PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2000-D3

PROVIDER - Sutter Memorial Hospital
Sacramento, CA

Provider No. 05-0109

vs.

INTERMEDIARY -Blue Cross and Blue Shield Association/Blue Cross of California

DATE OF HEARING-
September 21, 1999

Cost Reporting Period Ended - December 31, 1981, December 31, 1982 and July 31, 1983

CASE NO. 97-2434

INDEX

ISSUE:

Did the Intermediary properly implement PRRB Decision No. 96-D35?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Sutter Memorial Hospital ("Provider") is a non-profit general acute care hospital which provides health care services to the population living in and around Sacramento, California. As part of its charitable mission to provide quality health care services, the Provider furnishes health care services to the local Medicare population.

The Provider, and its sister provider, Sutter General Hospital ("SGH"), appealed to the Provider Reimbursement Review Board ("Board") the partial denial of its request for an exception to the Medicare Program's end stage renal disease ("ESRD") payment screens as applied to its fiscal years ending on December 31, 1981, 1982 and the seven months ending on July 31, 1983. Prior to the Board hearing, the Provider, in a letter to the Blue Cross and Blue Shield Association ("Intermediary") dated May 8, 1995, attempted to enter into a negotiated settlement of the outstanding appeals with the Intermediary.[1] As part of the negotiation, the Provider proposed reducing its administrative and general ("A&G") costs "in order to facilitate the current negotiations between the [parties]." Id. The Provider offered a reduction in its actual cost per treatment ("CPT") for purposes of entering into a negotiated settlement with HCFA and the Intermediary. Id. The Provider and the Intermediary were unable to reach a settlement. Accordingly, the Provider contends that it withdrew the settlement offer in the May 8 letter.

After the settlement offer was withdrawn, the Provider (and "SGH") appeared before the Board on May 25, 1995 to decide the issues on appeal. On June 7, 1996, the Board issued Decision No. 96-D35 and remanded the Provider's ESRD exception request to HCFA.[2] On July 16, 1996, the Health Care Financing Administration ("HCFA") Administrator declined to review the Board's determination.[3]

As stated in the Board's decision,

> [t]he Board finds that the Provider's costs are reasonable. The Provider's costs were subject to a desk audit followed by an onsite

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[1] See Provider Exhibit P-1.

[2] Sutter Memorial Hospital v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 96-D35, June 7, 1996, Medicare & Medicaid Guide (CCH) ¶44,485. (Provider Exhibit P-2.)

[3] Provider Exhibit P-3.

> audit to verify their reasonableness. The Board concludes that HCFA's challenge to the reasonableness of these costs in light of the Intermediary's actual verification, is erroneous. Under the circumstances of this case, the Intermediary's determination that the costs were reasonable is sufficient and complies with ILs 78-9, 79-7 and 82-1.

Provider Exhibit 2, pg. 13 (footnotes omitted).

Although the Board concluded that the ESRD costs at issue were reasonable, the Board determined that there was no evidence to support a finding that HCFA "considered the Provider's exception request individually....." (i.e. separate from SGH, see Provider Exhibit P-2, pg. 13). Accordingly, the Board concluded that it would be improper for it to review the Provider's request absent HCFA's review. Therefore, the Board ordered HCFA and the Intermediary to disaggregate the Provider's and SGH's costs, compare the disaggregated costs to the median CPT and reimburse the Provider and SGH using their actual CPTs, which the Board determined were reasonable. (Exhibit P-2, pg. 13). As stated by the Board, "HCFA's review will not include evaluating the reasonableness of the Provider's costs in delivering ESRD services." (See, Exhibit P-2, pg. 13). It is the Provider's position that the Board specifically instructed HCFA not to adjust the Provider's CPT when determining the appropriate ESRD exception request adjustment.

In response to the Board's remand, HCFA issued a determination on January 2, 1997 (Provider Exhibit P-4). However, instead of using the Provider's actual CPT when calculating the ESRD exception amount, HCFA used the CPT amount proposed by the Provider as part of the pre-hearing negotiations in its letter of May 8, 1995. Accordingly, HCFA did not use actual costs in its ESRD calculation, but instead, based it upon the CPT amount offered by the Provider as part of its withdrawn settlement proposal.[4]

Since HCFA did not base its calculation on the Provider's actual CPT, the Provider submitted a letter to HCFA on January 15, 1997, challenging HCFA's implementation of the Board's determination.[5] In response, HCFA stated that "we still have significant reservations about approving these exceptions considering the inefficiencies that may have occurred at the hospitals during the years 1981, 1982 and 1983."[6] (Emphasis in original.) Accordingly, HCFA again refused to accept the Provider's actual CPT when implementing the Board's determination.

