.C § 1395xx(a)(1) and (2).[32] This means that even though Congress authorized HCFA to establish limits for HBP costs, and to not recognize as reasonable those costs which exceed the limits, the limits themselves must be valid and reasonable in order to comply with the Congressional mandate, i.e., they must result in reasonable reimbursement to providers. Therefore, even if the Board is inclined to accept prior arguments that HCFA is not required to annually update the RCE limits, it cannot stop there without also considering whether the regulation, so interpreted, is consistent with the statute under which it is promulgated. United States v. Larionoff, 431 U.S. 864, 873 (1977).[33] Accordingly, HCFA's failure to update the 1984 RCE limits during a period of almost unprecedented inflation in health care costs, as discussed above, violates Congressional intent that reimbursement of physicians' costs be reasonable.

Next, the Provider contends that the Board never considered that HCFA's failure to apply annual CPI updates to the RCE limits violates the Administrative Procedure Act ("APA").[34] This violation means that no valid RCE limits were established for the subject cost reporting period and, as a result, the Provider must be reimbursed its actual HBP costs, as discussed above.

The APA requires HCFA to publish a notice in the Federal Register regarding any new standard it wishes to impose, and to allow interested persons the opportunity to comment

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31 Position Paper and Exhibits in Support of Provider at 18-19.

32 Id. Tr. at 8-9.

33 Exhibit P-22.

34 Tr. at 9, 12, and 18. Position Paper and Exhibits in Support of Provider at 22.

before it can be adopted in final. 5 U.S.C.A. § 553.[35] Substantive rules affecting Medicare reimbursement are invalid unless promulgated in accord with APA procedures. Buschmann v. Schweiker, 676 F.2d 352, 355-56 (9th Cir.1982).[36]

HCFA, in compliance with the APA's notice and comment rulemaking requirement, established the methodology to be applied in annually updating the RCE limits. 48 Fed. Reg. 8902 (March 2, 1983).[37] Furthermore, HCFA complied with the established methodology by setting RCE limits for the 1982, 1983 and 1984 cost years. For each year, application of the methodology resulted in an increase in the RCE limits in accordance with data on average physician specialty compensation and updated economic index data.

However, HCFA thereafter, 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, abruptly stopped updating the RCE limits even though inflationary changes mandated an update. Accordingly, HCFA's failure to apply its published methodology constitutes a change in the methodology, which is invalid because it violates the express requirements of the APA.

The Provider adds that HCFA acknowledged the APA requirements by stating in 42 C.F.R. § 405.482(f)(2):

> [i]f HCFA proposes to revise the methodology by which payment limits under this section are established, HCFA will publish a notice, with opportunity for public comment, to that effect in the Federal Register. The notice would explain the proposed basis for setting limits, specify the limits that would result, and state the date of implementation of the limits.

42 C.F.R. § 405.482(f)(2).

As discussed above, the Supreme Court noted in Morton v. Ruiz, 415 U.S. at 235, an agency must comply with its own procedures when the rights of individuals are at stake. Therefore, HCFA's failure to update the RCE limits in compliance with its published methodology constitutes a change in methodology which is invalid, and no valid RCE limits have been established for fiscal year 1989. Consequently, the Provider must be reimbursed its actual HBP costs.

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35 Exhibit P-24.

36 Exhibit P-25.

37 Exhibit P-5.

Finally, the Provider contends that the Board is free to depart from its earlier decisions regarding the applicability of the 1984 RCE limits to subsequent period cost reports because no consideration was given to the fact that HCFA's's failure to update the limits results in "cost shifting".[38] 42 U.S.C. § 1395x(v)(1)(A) provides, in part, that HCFA must assure through regulations that:

> the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs . . .

42 U.S.C.§ 1395x(v)(1)(A).[39]

Clearly, HCFA's failure to update the RCE limits after 1984, means that Medicare has under-reimbursed providers for their Part A physicians' costs, and that these costs were borne by non-Medicare covered patients in violation of the statute.

Intermediary's Contentions:

The Intermediary contends that its adjustment restricting program payments for the Provider's fiscal year ended June 30, 1989 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.[40]

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.[41] 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.[42]

Contrary to the Provider's contention that the RCE limits published in 1985 should not have been applied to its fiscal year 1989 HBP costs because they had not been updated and were

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38 Tr. at 10. Position Paper and Exhibits in Support of Provider at 24.

