UNITED STATES
CIVILIAN BOARD OF CONTRACT APPEALS

THIS OPINION WAS INITIALLY ISSUED UNDER PROTECTIVE ORDER AND IS BEING PUBLICLY RELEASED IN ITS ENTIRETY ON AUGUST 29, 2023

MOTION FOR SUMMARY JUDGMENT
GRANTED IN PART: August 23, 2023

CBCA 6808

SOUTH TEXAS HEALTH SYSTEM,

Appellant,

v.

DEPARTMENT OF VETERANS AFFAIRS,

Respondent.

Christian B. Nagel and Kelsey M. Hayes of Holland & Knight LLP, Tysons, VA, counsel for Appellant.

David G. Fagan, Office of General Counsel, Department of Veterans Affairs, Bend, OR, counsel for Respondent.

Before Board Judges **LESTER**, **RUSSELL**, and **CHADWICK**.

LESTER, Board Judge.

This appeal is the sixth in which appellant, South Texas Health System (STHS), has complained that respondent, the Department of Veterans Affairs (VA), failed appropriately to pay individual medical claims for patients that STHS had treated under its medical

services contract with the VA.[1] STHS's current appeal relates to the manner in which the VA responded to medical claims involving "emergent" admissions of eligible veterans—that is, where a veteran who either self-reported or was referred by a contract provider to an emergency room requires hospital admission. The current claim is based upon the same issue, arises under the same contract, and involves hospital and medical claims from the same years of service as those at issue in *McAllen Hospitals LP dba South Texas Health System v. Department of Veterans Affairs*, CBCA 3798, which the Board dismissed with prejudice in February 2019 following the parties' voluntary settlement.

The VA has filed a motion seeking dismissal of this appeal for failure to state a claim or, in the alternative, for summary judgment. The VA identifies three bases for its motion: (1) that STHS failed to exhaust mandatory administrative remedies under the contract, which precludes STHS from challenging medical claim non-payments now; (2) that the parties' settlement agreement resolving CBCA 3798 contained release language that precludes the recovery requested here; and (3) that the six-year statute of limitations in the Contract Disputes Act (CDA), 41 U.S.C. §§ 7101–7109 (2018), bars some of STHS's claims. Because the VA cites to documents and evidence outside of those referenced in STHS's notice of appeal and STHS's complaint, we treat the entirety of the VA's motion as a motion for summary judgment, which we grant in part.

Background

I. The Contract

Effective April 6, 2009, the VA awarded indefinite-quantity contract no. VA257-P-0287 to STHS, which was to run for twelve months from the effective date of award but contained options for four consecutive one-year renewals that the VA ultimately exercised. Under that contract, STHS was to provide inpatient, emergency, and outpatient services for veterans in the Lower Rio Grande Valley region in South Texas.[2] The contract included the clause from Federal Acquisition Regulation (FAR) 52.212-4 (48 CFR 52.212-4 (2009)) titled "Contract Terms and Conditions—Commercial Items (Feb 2007)." Appeal

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[1] The prior appeals identified the appellant as "McAllen Hospitals LP dba South Texas Hospital System." The VA has not objected to the appellant's use of the name "South Texas Hospital System" in this appeal.

[2] Additional discussion of the solicitation and contract can be found in the Board's decision in *McAllen Hospitals LP v. Department of Veterans Affairs*, CBCA 2774, et al., 14-1 BCA ¶ 35,758.

File, Exhibit 3 at 640-45.[3] This clause provided that "[c]hanges in the terms and conditions of this contract may be made only by written agreement of the parties." *Id.* at 640 (quoting FAR 52.212-4(c)).

Under the contract, the VA was to pay claims by STHS for "actual services provided" in accordance with a specified percentage of current Medicare rates, based on the service. Exhibit 3 at 605; *see* Complaint ¶ 18. The VA was to "be the primary payor for an eligible/enrolled individual . . . whether or not the individual ha[d] a service-connected injury or illness." Exhibit 3 at 605. The contract was clear, however, that "[p]ayment [would] be made only for those claims [the] VA ha[d] authorized for payment." *Id.* at 607. The contract also provided that "[a]uthorization for payment must be made by [the] VA within the next business day of being contacted by Contractor" of the admission of a patient. *Id.*

The typical process for an emergent, non-VA referral admission,[4] as originally awarded under the base contract, looked as follows: first, the patient would present himself or herself at STHS's hospital. STHS would then determine whether the patient was undergoing a medical emergency[5] that required hospital admission. Exhibit 3 at 632. In making that determination, STHS was required to use "the full suite of the McKesson InterQual Standards and Process in effect at the time of service delivery under th[e] contract." *Id.* at 629. InterQual is a commercially available software program that assists in determining an appropriate level of care for each patient in light of clinical indicators, signs, and symptoms exhibited by the patient. Complaint ¶ 13; *see* Exhibit 3 at 636 ("InterQual criteria are [a] set of measurable, clinical indicators, as well as diagnostic and therapeutic services, that reflect a patient's need for hospitalization.").

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[3] Unless otherwise noted, all exhibits are contained in the appeal file.

[4] Referrals made directly by the VA as well as scheduled admissions followed a similar but distinct process under the contract. *See* Exhibit 3 at 632-33. It does not appear from the record, however, that such claims are at issue in this appeal.

[5] The term "medical emergency" is defined in the contract as "any medical condition of a recent onset and severity, including, but not limited to severe pain that would lead a 'prudent layperson,' possessing an average knowledge of medicine and health, to believe that his or her health condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in: (a) [p]lacing the patient's health . . . in serious jeopardy; (b) [s]erious impairment to bodily functions; or (c) [s]erious dysfunction of any bodily organ or part." Exhibit 3 at 635.

If STHS admitted the individual, it was required to contact the VA Quality Management/Utilization Management (QM/UM) clinician[6] as soon as possible, but no later than the next business day, to inform the VA of the admission. Exhibit 3 at 632. Once notified, the VA QM/UM clinician was required to make a determination of coverage and an authorization decision on behalf of the VA within one business day and notify the appellant of that decision. *Id.* at 607, 635. The VA could "not later determine a service is not authorized once an authorization ha[d] been given." *Id.* at 607. If the VA QM/UM clinician did not make the coverage determination "within twenty-four (24) hours," STHS was to "consider the patient private pay and . . . bill other insurance or the patient." *Id.* at 635.