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[4] The CPT amounts offered by the Provider, in its May 8, 1995 letter to the Intermediary, were lower than its actual costs for each of the years at issue in this case. See Provider Position Paper at 4, see also Provider Exhibit P-4. Pg. 4.

[5] See Provider Exhibit P-5.

[6] See Provider Exhibit P-6.

It is the Provider's position that although it prevailed in its appeal, HCFA and, in turn, the Intermediary, disregarded the Board's determination and continues to deny the Provider the ESRD reimbursement to which it is entitled. The Provider contends the Medicare reimbursement impact of HCFA's and the Intermediary's failure to implement the Board's decision is $117,000.[7] On June 12, 1997, the Provider filed an appeal of HCFA's determination under the regulations at 42 C.F.R. §§405.1835-.1841. The Provider is represented by Kenneth J. Yood, Esquire, of Paul, Hastings, Janofsky & Walker LLP. The Intermediary is represented by Bernard M. Talbert, Esquire, of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that HCFA failed to rely on those CPT amounts deemed reasonable by the Board when analyzing the ESRD exception request subsequent to the Board's decision. The Provider maintains that this failure is inappropriate. First, the Board specifically instructed HCFA to accept the Provider's and SGH's CPTs as reasonable. By failing to award the Provider an ESRD exception based upon the Provider's actual CPT, which the Board deemed reasonable, the Provider contends that HCFA defied the Board's order. Second, the Provider argues that the CPT amounts relied on by HCFA were offered as part of the negotiation process and have no relevance given the failure of the parties to negotiate a final settlement. Finally, as acknowledged by the Board, the ESRD exception standards applicable to the fiscal years at issue only require that a provider's costs be reasonable and above the applicable median CPT to obtain an exception to the ESRD payment screens.[8] Therefore, the Provider maintains that HCFA is obligated to award the Provider an ESRD exception based upon the CPTs included in its original exception request and not those in its May 8 letter.[9]

The Provider argues that by rejecting its actual CPT amount in its ESRD determination, HCFA has deemed the Provider's costs unreasonable in contravention of the Board's order. When remanding the ESRD exception requests to HCFA for individual consideration, the Provider contends that the Board specifically limited the scope of HCFA's review. The Provider points out that since HCFA had previously analyzed the ESRD exception requests for SGH and the Provider on an aggregated basis, the Board instructed HCFA to simply individually compare the Provider's and SGH's exception requests and CPTs to the median CPTs that were in existence during the applicable periods. The Provider contends that the Board specifically counseled HCFA that it should not evaluate the

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[7] Provider Position Paper at 1.

[8] Provider Position Paper at 5.

[9] See Provider Position Paper at 6.

reasonableness of the Provider's or SGH's ESRD costs.[10] In its decision, the Board noted that it found sufficient evidence that the costs at issue were reasonable. Therefore, as concluded by the Board, HCFA need only determine that the individual CPTs were higher than the median CPTs to award the Provider and SGH exceptions to the applicable ESRD payment screens.

The Provider contends that HCFA disregarded the Board's instructions by ignoring the Provider's actual CPT and, in turn, challenged the reasonableness of the Provider's ESRD costs. Specifically, the Provider points out that given its "significant reservations about approving these exceptions considering the inefficiencies that may have occurred at the hospitals during the years 1981, 1982 and 1983" (See Provider Exhibit P-6), HCFA determined that the Provider's CPT was too high and, therefore, elected to rely on the CPT amounts offered in compromise and included in the May 8, 1995 memorandum (See Provider Exhibit P-1).

The Provider contends that despite the Intermediary's assertion in its position paper[11] that it and HCFA did not make any determination regarding the reasonableness of the Provider's costs in issuing the ESRD exception request determination, HCFA's and the Intermediary's disallowance of a portion of the Provider's CPT clearly is a "reasonableness" determination. Since the Board determined that all reasonable costs above the ESRD payment screen were entitled to reimbursement as an exception to the screen, the Intermediary's and HCFA's failure to reimburse the Provider for all such costs based upon the Provider's actual CPT is, in effect, a determination that the disallowed costs are unreasonable. Therefore, the Provider maintains that the Intermediary and HCFA have challenged the reasonableness of the Provider's costs in violation of the Board's order.