39 See 42 C.F.R. § 413.5.

40 Intermediary Position Paper at 1-2.

41 Exhibit I-3.

42 Exhibit I-4.

obsolete, the Intermediary argues that HCFA is not required by regulation or statute to update the limits. The Intermediary finds support for its position in six prior Board decisions, one district court decision and one court of appeals decision, as follows:[43]

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 (Exhibit P-19); 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) ¶ 42,993, declined rev. HCFA Admin., January 12, 1995 (Exhibit I-6a); 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 (Exhibit I-6b); 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 (Exhibit I-6c); 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 (Exhibit I-6d); 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 ("Rush-Presbyterian"); County of Los Angeles v. Shalala, Case No. CV 95-0163 LGB (SHx) (C.D. Cal. 1995) (Exhibit 6e); and, County of Los Angeles v. Secretary of Health and Human Services, ("County of Los Angeles")113 F.3d 1240, (9th Cir. 1997) (Exhibit P-34).

The Intermediary also disagrees with the Provider's contention that there are three new arguments in the instant case which distinguish it from the cases previously heard by the Board and courts.[44] The first argument the Provider alleges to be new is that HCFA's failure to update the RCE limits violates the enabling statute. Specifically, the Provider contends that 42 U.S.C.
§ 1395xx(a)(2)(B) requires HCFA to reimburse the "reasonable cost" of HBP services. However, since the 1984 RCE limits had not been updated to reflect costs in the subject cost reporting period they resulted in reimbursement that is less than reasonable.

The Intermediary asserts this argument was made in Rush-Presbyterian, and rejected by the Board. In Rush-Presbyterian, a case in which the Board majority found in favor of the intermediary, the provider argues:

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[43] Tr. at 23. Intermediary Position Paper at 2.

[44] Tr. at 25.

> [b]y using the term "reasonable compensation equivalents,"Congress clearly intended that the Secretary establish compensation limits that are (i) "reasonable" and fair in amount, and (ii) "equivalent" or equal in amount to compensation levels being earned by physicians. In an economy in which all major economic indices had increased by double digits over the period between 1984 and 1988, the Secretary's application of 1984 compensation level to 1988 physician salaries results in neither reasonable nor equivalent compensation and, therefore, violates the plain language of the statute.

Rush-Presbyterian, Medicare & Medicaid Guide (CCH) ¶ 45,037 at 52,566.

Clearly, this argument is not new; it has been heard before and rejected.

Also regarding the Provider's allegation that HCFA's failure to update the RCE limits violates the enabling statute, the Intermediary asserts that a plain reading of the statute reveals that Congress directed the Secretary to define and establish RCE limits; Congress itself, did not define what the RCE limits would be. Furthermore, with respect to violating the statute, the Intermediary asserts that the Secretary provided an "exceptions process" to the RCE limits. In accordance with 42 C.F.R. § 405.482(e), the Provider could have received an exception to the RCE limits by demonstrating to the Intermediary that it could not recruit or maintain physicians at those compensation levels. The Provider, however, did not request an exception.[45]

The second argument the Provider alleges to be new is that HCFA's failure to update the RCE limits constitutes a change in the RCE methodology, violating the APA. The Intermediary asserts, however, that this argument was heard in County of Los Angeles, and was rejected by the Court of Appeals. In that case the court stated:

> [n]or do we believe the provision requiring the Secretary to provide a new opportunity for notice and comment if she changes the "methodology" for calculating the limits, Id. (f)(2), obligates the Secretary to promulgate a new rule if she decides not to update the limits every year, as the County argues. The "methodology" the rule refers to is HCFA's econometric formula. See 50 Fed. Reg. at 7124-25. That formula hasn't changed.

County of Los Angeles 113 F.3d 1240, (9th Cir. 1997).[46]

Accordingly, there is no violation of the notice and comment requirements of the APA for not updating the limits.

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[45] Tr. at 27.

[46] Id. Exhibit P-34 at 3.

Finally, the Intermediary contends that the third and final argument the Provider alleges to be new was also made in a previous case and rejected by the Board. The Provider asserts that the Board had not previously considered whether or not HCFA's failure to update the limits results in cost shifting in violation of 42 U.S.C. § 1395x(v)(1)(A).[47] However, in Rush-Presbyterian the provider argued:

> [n]onetheless, Medicare is refusing to undertake its appropriate share of physician compensation costs because HCFA has frozen reimbursement of physician compensation at 1984 levels. Unless Medicare shares in FY 1988 costs at current compensation levels, the difference between 1988 and 1984 compensation levels will be borne entirely by non-Medicare patients in violation of Section 1861(v)(1)(A) [42 U.S.C. § 1395x(v)(1)(A].

