

*G. Notification of Updates to the Reasonable Compensation Equivalent (RCE) Limits (§ 415.70)*

1. Background

Under the Medicare program, payment for services furnished by a physician is made under either the Hospital Insurance Program (Part A) or the Supplementary Medical Insurance Program (Part B), depending on the type of services furnished. In accordance with section 1848 of the Act, physicians' charges for medical or surgical services to individual Medicare patients generally are covered under Part B on a fee-for-service basis under the Medicare physician fee schedule. The compensation that physicians receive from or through a provider for services that benefit patients generally (for example, administrative services, committee work, teaching, and supervision) can be covered under Part A or Part B, depending on the provider's setting.

As required by section 1887(a)(2)(B) of the Act, allowable compensation for services furnished by physicians to providers that are paid by Medicare on a reasonable cost basis is subject to reasonable compensation equivalent (RCE) limits. Under these limits, payment is determined based on the lower of the actual cost of the services to the provider (that is, any form of compensation to the physician) or a reasonable compensation equivalent. For purposes of applying the RCE limits, physician compensation costs means monetary payments, fringe benefits, deferred compensation and any other items of value (excluding office space or billing and collection services) that a provider or other organization furnishes a physician in return for the physician's services.

The RCE limits do not apply to the costs of physician compensation that are attributable to furnishing inpatient hospital services paid for under the IPPS or GME costs. In addition, RCE limits do not apply to the costs CAHs incur in compensating physicians for services. Furthermore, compensation that a physician receives for activities that may not be paid for under either Part A or Part B are not considered in applying the RCE limits.

The limits apply equally to all physician services to providers that are payable on a reasonable cost basis under Medicare. If a physician receives any compensation from a provider for his or her physician services to the provider (that is, those services that benefit patients generally), payment to those affected providers for the costs of such compensation is subject to the RCE

limits. The RCE limits are not applied to payment for services that are identifiable medical or surgical services to individual patients and paid for under the physician fee schedule, even if the physician agrees to accept compensation (for example, from a hospital) for those services. (However, payments to teaching hospitals that have elected to be paid for these services on a reasonable cost basis in accordance with section 1861(b)(7) of the Act are subject to the limits.)

Section 415.70(b) of the regulations specifies the methodology for determining annual RCE limits, considering average physician incomes by specialty and type of location, to the extent possible using the best available data. On October 31, 1997, the revised RCE limits update methodology was published in the **Federal Register** (62 FR 59075). For cost reporting periods beginning on or after January 1, 1998, updates to the RCE limits are calculated using the Medicare Economic Index (MEI). The inflation factor used to develop the initial RCE limits and, subsequently, to update those limits to reflect increases in net physician compensation was the Consumer Price Index for All Urban Consumers (CPI-U). In 1998, we revised the RCE limits update methodology by replacing the CPI-U with the physician fee schedule's inflation factor (the MEI), to achieve a measure of consistency in the methodologies employed to determine reasonable payments to physicians for direct medical and surgical services furnished to individual patients and reasonable compensation levels for physicians' services that benefit provider patients generally.

2. Publication of the Updated RCE Limits

We intend to publish updated payment limits on the amount of allowable compensation for services furnished by physicians to providers in the FY 2004 IPPS final rule. These revised limits will be mere updates that will be calculated by applying the most recent economic index data. We are not proposing any change in the methodology. Therefore, in accordance with § 415.70(f), we are allowed to publish the revised RCE limits in a final rule without prior publication of a proposed rule for public comment. Furthermore, we believe that publication of the revised RCE limits in a proposed rule with opportunity for public comment is unnecessary, and we find good cause to waive the procedure.

**V. PPS for Capital-Related Costs**

In this proposed rule, we are not proposing any changes in the policies governing the determination of the payment rates for capital-related costs for short-term acute care hospitals under the IPPS. However, for the readers' benefit, in this section of this proposed rule, we are providing a summary of the statutory basis for the PPS for hospital capital-related costs, the methodology used to determine capital-related payments to hospitals, and a brief description of the payment policies under the PPS for capital-related costs for new hospitals, extraordinary circumstances, and exception (regular and special) payments. (Refer to the August 1, 2001 IPPS final rule (66 FR 39910) for a more detailed discussion of the statutory basis for the system, the development and evolution of the system, the methodology used to determine capital-related payments to hospitals both during and after the transition period, and the policy for providing regular and special exceptions payments.)

Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of inpatient hospital services "in accordance with a PPS established by the Secretary." Under the statute, the Secretary has broad authority in establishing and implementing the PPS for capital related costs. We initially implemented the capital PPS in the August 30, 1991 IPPS final rule (56 FR 43358), in which we established a 10-year transition period to change the payment methodology for Medicare hospital inpatient capital-related costs from a reasonable cost-based methodology to a prospective methodology (based fully on the Federal rate).

Federal fiscal year (FY) 2001 was the last year of the 10-year transition period established to phase in the PPS for hospital inpatient capital-related costs. Beginning in FY 2002, capital PPS payments are based solely on the Federal rate for the vast majority of hospitals. The basic methodology for determining capital prospective payments based on the Federal rate is set forth in § 412.312. For the purpose of calculating payments for each discharge, the standard Federal rate is adjusted as follows:

$$(\text{Standard Federal Rate}) \times (\text{DRG Weight}) \\ \times (\text{Geographic Adjustment Factor (GAF)}) \times (\text{Large Urban Add-on, if applicable}) \times (\text{COLA Adjustment for hospitals located in Alaska and Hawaii}) \times (1 + \text{DSH Adjustment Factor} + \text{IME Adjustment Factor, if applicable})$$