The Provider argues further that HCFA and the Intermediary may not rely on an offer made in compromise when awarding an ESRD exception request for the Provider. The Provider notes that the CPT amounts included in the May 8, 1995 memorandum (See Provider Exhibit P-1) were presented by the Provider's legal counsel as a possible settlement compromise and not as a correction of the Provider's actual CPT amounts. The Provider contends that its actual CPT amounts were included in the its original ESRD exception request (as well as the May 8, 1995 memorandum), approved by the Intermediary and set forth on page one of HCFA's June 5, 1990 determination letter. The Provider points out that as stated in its memorandum, the proposed reduction to the Provider's CPT amount was offered to "facilitate the current negotiations between the [Provider, SGH] and the Intermediary." Moreover, notwithstanding the compromise offer made by the Provider and SGH, both the Provider and SGH maintained in the memorandum that the Provider's A&G costs are "appropriate" and, in turn, reasonable given the size of the Provider's ESRD facility and the services provided therein. Therefore, since the Provider and the Intermediary did not agree to any settlement prior to the Board hearing, the

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[10] Provider Exhibit P-2, pg. 13.

[11] Intermediary Position Paper at 4.

Provider maintains it is inappropriate to rely on those CPT amounts which were merely proposed as a part of settlement negotiations between the parties.

The Provider maintains that its above conclusion is clearly supported by common law as well as the Federal Rules of Evidence. According to Rule 408, evidence of offering valuable consideration in the compromise of a claim is not admissible to substantiate the amount of the claim.[12] The Provider notes that although the Federal Rules of Evidence are not directly applicable to the current case, Rule 408 evidences the general common law principle that settlement offers do not have any force or effect outside the scope of the negotiation in which they are offered.[13] As described by the court in United States v. Contra Costa County Water District, 678 F.2d 90, 92 (9th Cir. 1982) (Provider Exhibit P-8), the policy rationale which excludes an offer of settlement arises from the fact that the law favors settlements of controversies. The Provider contends that if an offer of a dollar amount by way of compromise were taken as an admission of liability, voluntary efforts at settlement would be chilled. Clearly, this same rationale can be applied equally to the substantiation of the amount of a claim as well as the existence of liability.

As applied to the present case, the Provider contends that the compromise offered in its May 8 memorandum was designed to facilitate the settlement of the dispute so as to avoid the expense of the appeal at issue. The compromise was not offered based upon any understanding that the CPT amounts included in the original ESRD exception request were not reasonable. Therefore, it is the Provider's position that the use of the settlement offer made by the Provider prior to the Board appeal is inappropriate.

Finally, notwithstanding the Provider's actual CPT amounts and the atypicality of its patient population, the Provider maintains that it is entitled to full reimbursement for all reasonable costs incurred in the provision of ESRD services to Medicare patients during the fiscal years at issue. According to the Board, "for the fiscal periods at issue, atypicality was not a legal criterion for determining whether an exception to an ESRD payment screen was "warranted." (See. Provider Exhibit P-2, pg. 12). Moreover, the Provider points out that the Board stated that HCFA may only apply those standards set forth in Intermediary Letters ("ILs") 78-9, 79-7 and 82-1.

The Provider notes that the Board found its costs reasonable, (See Provider Exhibit 2, pg. 13). The Provider also asserts that it fully responded to all HCFA and Intermediary documentation requests. Id. Therefore, further inquiry into the reasonableness of its costs is unnecessary and unwarranted. Accordingly, the Provider contends that all of its costs above the ESRD screen limitations are reasonable and, in turn, reimbursable.

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[12] Provider Exhibit P-7.

[13] Provider Position Paper at 8.

In summary, the Provider maintains that it is entitled to full reimbursement for its actual CPT amounts as reflected in the ESRD exception request submitted by the Provider, and accepted by the Intermediary. Moreover, the Intermediary and HCFA should be compelled to adhere to the Board's determination and award the Provider the appropriate level of ESRD reimbursement.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its determination of the Provider's exception request was in accordance with the Board's instructions on the remand of this case. Specifically, the Intermediary asserts that it has followed the procedures and applied the standards used by HCFA to determine ESRD exception requests for costs above the median cost per treatment for the applicable cost reporting period. Also, in accordance with the Board's orders, the Intermediary asserts that it had reviewed and evaluated the Provider's ESRD exception request separately from that of Sutter Memorial Hospital's request. And finally, the Intermediary asserts that it has made no determination as to the reasonableness of the Provider's costs.