Rush-Presbyterian, Medicare & Medicaid Guide (CCH) ¶ 45,037 at 45,044.

The Intermediary concludes that there is no basis to distinguish the instant case from those previously heard by the Board or courts.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - 42 U.S.C.:

§ 42 U.S.C. § 1395x(v)(1)(A)	-	Reasonable Cost
§ 42 U.S.C § 1395xx	-	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	-	Payment for Services of Physicians to Providers: General Rules
§ 405.482	-	Limits on Compensation for Services of Physicians in Providers
§§ 405.1835-.1841	-	Board Jurisdiction

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[47] Tr. at 28.

§ 405.1867 - Sources of Board's Authority

§ 413.5 - Cost Reimbursement: General

3. 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) ¶ 42,993, 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.

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. 97C 1726 (E.D. IL. filed Aug. 27, 1997).

Mercy Hospital of Laredo et al. v. Heckler, No. 84-2382 (5th Cir. 1985).

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

Abington Memorial Hospital v. Heckler, 750 F.2d 242 (3rd Cir. 1994).

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

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

4. Other:

47 Fed. Reg. 43596 (Oct 1, 1982).
48 Fed. Reg. 8902 (March 2, 1983).
50 Fed. Reg. 7123 (Feb. 20, 1985).
54 Fed. Reg. 5946 (Feb. 7, 1989).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, evidence presented, and oral arguments, finds and concludes as follows:

Procedural Findings-Jurisdiction

The Intermediary challenged the Board's jurisdiction to decide the subject case because the Provider failed to request an "exception" to the RCE limits provided by 42 C.F.R. § 405.482(e). The Intermediary contends that the Provider failed to exhaust its administrative remedies before appealing to the Board.

The Provider argues that the enabling statute and regulations require the RCE limits to be updated annually, and it is only asking the Board to enforce existing authorities, which it is required to do pursuant to 42 C.F.R. § 405.1867.

The Board finds that the issue brought by the Provider in this appeal has been before the Board on six previous occasions. In each instance, the Board accepted jurisdiction and ruled on the merits of the case. The issue has also been before the United States District Court for the Northern District of Illinois, Eastern Division, the United States District Court for the Central District of California, and the United States Court of Appeals, Ninth Circuit. In each of these instances, the courts also ruled on the substantive arguments of the parties.

As in the past, the Board finds that it has jurisdiction to decide the subject case. The Provider is not contesting an amount of Medicare program reimbursement it may have received had it filed for and received an exception to the RCE limits. Rather, the Provider is contesting the validity of the RCE limits themselves based, in part, upon statute and regulation, and HCFA's failure to comply with its own rules. None of the evidence presented by the Provider, nor any of its arguments, pertain to the effect the limits had on hiring and maintaining physicians, which is the underlying concern of 42 C.F.R. § 405.482(e).

Substantive Findings

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, 1989. 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 fully considered the Provider's argument that data compiled by the American Medical Association, as well as increases in the CPI, 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, the Board is bound by the governing law and regulations.

The Board also rejects the Provider's contention that three new arguments distinguish the instant case from previous cases challenging the application of the 1984 RCE limits to subsequent period physicians' costs. The Board finds the three arguments the Provider represents as new and distinguishing have, in fact, been heard and rejected in prior cases.

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). This argument was considered in Rush-Presbyterian where the Board ruled in favor of the intermediary. Likewise, in Rush-Presbyterian, the Board considered and rejected the Provider's second "new" 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 third and last "new" argument, that HCFA violated the APA by not allowing for public comment on its decision not to update the RCE limits, a substantive change, 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 finds that the United States District Court for the Northern District of Illinois, Eastern Division, found 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). This decision was rendered after the date of the Provider's hearing before the Board, and was not submitted into evidence.

Nevertheless, the Board reviewed the court's decision as constructive to the instant case. The Board found the court's analysis hinged on the factor that the Secretary failed to articulate her reasons for not updating the RCE limits. In light of its previous decisions, as well as the court decisions issued in County of Los Angeles v. Shalala and County of Los Angeles v. Secretary of Health and Human Services, the Board chooses to affirm its prior position.

The Board concludes that the District Court's decision in Rush-Presbyterian is not persuasive, and that the application of the 1984 RCE limits to subsequent period physicians' costs is proper.

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
Teresa B. Devine
Henry C. Wessman, Esquire

FOR THE BOARD:

Irvin W. Kues
Chairman