The contract defined "episode of care" as "[h]ealthcare services provided from the date of admission to the date of discharge for inpatient care and [a] group of services related to [an] office visit or procedure for outpatient care." Exhibit 3 at 635. Following an authorized patient's "episode of care," STHS had forty-five days to submit full invoices, also called "medical claims,"[7] to the VA for processing. *See id.* at 634 ¶ a ("Contractor will submit a full invoice within 45 days of patient treatment or discharge."), ¶ c ("Invoices . . . must be submitted within 45 days of the service . . . ."). Payment by the VA, or rejection, would then be made according to timeliness standards as set out in the contract, which called for payment or rejection within thirty days.[8] *Id.* at 633-34. If an invoice was not rejected but also was not paid within thirty days, interest under the Prompt Payment Act (PPA), 31 U.S.C. § 3903, would accrue.

II. The VA's Unilateral Addition of an Authorization Decision Appeal Process

On October 1, 2010, the VA issued a unilateral modification (mod 0002) to the contract that the VA described as incorporating certain "administrative changes" into the contract. Exhibit 5 at 682. These changes included, among other things, what the VA

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[6] VA QM/UM clinicians were located offsite but could be reached through telephone numbers provided in the contract. Exhibit 3 at 631.

[7] The contract defined "medical claims" as "invoices prepared and submitted by the contractor that consist of the charges of the provider(s) for the health care services rendered to veterans as authorized by [the] VA." Exhibit 3 at 622; *see id.* at 633.

[8] The contract established a timeliness standard of 95% in thirty days for claims that were submitted with valid information. Exhibit 3 at 633. The VA was obligated to pay STHS monthly upon receipt of proper invoices for the service furnished in the previous month, subject to interest accrual for any late payment. *Id.* at 634.

described as clarification of the "[a]uthorization/pre-certification for care process," *id.*, creating an agency-level appeal process for disapproved authorizations that was not contained in the original contract:

> 5. Reconsideration for Disapproved Authorizations for Care – Non-authorization of care can be appealed by submitting a formal request in writing through the VA UM nurse to the Valley Coastal Bend Chief of Staff or appointed designee.
>
> a) Appeals are to be submitted within 30 calendar days of denial of authorization
> - Responses to all appeals shall be made within 30 calendar days

Id. at 686. The modification also increased the time for the VA QM/UM clinician to authorize emergent admissions to "48 hours of receipt of required clinical documentation by the UM clinician." *Id.* at 687.

STHS's performance under the contract continued until March 1, 2015, when the contract expired in accordance with its terms.

III. Invoicing and Payment Disputes Pre-Dating CBCA 6808

A. Reimbursement Classification (CBCA 2774, 2775, 4445, and 5809)

1. CBCA 2774, 2775, and 4445

During contract performance, multiple disputes arose regarding bills that STHS submitted and payments that it received under the contract. CBCA 2774, 2775, and 4445[9] concerned disputes over inpatient rehabilitation medical claims for patient treatment from April 6, 2009, through September 30, 2010, the reimbursement of which STHS argued the VA had improperly limited to the Centers for Medicare & Medicaid Services' Diagnostic-Related Group (DRG) reimbursement rate, precluding reimbursement at the typically higher

[9] The Board docketed the first two appeals that STHS filed on March 13, 2012, as CBCA 2774 and 2775. The Board subsequently dismissed CBCA 2774 for lack of jurisdiction, and STHS submitted a new claim to cover the medical claims at issue in CBCA 2774. STHS then appealed the denial of the new claim, and the Clerk docketed that appeal as CBCA 4445.

Case-Mix Group (CMG) rate. *See McAllen Hospitals LP v. Department of Veterans Affairs*, CBCA 2774, et al., 14-1 BCA ¶ 35,758, at 174,972-74. STHS argued when seeking summary judgment, and the Board ultimately agreed, that STHS was entitled to reimbursement at the higher CMG rate, but the Board was unable to decide quantum. *See id.* STHS also alleged that, unrelated to the DRG/CMG reimbursement rate issue, the VA's claims processing system indiscriminately altered reimbursement amounts so that STHS was variously underpaid and overpaid in amounts that conflicted with then-current Medicare rates. *Id.* at 174,974. In support, STHS provided the contracting officer, but not the Board, with 1434 medical claims. *See id.* at 174,968. The Board, in response to the parties' cross-motions for summary judgment, found that it lacked sufficient information in the record to resolve the later underpayment issue. *Id.* at 174,974.

Subsequently, in September 2015, the parties entered into a settlement of "all claims arising under the appeals" docketed as 2775 and 4445. Complaint, Exhibit 7 ¶ 1. Pursuant to the parties' settlement agreement, STHS, upon payment of a judgment by the Government, "release[d] [the VA] and the United States Government from any and all liability heretofore accrued under the contract regarding the aforementioned appeals." *Id.* ¶ 3. At the parties' request, the Board entered a stipulated judgment on December 16, 2015, requiring the VA to pay STHS $816,000 in CBCA 2775 and 4445. *McAllen Hospitals LP v. Department of Veterans Affairs*, CBCA 2775, et al., 16-1 BCA ¶ 36,190, at 176,569 (2015).

2. CBCA 5809

On August 7, 2017, STHS filed another appeal, this time seeking payment of $3.072 million, which the Clerk docketed as CBCA 5809. That appeal involved a certified claim, which STHS had submitted to the contracting officer on September 12, 2016, involving the same theories as those underlying CBCA 2774, 2775, and 4445—specifically, that the VA had underpaid inpatient rehabilitation medical claims (beyond those identified in CBCA 2774, 2775, and 4445) using a DRG rather than CMG reimbursement classification and had indiscriminately underpaid other medical claims because of a defect in the VA's claims processing system. *See* Complaint, Exhibit 8 at 1-5. The medical claims in CBCA 5809 involved services provided from the commencement of the contract up until March 20, 2015.