Accordingly, since the Intermediary believes it has complied with the Board's order, it must defer to HCFA's decision since HCFA has the ultimate responsibility for making a decision regarding the Provider's ESRD exception request. In its Position Paper, the Intermediary included HCFA's response to the Provider regarding the Provider's concern of HCFA's implementation of the remand orders in Board Decision 96-D35. In its letter to the Provider dated February 27, 1997[14], HCFA noted the Provider's disagreement with HCFA's decision to utilize data in the Provider's May 8, 1995 proposed settlement memorandum. Further HCFA stated that, "we still have significant reservations about approving these exceptions considering the inefficiencies that may have occurred at the hospitals during the years 1981 to 1983. Therefore, we continue to believe that we have complied with the decision and order of the Board." Id. (emphasis in original.)

Accordingly, the Intermediary contends that its and HCFA's determination was in accordance with the Board's orders.

CITATIONS OF LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS:

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

   § 1395x(v) - Reasonable Cost

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

   §405.402 - Cost Reimbursement; General

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[14] Intermediary Exhibit I-1, Provider Exhibit P-6.

§§ 405.1835-.1841	-	Board Jurisdiction

3. Cases:

Sutter Memorial Hospital v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 96-D35, June 7, 1996, Medicare & Medicaid Guide (CCH) ¶44,485 .

United States v. Contra Costa County Water District, 678 F.2d 90 (9th Cir. 1982).

4. Part A Intermediary Letters:

78-9	-	Submission of Renal Dialysis Facility Cost and Statistical Information
79-7	-	Revised Cost Information to be Reported by All Non-Provider End Stage Renal Disease (ESRD) Facilities
82-1	-	End Stage Renal Disease Facilities-Documentation for Exceptions to Payment Screens

5. Other:

Federal Rules of Evidence-Rule 408

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, and evidence presented, finds and concludes that HCFA did not adhere to the Board's previous determination on this case.[15]

The Board notes that the facts in this case are very clear. Specifically, the Provider had originally appealed to the Board the partial denial of its request for an ESRD exception as applied to its fiscal

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[15] See Sutter Memorial Hospital v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 96-D35, June 7, 1996, Medicare & Medicaid Guide (CCH) ¶44,485. (Provider Exhibit P-2)

years ending on December 31, 1981, 1982 and the seven months ending on July 31, 1983.[16] Prior to the Board hearing on the original appeal, the Provider, in a letter to the Intermediary dated May 8, 1995, attempted to enter into a negotiated settlement for its outstanding appeals with the Intermediary.[17] As part of the negotiation, the Provider proposed reducing its administrative and general ("A&G") costs "in order to facilitate the current negotiations between the [parties]." Id. The Provider offered a reduction in its actual CPT for purposes of entering into a negotiated settlement with HCFA and the Intermediary. Id. The proposed and actual CPTs are as follows:

	1981	1982	1983
Actual CPT amounts[18]	$210.42	$219.77	$227.73
Proposed CPT amounts[19]	$208.89	$214.81	$224.00

The Provider and the Intermediary were unable to reach a settlement and appeared before the Board on May 25, 1995 to decide the issues on appeal. On June 7, 1996, the Board issued Decision No. 96-D35.[20] In its decision, the Board found in favor of the Provider and remanded the case to HCFA with very specific orders. As noted in its decision:

> [t]he Board finds that the Provider's costs are reasonable. The Provider's costs were subject to a desk audit followed by an onsite audit to verify their reasonableness. The Board concludes that HCFA's challenge to the reasonableness of these costs in light of the Intermediary's actual verification, is erroneous. Under the circumstances of this case, the Intermediary's determination that the costs were reasonable is sufficient and complies with ILs 78-9, 79-7 and 82-1. . . .
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> . . . [t]hus the Board restricts HCFA's review of the Provider's reasonable cost above the ESRD payment screens as limited to

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16 Provider originally appealed HCFA's June 5, 1990 denial of its exception request.