The parties settled that dispute before the Board considered the merits and, in the September 4, 2019, settlement agreement through which the VA agreed to pay STHS an additional $1.65 million, included the following release language:

> STHS' Release of VA: Subject to and contingent upon the VA fulfilling its obligations under this Agreement, STHS . . . agrees that such relief constitutes full and complete settlement and satisfaction and releases the VA from any and

> all claims of any nature, filed or not, arising out of or relating to any and all requests for payment for all of the claims for services contained in the Appeal, more specifically identified in the Claims as inpatient rehab claims (IRF), Inpatient claims (DRG), physician and facility underpayments, "miscellaneous claims," or any other bases, for the time period covering April 6, 2009 through March 1, 2015 . . . .

Complaint, Exhibit 9 ¶ 4. On September 25, 2019, at the parties' request, the Board dismissed CBCA 5809 with prejudice.

B. Observation-Status Versus Inpatient-Status Authorization (CBCA 3798)

In CBCA 3798, STHS presented a different type of payment dispute under its contract. For several patients, STHS billed the VA for "inpatient" status even though the VA had authorized only "observation" status for those patients. Exhibit 19; Respondent's Statement of Undisputed Facts (RSUF) ¶ 10; Appellant's Statement of Genuine Issues (ASGI) ¶ 10. According to STHS, when each patient presented to STHS's hospital, STHS's onsite medical personnel would observe the patient and assess the veteran's medical needs based on the InterQual or comparable criteria. STHS alleges that the contract essentially required application of the Centers for Medicare and Medicaid Services' "two midnight" rule: a patient would be classified as "inpatient" if expected to have to stay in the hospital for two or more midnights but would be classified as "observation" if less than two midnights in the hospital were anticipated. Complaint ¶ 25 n.3. In the situations that STHS raised in CBCA 3798, STHS had determined that patients needed to be admitted to the hospital and performed services that it deemed medically necessary based upon that inpatient status. STHS informed the VA QM/UM clinicians of the admission, as required under the contract, but, for the medical claims raised in CBCA 3798, the VA QM/UM clinicians only authorized observation status, making a coverage eligibility determination that differed from what STHS had recommended.

STHS subsequently submitted bills to the VA for the services that it actually provided under the medical claims in CBCA 3798, rather than the services that the VA QM/UM clinicians had authorized. The VA rejected these bills because STHS was billing for an unauthorized status. RSUF ¶ 10; ASGI ¶ 10. STHS alleges that, in July 2013, pursuant to ongoing negotiations with the VA, STHS resubmitted ninety-eight disputed patient claims, downgrading them from inpatient to observation status. Complaint, Declaration of Diana Vittitoe ¶¶ 9-10; Appellant's Opposition Brief at 8; Appellant's Response to Respondent's Submission at 2. Despite the change in status in the submission, the VA allegedly rejected

these resubmitted claims. Vittitoe Declaration ¶ 11.[10] On December 1, 2013, STHS submitted a certified claim alleging improper classification of the ninety-eight patient claims (but not mentioning the allegedly unpaid resubmitted observation status claims) and seeking payment at the inpatient status amount:

> STHS Case Managers have sought on multiple occasions to explain to VA QM/QA clinicians how these 98 patients satisfied the InterQual and medical necessity criteria for inpatient status, but have been unsuccessful obtaining inpatient authorization for these cases. STHS should have been paid $950,469.01 for these patients and claims this amount as part of this certified claim.

Complaint, Exhibit 11 at 2. STHS included in that claim a separate request for the return of $1,295,595.21 in monies that STHS had been paid but had voluntarily refunded to the VA. *Id.* STHS had originally refunded the money because it had believed that the VA's claims system had, in error, "automatically added approximately 2.0% to the payment for all inpatient DRGs under the contract," but STHS subsequently determined the 2% markup was appropriate and asked in the claim for a return of its refund. *Id.* The contracting officer denied the claim, and, on June 30, 2014, STHS filed a notice of appeal with the Board, which the Clerk docketed as CBCA 3798.

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[10] We note that this allegation—that, in July 2013, STHS resubmitted ninety-eight medical claims for observation status payment and that the VA still failed to pay them, causing STHS to submit its certified claim—is inconsistent with the record that the parties previously developed in CBCA 3798. In the certified claim underlying CBCA 3798, which STHS alleges post-dates its resubmission of the ninety-eight medical claims as observation, STHS sought payment of ninety-eight medical claims on an inpatient status basis, without mentioning any resubmissions or outstanding requests for observation status payments. *See* Complaint, Exhibit 11. The "Whereas" clauses in the parties' subsequent settlement agreement in CBCA 3798 provided that, "following mediation" before the Board in mid-2018, "STHS re-submitted claims as observation to coincide with the authorization code provided at the time of service by [the VA] that were initially billed by STHS as inpatient" and that the "VA re-processed and paid th[os]e claims." *Id.*, Exhibit 12 at 1-2. Nowhere in the CBCA 3798 settlement agreement or anywhere else in the CBCA 3798 record do the parties indicate that, at some date *prior* to mid-2018, STHS had resubmitted its inpatient status medical claims as observation status medical claims. For purposes of the VA's current motion, as discussed below, we need not resolve this inconsistency.

The Board commenced a hearing in CBCA 3798 on November 5, 2018, but suspended proceedings when, before testimony had commenced, the parties announced that they had reached a settlement. On December 12, 2018, the parties entered into a settlement agreement that included the following language:

> Payment by the VA. (a) The VA shall pay STHS the sum of SIX HUNDRED AND FORTY THOUSAND DOLLARS AND NO/100 ($640,000.00) representing full and final payment, inclusive of interest, under the Contract. The VA has such funds available and shall make such payment within 45 days of the execution of this Agreement.
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> . . . .
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> STHS' Release of VA: Subject to and contingent upon the VA fulfilling its obligations under this Agreement [to pay STHS $640,000], STHS, for and on behalf of its shareholders, officers, directors, employees, affiliates, surety, legal successors, heirs, assigns, attorneys, subcontractors and suppliers hereby agrees that such relief constitutes full and complete settlement and satisfaction of and releases the VA from all claims of any nature, filed or not arising out of or relating to requests for payment for "refunds, overpayments and admission status disputes" for the time period covering April 4, 2009 through July 4, 2014, STHS' Claim dated December 1, 2013, and VA's [contracting officer's final decision (COFD)], which were or which could have been asserted in the Appeal, including but not limited to any and all claims for costs, direct and indirect; all interest, including Contract Disputes Act interest; and attorney fees, including those recoverable under the Equal Access to Justice Act (EAJA).

Complaint, Exhibit 12 ¶¶ 2, 4. The settlement agreement contained an integration clause providing that the agreement "constitutes the entire agreement between the Parties with respect to the subject matter hereof and supersedes all prior negotiations and agreements between the Parties, whether written or oral, concerning the subject matter of this Agreement" and that "[n]o other representations, covenants, undertakings or other prior or contemporaneous agreements, oral or written, respecting such matters . . . shall be deemed in any way to exist or bind any of the Parties hereto." *Id.* ¶ 16.

On February 9, 2019, the parties filed a status report with the Board in CBCA 3798, representing that, on December 26, 2018, STHS had received the payment identified in the settlement agreement. On February 14, 2019, at the parties' request, the Board entered an order dismissing CBCA 3798 with prejudice.

IV. STHS's Current Certified Claim

On February 3, 2020, STHS submitted a new certified claim to the contracting officer seeking payment of an additional $3,076,320.59 under the same rationale that it set forth in CBCA 3798. Specifically, STHS sought payment of an unidentified number of medical claims that, like the ninety-eight medical claims that were the subject of CBCA 3798, it had billed for payment as inpatient status but that the VA had only authorized for observation; STHS alleged that the VA never paid these medical claims. Exhibit 13 at 723-26.[11] On February 4, 2020, the contracting officer issued a final decision denying the claim on several bases, including that STHS did not identify in the certified claim any particular medical claims that it contended were unpaid, leaving the contracting officer to guess at what medical claims were at issue, and that the VA had "paid in full for all services performed under this contract through proper payments and under the multiple CBCA settlement agreements." Exhibit 14 at 908.

STHS filed a notice of appeal with the Board on May 4, 2020, which the Clerk docketed as CBCA 6808. STHS subsequently filed a complaint in which it identified 393 medical claims that the VA had authorized for "observation," that STHS had submitted for payment only as "inpatient," that the VA had not paid, and for which STHS was now seeking payment. Complaint ¶¶ 45-47, 49; Vittitoe Declaration ¶ 14 & Exhibit A. STHS also alleged that there was no overlap between the ninety-eight medical claims at issue in CBCA 3798 and the 393 medical claims at issue in CBCA 6808. *Id.* ¶¶ 38, 48.

In lieu of an answer, the VA filed the dispositive motion now before us. After the parties completed briefing, the Board requested additional information and clarifications to which the parties responded through supplemental filings.

Discussion

I. Standard of Review

The VA asks us to dismiss this appeal for failure to state a claim or, in the alternative, for summary judgment. In its motion, the VA quotes the deposition testimony of various individuals taken in CBCA 3798, none of which is contained in STHS's notice of appeal or complaint. With its reply to STHS's response to the VA's motion, the VA provides witness declarations and other documentary evidence to support its entitlement to judgment. "[I]f

[11] Unlike CBCA 3798, STHS did not include a request for the return of refunds that STHS had previously made.

matters outside the complainant's pleading are presented to the [tribunal] the motion shall be treated as one for summary judgment." *Advanced Cardiovascular Systems, Inc. v. SciMed Life Systems, Inc.*, 988 F.2d 1157, 1164 (Fed. Cir. 1993); *see* 5C Charles Alan Wright & Arthur R. Miller, Federal Practice and Procedure § 1366 (3d ed. 2018). Even if some of the VA's arguments might stand without reference to the outside evidence, where "the facts are not in dispute and only legal issues are contested," a tribunal has the discretion to treat a motion to dismiss for failure to state a claim as a summary judgment motion. *Canadian Wheat Board v. United States*, 580 F. Supp. 2d 1350, 1356 (Ct. Int'l Trade 2008), *aff'd*, 641 F.3d 1344 (Fed. Cir. 2011). In the circumstances here, we treat the entirety of the VA's motion as one for summary judgment. Because the VA provided a comprehensive statement of undisputed material facts covering the entirety of its motion, to which STHS has responded through a statement of genuine issues, STHS can suffer no prejudice from this conversion. In accordance with Rule 12(d) of the Federal Rules of Civil Procedure, both parties have been given a reasonable opportunity to present all material pertinent to the VA's motion.

"The standards of review and obligations of each party to prevail on a motion for summary judgment are well established." *Mission Support Alliance, LLC v. Department of Energy*, CBCA 6477, 20-1 BCA ¶ 37,657, at 182,834 (citing *Pernix Serka Joint Venture v. Department of State*, CBCA 5683, 20-1 BCA ¶ 37,589, at 182,522). "[A] party may move for summary judgment on all or part of a claim or defense which we will only grant if the party 'is entitled to judgment as a matter of law based on undisputed material facts.'" *Id.* (citing Board Rule 8(f) (48 CFR 6101.8(f) (2019)); *see CSI Aviation, Inc. v. General Services Administration*, CBCA 6543, 20-1 BCA ¶ 37,580, at 182,479. "We draw inferences in the light most favorable to the party opposing the motion." *Mission Support*, 20-1 BCA at 182,834 (citing *Celotex Corp. v. Catrett*, 477 U.S. 317 (1986)).

II. STHS's Alleged Failure to Exhaust Administrative Remedies

The VA argues that the Board should dismiss this appeal because, when the VA originally declined to authorize inpatient status, STHS failed to exhaust available administrative remedies under its contract through which it could have challenged that determination. The administrative remedy that the VA identifies is contained in mod 0002 of the contract, which, as previously discussed, was issued unilaterally by the contracting officer in October 2010. Exhibit 5. Prior to the issuance of mod 0002, the contract provided that, after STHS notified the VA QM/UM clinician of a patient admission, the clinician had one business day to decide whether to authorize coverage. Exhibit 3 at 607, 635. If the VA QM/UM clinician did not make the coverage determination "within twenty-four (24) hours" after notification, STHS had to "consider the patient private pay and . . . bill other insurance or the patient." *Id.* at 635. Once authorization was decided, it was not subject to revision.