17 See Provider Exhibit P-1.

18 See Provider Position Paper at 6. The Intermediary originally recommended approval of the Provider's exception request to HCFA. This exception request included the actual CPT amounts that are the controversy in the current appeal.. See HCFA letter of June 5, 1990 at Intermediary Exhibit I-1.

19 See Provider Exhibit P-1.

20 Sutter Memorial Hospital v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 96-D35, June 7, 1996, Medicare & Medicaid Guide (CCH) ¶44,485. (Provider Exhibit P-2.)

> applying the median CPT that was in existence during the applicable periods. HCFA's review will not include evaluating the reasonableness of the Provider's costs in delivering ESRD services. The Board has found sufficient support in the record to conclude that the Provider's costs were reasonable under 42 U.S.C. § 1395x(v) and 42 C.F.R. § 405.402. Accordingly, the Board remands the Provider's ESRD exception request to HCFA to be evaluated separately from SGH and use the median CPT that was applicable to the exception requests during the fiscal periods at issue.

PRRB Decision 96-D35, pg. 13 (Provider Exhibit 2)(footnotes omitted).

On July 16, 1996, the HCFA Administrator declined to review the Board's determination.[21] In response to the Board's remand, HCFA issued a determination on January 2, 1997 (Provider Exhibit P-4). However, instead of using the Provider's actual CPT amounts when calculating the ESRD exception amount, HCFA used the CPT amounts proposed by the Provider as part of the pre-hearing negotiations in its letter of May 8, 1995. In other words, HCFA did not use actual CPT amounts in its ESRD calculation, but instead, based it upon the CPT amounts offered by the Provider as part of its withdrawn settlement proposal.

Since HCFA did not base its calculation on the Provider's actual CPT amounts, the Provider submitted a letter to HCFA on January 15, 1997, challenging HCFA's implementation of the Board's determination.[22] In a response dated February 26, 1997, HCFA stated that "we still have significant reservations about approving these exceptions considering the inefficiencies that may have occurred at the hospitals during the years 1981 to 1983. . .if the providers wish to appeal this decision, the applicable regulation is. . . "[23] (emphasis in original.) On June 12, 1997, the Provider appealed HCFA's January 2, 1997 determination.

The Board notes that in two (2) responses to the Provider, HCFA did not give any reasons or substantive arguments, other that its "significant reservations," for not complying with the Board's orders to use the Provider's actual costs, which the Board determined were reasonable.[24] Accordingly, the Board finds that HCFA did not comply with the Board's "Decision and Order" in PRRB Decision

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[21] Provider Exhibit P-3.

[22] See Provider Exhibit P-5.

[23] See Provider Exhibit P-6.

[24] The Board is referring to HCFA's January 2, 1997 determination and HCFA's February 26, 1997 response. See Provider Exhibits P-4, P-6.

96-D35, when it by refused to allow the Provider's actual CPT amounts when implementing the Board's determination.

The Board agrees with the Provider that although the Federal Rules of Evidence are not directly applicable to the current case, Rule 408 evidences the general common law principle that settlement offers do not have any force or effect outside the scope of the negotiation in which they are offered. As pointed out by the Provider and as described by the court in United States v. Contra Costa County Water District, 678 F.2d 90, 92 (9th Cir. 1982), the policy rationale which excludes an offer of settlement arises from the fact that the law favors settlements of controversies. The Board agrees that if an offer of a dollar amount by way of compromise were taken as an admission of liability, voluntary efforts at settlement would be chilled. Further, the Board believes that providers must continue to engage in pre-hearing settlement negotiations, without the fear that any offers or compromise positions extended prior to Board hearings, would be used to effect settlements after a Board hearing is held.

DECISION AND ORDER:

The Board concludes that when it remanded this case to HCFA, in Dec. 96-D35, HCFA in its letter of January 2, 1997[25], did not fully comply with the Board's determination. More specifically, instead of using the Provider's actual CPT amounts, which the Board determined were reasonable, HCFA used CPT amounts that were proposed by the Provider as part of a pre-hearing settlement offer, which for the reasons stated above, was improper.

Therefore, the Board orders the Intermediary to comply with its original determination in PRRB Dec. 96-D35. That is, the Intermediary is ordered to recompute the amounts due the Provider using its actual CPT amounts instead of the proposed CPT amounts used by HCFA in its January 2, 1997 determination.

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[25] Provider Exhibit P-4.

Board Members Participating:

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

Date of Decision: October 19, 1999

FOR THE BOARD:

Irvin W. Kues
Chairman