Id. at 607, 635. Through mod 0002, the VA attempted to add an administrative appeal process to the contract that STHS could pursue if it disagreed with the VA QM/UM clinician's original authorization decision, allowing for appeals "within 30 calendar days of denial of authorization." Exhibit 5 at 686.

The VA believes that, because STHS did not follow this appeal process for any of the medical claims that it is now pursuing, its current challenges are barred. STHS disagrees, arguing that the VA cannot enforce the administrative appeal process because it was added to the contract through a unilateral modification to which STHS says it never agreed. STHS asserts that, under FAR 52.212-4(c), "[c]hanges in the terms and conditions of this contract may be made only by written agreement of the parties" and that unilateral modifications do not evidence an agreement of the parties.

We need not address STHS's argument because, even if the administrative process set forth in mod 0002 was properly incorporated into STHS's contract, it does not purport to be mandatory, meaning that STHS would not have been required to utilize it. Mod 0002 provides that "[n]on-authorization of care *can* be appealed by submitting a formal request in writing through the VA UM nurse to the Valley Coastal Bend Chief of Staff or appointed designee," Exhibit 5 at 686 (emphasis added), but it does not purport to make that process the exclusive means of, or a mandatory procedure for, challenging an authorization decision. A claimant is not required to exhaust a claims processing administrative remedy if the administrative process at issue is not mandatory. *See Martinez v. United States*, 333 F.3d 1295, 1304 (Fed. Cir. 2003) ("[A] plaintiff is not required to exhaust a permissive administrative remedy before bringing suit."); *Friedman v. United States*, 310 F.2d 381, 388 (Ct. Cl. 1962) ("Where . . . an administrative remedy is permissive . . . , suit may be brought without exhausting the remedy."). STHS's failure to utilize the permissive administrative remedy contained in mod 0002 provides no basis for barring STHS's current challenges to the VA's medical claims denials.

III. The Release in the CBCA 3798 Settlement Agreement

The VA argues that STHS is barred from pursuing the 393 medical claims identified in STHS's complaint because, as part of the settlement of CBCA 3798, it signed a release that bars any further claims challenging the VA's decisions authorizing "observation" rather than "inpatient" status.

"A release is a contract whereby a party abandons a claim or relinquishes a right that could be asserted against another." *Holland v. United States*, 621 F.3d 1366, 1377 (Fed. Cir. 2010) (citation omitted). "As a general rule, the execution by a contractor of a release which is complete on its face reflects the contractor's unqualified acceptance and agreement with

its terms and is binding on both parties." *K-Con Building Systems, Inc. v. United States*, 107 Fed. Cl. 571, 600 (2012) (quoting *Clark Mechanical Contractors, Inc. v. United States*, 5 Cl. Ct. 84, 86 (1984)); *see H.L.C. & Associates Construction Co. v. United States*, 367 F.2d 586, 590 (Ct. Cl. 1966) ("[A] general release precludes a party to the contractual armistice from renewing or initiating further combat."). Nevertheless, "[i]n interpreting the release, we first ascertain whether its language clearly bars the asserted claim." *Dureiko v. United States*, 209 F.3d 1345, 1356 (Fed. Cir. 2000). "If the provisions of a release are 'clear and unambiguous, they must be given their plain and ordinary meaning.'" *Holland*, 621 F.3d at 1378 (quoting *Bell BCI Co. v. United States*, 570 F.3d 1337, 1341 (Fed. Cir. 2009)). "If the release is ambiguous as to its scope of coverage, we construe its language to effect the parties' intent at the time they executed the release." *Dureiko*, 209 F.3d at 1356.

The language at issue here provides for the release of "all claims of any nature, filed or not arising out of or relating to requests for payment for 'refunds, overpayments and admission disputes' for the time period covering April 4, 2009 through July 4, 2014, STHS' Claim dated December 1, 2013, and VA's COFD, *which were or which could have been asserted in the [CBCA 3798] appeal*." Complaint, Exhibit 12 ¶ 4 (emphasis added). Although, on its face, the provision uses broad language to describe the scope of the release (i.e., "all claims of any nature" and "filed or not arising out of or relating to requests for payment"), the end of the clause limits that broad language to those claims "which were or which could have been asserted in the [CBCA 3798] appeal." *Id.* That limitation is fatal to the VA's release argument.

As a jurisdictional prerequisite to the Board's consideration of a contract appeal, "[t]he CDA requires a claimant to submit [a] claim 'to the contracting officer for a decision'" that includes a request for monetary relief in a sum certain. *Lee's Ford Dock, Inc. v. Secretary of the Army*, 865 F.3d 1361, 1369 (Fed. Cir. 2017) (quoting 41 U.S.C. § 7103(a)(1)). On appeal, "the Board may not consider 'new' claims [that] a contractor failed to present to the contracting officer." *Id.* Only if the 393 medical claims that STHS is now pursuing were encompassed within the certified claim underlying CBCA 3798—that is, if they "ar[o]se from the same operative facts, claim[ed] essentially the same relief, and merely assert[ed] differing legal theories for that recovery," *Scott Timber Co. v. United States*, 333 F.3d 1358, 1365 (Fed. Cir. 2003)—could they, as required by the language of the CBCA 3798 settlement agreement, "have been asserted in the [CBCA 3798] appeal." Complaint, Exhibit 12 ¶ 4.

In the CBCA 3798 certified claim, STHS identified ninety-eight specific medical claims that it alleged the VA had incorrectly authorized as observation rather than inpatient, stating that "STHS Case Managers have sought on multiple occasions to explain to VA [QM/UM] clinicians how these 98 patients satisfied the InterQual and medical necessity

criteria for inpatient status, but have been unsuccessful obtaining inpatient authorization for these cases." Complaint, Exhibit 11 at 2. Each of those medical claims was essentially an invoice to the VA seeking payment. STHS's CBCA 3798 certified claim was limited to the VA's non-payment of those ninety-eight identified invoices. To the extent that STHS might have chosen to submit a certified claim that more broadly encompassed all medical claims for which the VA had ever limited authorization to observation status, it did not do so. Because STHS could not have asserted the 393 patient claims in CBCA 3798, they are not covered by the release in the CBCA 3798 settlement agreement, and the medical claims at issue in this appeal are not barred by that release.[12]

That does not mean that the CBCA 3798 settlement agreement is necessarily irrelevant to the viability of the 393 medical claims being presented here. Paragraph 2 of the CBCA 3798 settlement agreement expressly provides that "[t]he VA shall pay STHS the sum of [$640,000], representing full and final payment, inclusive of interest, under the Contract," suggesting a finality to the entire contract that is not reflected in the release. Complaint, Exhibit 12. The absence of that language in the release does not, in and of itself, automatically mean that the medical claims could not be covered by an accord and satisfaction. *See Holland*, 621 F.3d at 1377 ("In an accord and satisfaction . . . a claim is discharged because some performance other than that which was claimed to be due is accepted as full satisfaction of the claim."). It is unclear from its briefing, however, whether the VA intended its release argument to encompass the related accord and satisfaction doctrine. The VA never expressly mentions accord and satisfaction, and STHS does not address it in its responses, but the doctrines of release and of accord and satisfaction are frequently mixed together without distinguishing between them, even though release and accord and satisfaction are separate contractual defenses with separate elements. *Id.*; *see McLain Plumbing & Electrical Service, Inc. v. United States*, 30 Fed. Cl. 70, 78-79 (1993) (thoroughly explaining the distinctions between the doctrines of release and of accord and satisfaction).

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[12] Although in its motion for summary judgment the VA only requests judgment based upon the CBCA 3798 settlement agreement release, the discussion in its briefing appears to suggest that STHS's current medical claims are also barred by the release in the CBCA 5809 settlement agreement. The CBCA 5809 release is tied to "claims for services contained in the [CBCA 5809] Appeal," Complaint, Exhibit 9 ¶ 4, which does not involve the issues or medical claims at issue in this appeal. The VA has not established that the CBCA 5809 release affects STHS's ability to pursue its observation-versus-inpatient issue here.

We are wary of addressing a defense that the VA raised, if at all, in a manner that did not put STHS on notice that it was required to respond to it. Although the VA might have equated the release doctrine with the accord and satisfaction doctrine and expected us to address both here, we will put aside any concerns about a potential accord and satisfaction unless and until the VA elects to present such an argument to us, and to STHS, in a more direct and fulsome manner.

IV. Time-Barred Claims

A. Claim Accrual

Of the 393 medical claims at issue in this appeal, 262 of them involve episodes of care that occurred between November 2009 and January 2014. STHS did not submit its certified claim seeking payment on those medical claims until February 3, 2020. The VA argues that all medical claims involving episodes of care that occurred on or before February 3, 2014, are barred by the CDA's statute of limitations.

Pursuant to the CDA, "[e]ach claim by a contractor against the Federal Government relating to a contract . . . shall be submitted within 6 years after accrual of the claim." 41 U.S.C. § 7103(a)(4); *see* FAR 33.206(a) ("Contractor claims shall be submitted, in writing, to the contracting officer for a decision within 6 years after accrual of a claim, unless the contracting parties agreed to a shorter time period."). "A party's failure to submit a claim within six years of accrual is an affirmative defense to the claim," and, as such, the burden is on the VA to prove that the medical claims are barred by the statute of limitations. *ThinkGlobal Inc. v. Department of Commerce*, CBCA 4410, 16-1 BCA ¶ 36,489, at 177,793. "Whether and when a claim has accrued is determined according to the [FAR], the language of the contract, and the facts of the particular case." *Electric Boat Corp. v. Secretary of the Navy*, 958 F.3d 1372, 1375 (Fed. Cir. 2020).

The FAR defines claim accrual as "the date when all events that fix the alleged liability on either the Government or the contractor and permit assertion of the claim, were known or should have been known. For liability to be fixed, some injury must have occurred. However, monetary damages need not have been incurred." FAR 33.201. "Generally, '[i]n the case of a breach of a contract, a cause of action accrues when the breach occurs.'" *Alder Terrace, Inc. v. United States*, 161 F.3d 1372, 1377 (Fed. Cir. 1998) (quoting *Manufacturers Aircraft Ass'n v. United States*, 77 Ct. Cl. 481, 523 (1933)). "[O]nce a party is on notice that it has a potential claim the limitations period begins to run." *ThinkGlobal Inc.*, 16-1 BCA at 177,793 (quoting *Cardinal Maintenance Service, Inc.*, ASBCA 56885, 11-1 BCA ¶ 34,616, at 170,610 (2010)). "Claim accrual does not depend on the degree of detail provided. . . . It is enough that the [party] knows, or has reason to know, that some

costs have been incurred, even if the amount is not finalized or a fuller analysis will follow." *Raytheon Co., Space & Airborne Systems*, ASBCA 57801, et al., 13 BCA ¶ 35,319, at 173,377. "The issue of 'whether the pertinent events have occurred [to allow a claim to accrue] is determined under an objective standard; a plaintiff does not have to possess actual knowledge of all the relevant facts in order for the cause of action to accrue.'" *FloorPro, Inc. v. United States*, 680 F.3d 1377, 1381 (Fed. Cir. 2012) (quoting *Fallini v. United States*, 56 F.3d 1378, 1380 (Fed. Cir. 1995)).

"[T]o determine when appellant's claims accrued, and the events that fixed the alleged liability, we start by examining the legal basis for each particular claim." *Crane & Co. v. Department of the Treasury*, CBCA 4965, 16-1 BCA ¶ 36,539, at 178,007 (quoting *Environmental Safety Consultants, Inc.*, ASBCA 54615, 07-1 BCA ¶ 33,483, at 165,984). Typically, "[w]here a claim is based upon a contractual obligation of the Government to pay money, the claim first accrues on the date when the payment becomes due and is wrongfully withheld in breach of the contract." *OST, Inc. v. Department of Homeland Security*, CBCA 7077, et al., slip op. at 17 (July 31, 2023) (quoting *Oceanic Steamship Co. v. United States*, 165 Ct. Cl. 217, 225 (1964)). Here, STHS could have attempted to argue that, because it had forty-five days after a patient's authorized "episode of care" to submit its medical claim or invoice (Exhibit 3 at 634) and the VA had thirty days either to pay or reject the medical claim (*id.* at 633-34), the CDA statute of limitations could not begin to run until the seventy-five-day total of those two periods expired for each of the 393 medical claims at issue here.

In this case, though, the event that established the VA's inability to pay for inpatient status—the alleged "breach"—pre-dated STHS's actual submission of its invoices. Under STHS's contract, "[p]ayment [would] be made only for those claims [the] VA ha[d] [previously] authorized for payment." Exhibit 3 at 607. When STHS admitted a patient, STHS was required to notify the VA QM/UM clinician of the admission by the next business day. *Id.* at 632. Once notified, the VA QM/UM clinician had one business day to make and notify STHS of the VA's coverage and authorization decision. *Id.* at 607, 635. If the VA QM/UM clinician did not make the coverage determination "within twenty-four (24) hours," STHS had to "consider the patient private pay and . . . bill other insurance or the patient." *Id.* at 635. The contract, as originally written, contained no administrative appeal process for authorization decisions with which STHS disagreed. Accordingly, within a maximum of seventy-two hours or so, the entire authorization determination and notification process was complete.

Once the VA informed STHS of the status that it had authorized (that is, observation status rather than inpatient status), the manner in which STHS could invoice the VA and the service level for which it could be paid was set, and STHS knew as soon as the VA told it of that decision that it could not be paid at the inpatient level. As noted above, under the

FAR, a claim accrues on "the date when all events that fix the alleged liability on either the Government or the contractor and permit assertion of the claim, were known or should have been known," so long as "some injury . . . ha[s] occurred." FAR 33.201. Here, STHS's receipt of the VA's unappealable authorization determination that the VA would only pay for observation status established the injury about which STHS now complains—the VA's refusal to pay for inpatient status. When the VA provided STHS with its authorization decision, STHS had already incurred some injury—the patient was already admitted to the hospital, and STHS was already incurring or had incurred costs associated with the patient's treatment. In such circumstances, the CDA statute of limitations accrued for each of the 393 medical claims at issue here when the VA provided STHS with its authorization decision on each claim or failed timely to respond to STHS's inpatient admission notification, whichever is earlier.

STHS's only defense to this claim accrual analysis is an argument that the contract creates no claim accrual deadline at all—ever—asserting that the contract "provides scant guidance on the medical claims process with respect to emergent care." Appellant's Response to Respondent's Submission at 1. To reach its conclusion, STHS ignores contract provisions that it does not like, pretending that they are not there, while arguing that other provisions, to the extent that it acknowledges them, are not actually a part of the contract.[13]

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[13] Clause B.4 in STHS's contract, titled "Statement of Objectives" (SOO), covers twenty pages of the sixty-eight-page contract and contains many of the contract's billing, authorization, and payment processing terms, plus provisions addressing the contract's periods of performance, contract definitions, insurance liability limitations, and duties of the contracting officer's technical representative. Exhibit 3 at 619-39. In the certified claim underlying this appeal and again in its complaint, STHS quotes from FAR 2.101, which defines the SOO as "a Government-prepared document incorporated into the solicitation that states the overall performance objectives." Complaint ¶ 11 n.1; *see* Exhibit 13 at 723 n.1. It then quotes from FAR 37.602(c), which provides that "[o]fferors use the SOO to develop the [performance work statement (PWS) in the contract]; however, the SOO does not become part of the contract." In its summary judgment briefing, STHS seems to suggest that some provisions in clause B.4 are not actually a part of the contract because the clause is titled "Statement of Objectives," even though, at other times, STHS cites to and relies on provisions within clause B.4. To the extent that STHS is arguing that clause B.4 is not a part of the contract, that argument must fail. Given the clause's position in the contract and the fact that it is referenced in other contract clauses, it is clear that the clause is intended to serve as the contract's PWS, and STHS never objected to the clause's inclusion in the contract (with the SOO title) prior to contract award or, as far as we can tell, at any time before submitting the certified claim underlying CBCA 6808. STHS's failure timely to

When interpreting a contract, we consider all of its provisions, read as a whole, rather than selectively picking and choosing among them. *United International Investigative Services v. United States*, 109 F.3d 734, 737 (Fed. Cir. 1997). STHS's contract interpretation based upon selective portions of the contract cannot prevail.

STHS also argues that there are material facts in dispute that preclude summary judgment because "[t]he Contract makes clear that STHS's medical professionals had the ultimate authority and responsibility to determine the best course of treatment for patients," "the VA did not have authority to question STHS's medical professional's judgments," and the parties' disagreement over "the Contract's clear language" creates a genuine dispute of material fact. Appellant's Opposition Brief at 20. Putting aside that the proper interpretation of "clear language" in a contract is viewed as a question of law rather than as a factual issue, *Varilease Technology Group, Inc. v. United States*, 289 F.3d 795, 798 (Fed. Cir. 2002), STHS's alleged genuine issue goes to the merits of its payment demands. It is irrelevant to the issue of when its claims accrued.

Although STHS does not cite to it, we recognize that the VA purported to add an administrative appeal process in mod 0002 that allowed STHS to challenge authorization decisions. Setting aside STHS's argument that unilateral mod 0002 is not even valid because STHS did not agree to the modification, mod 0002 could not defer claim accrual here for at least two other reasons. First, STHS never took advantage of the administrative process set forth in mod 0002, meaning that STHS did not attempt to use it to suspend or extend the finality of the VA's original authorization decision for any of its medical claims. Second, even if it had, the administrative appeal process in mod 0002 was permissive, and resort to a permissive administrative appeal process does not serve to extend claim accrual deadlines. *See Martinez*, 333 F.3d at 1304 ("[A] plaintiff's invocation of a permissive administrative remedy does not prevent the accrual of the plaintiff's cause of action, nor does it toll the statute of limitations pending the exhaustion of that administrative remedy.").

B. STHS's Arguments for Equitable Tolling

STHS argues that, even if some of its medical claims could have accrued more than six years before February 4, 2020, equitable tolling preserves all of them. The CDA's six-year limitation for submitting claims is subject to equitable tolling. *Arctic Slope Native Ass'n, Ltd. v. Sebelius*, 583 F.3d 785, 798-800 (Fed. Cir. 2009). Nevertheless, "a litigant is

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protest the title of clause B.4 prior to award waived any objections to it. *See, e.g.*, *Whittaker Electronic Systems v. Dalton*, 124 F.3d 1443, 1446 (Fed. Cir. 1997); *E. Walters & Co. v. United States*, 576 F.2d 362, 367-68 (Ct. Cl. 1978).

entitled to equitable tolling of a statute of limitations only if the litigant establishes two elements: '(1) that he has been pursuing his rights diligently, and (2) that some extraordinary circumstance stood in his way and prevented timely filing.'" *Menominee Indian Tribe of Wisconsin v. United States*, 577 U.S. 250, 255 (2016) (quoting *Holland v. Florida*, 560 U.S. 631, 649 (2010)). Equitable tolling is a very limited doctrine, typically available only if the adversary engaged in some kind of prejudicial trickery:

> Federal courts have typically extended equitable relief only sparingly. We have allowed equitable tolling in situations where the claimant has actively pursued his judicial remedies by filing a defective pleading during the statutory period, or where the complainant has been induced or tricked by his adversary's misconduct into allowing the filing deadline to pass. We have generally been much less forgiving in receiving late filings where the claimant failed to exercise due diligence in preserving his legal rights.

Irwin v. Department of Veterans Affairs, 498 U.S. 89, 96 (1990) (citations omitted).

STHS's first argument in support of equitable tolling is that it attempted, "[o]n several occasions, . . . to informally resolve these issues." Complaint ¶ 32. It alleges that the parties "engaged in discussions during the performance of the Contract in an effort to understand and resolve their differing understanding of the contract requirements" and that, "[i]n light of the parties' ongoing discussions and punitive resolutions, the date on which STHS knew or should have known all events fixing the VA's liability remains subject to disputed material fact." Appellant's Opposition at 5-6. Yet, "[t]he mere continuance of negotiations, even where United States representatives express a view that a settlement is likely, constitutes no reason to extend the limitations period." *Brighton Village Associates v. United States*, 52 F.3d 1056, 1061 (Fed. Cir. 1995) (quoting *Cuban Truck & Equipment Co. v. United States*, 333 F.2d 873, 879 n.15 (Ct. Cl. 1964)); *see Henry Products Co. v. United States*, 180 Ct. Cl. 928, 930 (1967) ("[V]oluntary settlement negotiations have no effect on the running of the statute of limitations once it has begun."). STHS's allegations do not support equitable tolling.

Additionally, STHS claims that the VA essentially tricked it into downgrading the ninety-eight medical claims at issue in CBCA 3798 (but not the 393 medical claims at issue in this appeal) even though the VA was never going to pay those bills and suggests that this chicanery caused STHS not to bother resubmitting these 393 medical claims. Appellant's Opposition at 8-9. STHS's declarant asserts that, after STHS submitted invoices seeking payment for inpatient status and the VA withheld payment, "the Chief Financial Officer of the VA's Veterans Integrated Services Network directed STHS to downgrade and resubmit the disputed patients from 'inpatient' status to 'observation' status"; that, in July 2013, STHS

resubmitted its medical claims as "observation" status; and that the VA still did not pay them. Vittitoe Declaration ¶¶ 9-11. Putting aside the previously-discussed inconsistency of these allegations with the record in CBCA 3798, the allegation is irrelevant to the monetary request that STHS is making here. STHS is not seeking an observation status payment in this appeal. It is only seeking payment for inpatient status. In fact, it *cannot* seek observation status payment here—nothing in the February 3, 2020, certified claim underlying this appeal alleges a resubmission of the 393 medical claims as "observation," nor does STHS in its certified claim request payment for observation status. *See* Exhibit 13; *see also Santa Fe Engineers, Inc. v. United States*, 818 F.2d 856, 858 (Fed. Cir. 1987) (tribunals lack jurisdiction to entertain claims not submitted for decision to the contracting officer). In its certified claim, STHS seeks only inpatient status payment.

To the extent that STHS is attempting to make some kind of argument that its inaction on the 393 medical claims now at issue is excused because the VA's treatment of the ninety-eight medical claims in CBCA 3798 showed that action (either to continue seeking inpatient status payment or to resubmit medical claims to obtain observation status payment) would be futile, STHS does not identify a viable basis for equitable tolling. Had STHS wanted to pursue observation status in lieu of inpatient status payments, it could have taken action to present such payment requests to the VA. "Its belief that presentment was futile was not an obstacle beyond its control," meaning that equitable tolling does not excuse its presentation failure or defer accrual of the claims for inpatient status payment that it had actually submitted. *Menominee Indian Tribe*, 577 U.S. at 258; *see Gavin v. Club Holdings, LLC*, No. 15-175-RGA, 2016 WL 1298964, at *7 (D. Del. Mar. 31, 2016) (A claimant must have been "prevented by extraordinary external obstacles from pursuing its claims" to invoke equitable tolling.).

Finally, even if events leading to STHS's alleged resubmission of its medical claims in CBCA 3798 could somehow be viewed as a basis for equitably tolling accrual of the 393 medical claims that STHS is now pursuing, STHS allegedly resubmitted the CBCA 3798 medical claims in July 2013. Under the contract, the VA was required to process and pay all invoices within thirty days after receipt, Exhibit 3 at 633-34, making the VA's payment due by August 2013. Even though the VA did not pay the CBCA 3798 medical claims by the August 2013 due date, STHS waited more than six years—until February 2020—to submit its claim for payment of the 393 medical claims now in dispute. STHS has identified no justifiable excuse for that delay.

Decision

For the foregoing reasons, we deny the VA's motion for summary judgment based upon STHS's alleged failure to exhaust administrative remedies and upon its alleged release of its claims. We **GRANT** the VA's motion for **PARTIAL SUMMARY JUDGMENT** on statute of limitations grounds and find that all medical claims for which the VA authorized observation status rather than the requested inpatient status prior to February 3, 2014, are time-barred. The Board will schedule further proceedings by separate order.

Harold D. Lester, Jr.
HAROLD D. LESTER, JR.
Board Judge

We concur:

Beverly M. Russell
BEVERLY M. RUSSELL
Board Judge

Kyle Chadwick
KYLE CHADWICK
Board Judge